Prime Super

Insurance application/ variation form

Apply for, increase, maintain, decrease or cancel your insurance cover using this form. You can also change your occupation rating.

Please read this information before you complete the form

Please use pen and BLOCK letters to complete this form. Any boxes should be marked with 'X'. Please make sure you have completed all relevant sections.

Complete this form to:

- Apply for new cover or increase existing, Death only, Death & Total and Permanent Disablement (TPD) and/ or Income Protection
- Alter your Income Protection insurance waiting period
- Change your occupation rating.

Please complete all relevant sections of the form as follows. If you are:

- Applying for or increasing your current insurance
  - You must complete Sections 1 through to 4, 6, and Sections A through to G and Member Declaration (as directed on the form).
- Applying to change your Income Protection waiting period
  - If you would like to decrease your waiting period you must complete Sections 1 through to 3, 5, 6, and Sections A through G and Member Declaration (as directed on the form).
  - If you would like to increase your waiting period you must complete Sections 2, 5, 6 and and Member Declaration
- Change of occupation rating
  - Complete section 1, 2, 3 and Member Declaration (as directed on the form)

Please provide as much information as possible to assist us in processing your request. Before completing this form, ensure you read the relevant Member Guide and Product Disclosure Statement – Super, Health or Education Division (together referred to as the PDS or Member Guide) and your Member Statement to identify your current insurance cover with the fund.

1 Your Duty to take reasonable care

When you apply for insurance, you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Under the *Insurance Contracts Act 1984 (Cth)* there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it would have been in if the duty had been met. For example, the Insurer may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including:

- whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances.
- what the Insurer would have done if the duty had been met – for example, whether it would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

Guidance for answering the questions in this form

You are responsible for the information provided to the Insurer. When answering questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.

1 Your Duty to take reasonable care (continued)

- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Please note that there may be circumstances where the Insurer later investigates whether the information given to it was true. For example, it may do this when a claim is made.

Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances As any changes might require further assessment or investigation, it could save time if you let us or the Insurer know about any changes when they happen.

If you need help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know if you're having difficulty due to a disability, understanding English or for any other reason – we're here to help and can provide additional support.

2 Your personal details

Surname	Given names	Title

Member number	Email[1]

Date of birth (DD/MM/YYYY)	Mobile number	Phone number

Other/Previous names (if applicable)

Residential address

Town/Suburb/City	State	Postcode

Occupation

Employer

[1] Please ensure the email address provided is your personal address as we may send information of a sensitive and personal nature to it.

3 Changing your occupational ratings

(!) For Prime Super or Health Division members only

If you are in a low risk occupation, you may be entitled to be in White collar or Professional occupation category. These occupation categories offer a higher level of cover than the Standard occupation category. If you do not complete this section, or do not qualify for a White Collar or Professional rating, your occupational rating will be Standard.

What is your current occupation?

Your employment status Full-time Part-time Casual

What is the average number of hours you work in a week in your main occupation? hours

Please provide a brief description of your duties.

Please indicate below whether the following statements are correct.

White Collar

1. My usual work duties do not require me to perform duties of a manual nature. Yes No
2. My work duties are of a clerical, administrative or management nature. Yes No
3. My work duties are undertaken within an office environment for 80% of the time (excluding travel time between offices). Yes No

If you answered Yes to all questions, you are eligible to be in White collar occupation category.

Professional

In addition to the requirements set out under White Collar:

1. I hold a tertiary qualification relevant to my current occupation, or am a member of a professional institute, or am a senior member of my organisation's executive team. Yes No
2. I earn in excess of $100,000 per annum from my profession. Yes No

If you qualify for a White collar occupation category rating and answered Yes to statements 1 and 2 above, you are eligible for a Professional occupation category rating.

4 Applying for/Increasing your cover

1. Type of cover

Please indicate the life event under which you are applying for additional cover:

Death only (including terminal illness) Death & TPD Income protection

Do you want the cover received in this application to replace your existing cover? Yes No

(If you choose no, any cover received in this application will be in addition to your existing cover and any existing cover will be matched to your election. This means if you're applying for fixed cover any existing unitised cover will also be converted to fixed cover.)

2. Death only (including terminal illness) or Death & TPD

Please indicate whether you would like unitised or fixed cover (you cannot have a combination of both).

Please refer to Section 8 of the PDS and the Member Guide for information on unit based cover vs fixed cover.

Unitised cover **OR** Fixed cover

Note: You can apply for a maximum of $5 million Death only (including terminal illness) and $2.5 million for TPD insurance.

Unitised cover: Please insert the number of units of cover you require. (Refer to the PDS and Member Guide for details of the cover available).

Death only (including terminal illness) ______ units **OR**

Death & TPD cover ______ units

Fixed cover: Please insert the dollar amount of cover you require.

Death only (including terminal illness) $ ______ **OR**

Death & TPD cover $ ______

3. Income protection cover

What is your current gross monthly income? $ ______ (Please refer to the Member Guide for the definition of income)

How much cover do you require per month? $ ______ (You can only insure up to 85% of your monthly income. Maximum $30,000 per month.)

What waiting period would you like to apply for? (for new member IP applications only) 30 days* 60 days* 90 days

5 Changing your income protection waiting period

I want to reduce my waiting period to 30 days* 60 days*

I want to increase my waiting period to 60 days* 90 days

* Not available to Education division members

6 Insurance: member election to maintain insurance cover

A. In the event of future account inactivity

We are required to cancel your insurance cover if your account has been inactive for a continuous period of 16 months, and you have not made an election to maintain your insurance cover. Please refer to Section 8 of the relevant Member Guide for the division applicable to you for details on when this may occur.

By marking this box, you consent to maintaining your insurance cover in the event that your account becomes inactive for a continuous period of 16 months.

If you do not mark this box, we will be required to cancel all your insurance cover in the event your account is inactive for a continuous period of 16 months.

B. In the event that your member account balance is less than $6000

The Putting Members' Interest First legislation (PMIF), which took effect on 1 April 2020 requires the Fund to cancel insurance cover for members with balances of less than $6,000, unless you communicate to us in writing that you wish to keep your insurance cover.

By marking this box, you consent to maintaining your insurance cover in the event that your account balance is less than $6000.

If you do not mark this box, and have not elected to opt in to Default cover, we will be required to cancel all your insurance cover.

C. In the event that you are aged between 15 and 24 years

In addition, the PMIF legislation effective 1 April 2020 also requires that any new members joining Prime Super will not be allocated Default cover until they are at least age 25, unless:

– They apply to receive Default cover (subject to other rules of the super fund regarding when insurance cover is provided).

Marking this box also opts you in to receiving Default cover or request additional or increased cover over and above the Prime Super Default cover offering (subject to eligibility) even if you are under age 25 and/or have an account balance of less than $6,000.

7 Reducing/cancelling your existing cover

A. I want to reduce my current level of cover and require the following NEW units/level of cover. (Please note that the amounts you enter here will REPLACE your existing level of cover)

	Units of cover		Fixed cover	
Death only (including terminal illness)		units	$	
Death & TPD		units	$	
Income protection	Not applicable		$	per month

B. I want to opt-out of my insurance cover within Prime Super

I am a new Prime Super member and wish to opt-out of Default insurance. I understand that this means I will have no insurance in the Fund and any premiums I have paid will be refunded to my member account. I understand that by requesting this I am opting out of insurance from the inception of my account and that I will not be eligible to make any retrospective insurance claims. If at some point in the future I choose to take out insurance through Prime Super, my application will be subject to the standard underwriting process which may include the need to provide detailed health and medical information.

To be eligible for this option, you must cancel your cover within 60 days from the date on your Welcome Letter from Prime Super. If it is after the 60 day period, you can still cancel your default insurance cover but any premiums paid will not be refunded to your member account.

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7 Reducing/cancelling your existing cover (continued)

C. I want to cancel my insurance cover with Prime Super. Yes No

I have been a member of Prime Super for longer than 60 days and wish to cancel the following insurance I hold with Prime Super. I understand that any cancellation I request will only be effective once my application has been received by Prime Super.

Death only (including terminal illness)

Death & TPD

Income protection

Please go straight to Member Declaration.

The reduction/cancellation is valid from the date of the receipt of this form.

A Your Details

1. What is your: Height ______ cm or ______ ft/in Weight ______ kg or ______ st/lb

2. Have you smoked tobacco, e-cigarettes or any other substance in the last 12 months?

Yes No If Yes, please indicate what you smoke ______

What is the average you smoke? ______ per day or ______ per week or ______ per year

3. Do you drink alcohol? Yes No

If Yes, please provide the average number of standard drinks consumed:

______ per day or ______ per week or ______ per year

A standard drink is 375ml of mid strength beer, 100ml of wine or 30ml of spirits.

B Personal Statement

1. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing? Yes No
2. The next three questions are about life insurance*. You may have this cover as part of your super or you may have bought it separately.
   a) Apart from this application, do you have or are you applying for any other life insurance*? Yes No
   b) Have you ever had an application for life insurance* turned down, been asked to pay higher premiums or had exclusions or special terms applied? Yes No
   c) Are you claiming or have you ever claimed a benefit from any source, e.g, TPD benefit, from any superannuation fund, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits? Yes No

   * Life insurance includes cover which pays out if you die (Life cover), or if you get sick or seriously injured (Trauma, Total and Permanent Disability (TPD), Salary Continuance or Income Protection cover).

B Personal Statement (continued)

Question	Yes	No
3. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?		
a) Chest pain, high blood pressure, raised cholesterol or any heart/circulatory disorder?	Yes	No
b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition?	Yes	No
c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder?	Yes	No
d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)?	Yes	No
e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout?	Yes	No
f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition?	Yes	No
g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind?	Yes	No
h) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhea, or gastro where these were short, isolated episodes from which you have made a full recovery?	Yes	No
i) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus?	Yes	No
4.		
a) In the last five years have you taken any illegal drugs or drugs that weren't prescribed for you?	Yes	No
b) Has a doctor or healthcare provider told you to reduce or stop drinking alcohol, or have you received counselling or treatment for alcohol, substance or drug use?	Yes	No
c) Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
d) In the last 5 years have you engaged in any activity reasonably expected to having an increased risk of exposure to the HIV/AIDS virus? (This includes unprotected anal sex, sex with a sex worker or sex with someone you know, or suspect to be HIV positive)?	Yes	No
5. a) Apart from any condition you have already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis?	Yes	No
b) Apart from any condition you have already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years?	Yes	No
6. This question is about your family's medical history. As far as you know, has your mother, father, sisters or brothers had any of the following (please select all that apply):		
a) Heart or circulatory problems, stroke, cardiomyopathy, diabetes?	Yes	No
b) Depression or any other mental illness?	Yes	No
c) Cancer of any type?	Yes	No
d) Huntington's disease, muscular dystrophy, MS (multiple sclerosis), polycystic kidney disease, Parkinson's disease or any other inherited blood or neurological disorder?	Yes	No

B Personal Statement (continued)

Only complete if you answered **Yes** to any part **question 6** of **Section B – Personal Statement**

Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

7. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months? Yes No

Before answering these questions you may wish to check the Smart Traveller website: smarttraveller.gov.au

If Yes please provide details below:

Country/destination	Date of departure from Australia (if applicable)	Date of return/arrival in Australia	Reason for travel

For each **Yes** answer you must complete a corresponding questionnaire as noted in the column beside your **Yes** answer above. Proceed to relevant questionnaire in **Section C**.

C Questionnaire A – Pastimes

Only complete if you answered **Yes** to any part **question 1** of **Section B – Personal Statement**

1. Do you engage in any high risk sports or activities:
   a) Aviation (other than as a fare paying passenger on a commercial airline)? Yes No
   b) Underwater diving (scuba)? Yes No
      If Yes
      i) do you dive at more than 40 metres, or engage in cave, nitrox or wreck diving? Yes No
      ii) do you dive alone? Yes No
   c) Football of any code (other than touch or Oztag)? Yes No
   d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing? Yes No
   e) Trail bike or quad bike riding (including off road and dirt bike)? Yes No
   f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports, horse riding, abseiling, mountaineering or recreations involving heights? Yes No

If you have answered Yes to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

C Questionnaire A – Pastimes (continued)

At what level do you participate? (tick ✓ the appropriate box)

Recreational only (non competition)

Recreational with competition

Semi-professional/professional

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)? Yes No

If Yes, please provide full details

C Questionnaire B – Insurance history

Only complete if you answered **Yes** to any part **question 2** of **Section B – Personal Statement**

1. Apart from this application, do you have or have you recently applied for life, total and permanent disability, trauma, income protection or salary continuance on your life with TAL or any other insurance company? Yes No

Please complete the table below:

Insurance company	Type of cover	Insurance benefit	To be replaced?		Date commenced
		$	Yes	No	/ /
		$	Yes	No	/ /
		$	Yes	No	/ /

2. Have you ever had an application for life, total and permanent disability, trauma, or salary continuance on your life turned down, been asked to pay higher premiums or had exclusions or special terms applied? Yes No

   If Yes please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

C Questionnaire B – Insurance history (continued)

3. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits? Yes No

If Yes please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
	/ /	$	/ /
	/ /	$	/ /
	/ /	$	/ /

C Questionnaire C – Joint/musculoskeletal

Only complete if you answered **Yes** to any part **question 3e** of **Section B – Personal Statement**

1. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did your symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

5. Was an x-ray or scan taken? Yes No

   If Yes, please complete the details below:
   Date of your most recent test

   / /

   Details of results of tests taken:

6. Is the nature of your condition degenerative or a disc problem? Yes No

7. Are you still undergoing treatment or experiencing symptoms? Yes No

   If No, please complete the details below:
   Date your symptoms ceased

   / /

   Date your treatment ceased

   / /

C Questionnaire D – Mental health

Only complete if you answered **Yes** to any part **question 3f** of **Section B – Personal Statement**

1. Please provide details of your condition (doctor's diagnosis):

2. Please indicate the reason or cause by marking the appropriate box(es):

   Bereavement/family illness

   Marital problems

   Post natal

   Work related

   Other (please specify)

3. Date symptoms first commenced:

   / /

4. Have the symptoms ceased? Yes No

   If Yes, please provide the date symptoms ceased:

   / /

5. Have you taken or are you taking medication? Yes No

   If Yes, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)

6. Have you attempted suicide or had suicidal thoughts? Yes No

C Questionnaire C – Joint/musculoskeletal (continued)

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities? Yes No

   If Yes, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition? Yes No

   If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes No

    If Yes, please complete the details below:

    Name of doctor

    Doctor's Address

    State

    Postcode

    Phone number

    (   )

    Fax Number

    (   )

C Questionnaire D – Mental health (continued)

7. Have you ever been hospitalised? Yes No

   If Yes, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work? Yes No

   If Yes, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way? Yes No

   If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes No

    If Yes, please complete the details below:

    Name of doctor

    Doctor's Address

    State

    Postcode

    Phone number

    (   )

    Fax Number

    (   )

C Questionnaire E – High blood pressure/ Raised cholesterol

(!) Only complete if you answered **Yes** to any part **question 3a** of **Section B – Personal Statement**

1. Name of condition

   High blood pressure

   Raised cholesterol

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain? Yes No

   If Yes, please provide details, including dosage:

4. Are you taking regular medication for this condition? Yes No

   If Yes, please provide details, including dosage:

5. High blood pressure
   When was your last blood pressure reading?

   / /

   Was it considered to be well controlled, e.g. less than 140/90?

   Yes No Don't know

   Raised cholesterol
   When was your last cholesterol reading?

   / /

   What was the result of your last cholesterol reading?

   2.0 to 6.5 mmol 6.6 to 7.5 mmol

   7.6 or above Don't know

C Questionnaire F – Cysts, moles, sunspots or skin lesion

(!) Only complete if you answered **Yes** to any part **question 3g** of **Section B – Personal Statement**

1. Please provide type:

   Cyst

   Mole

   Sunspot

   Skin lesion

   Basal cell carcinoma

   Other (please specify)

2. Location of growth(s)

   Face/head

   Back/shoulder

   Chest/front

   Arm/leg

3. When was this?

4. Was/were the growth(s) removed? Yes No

   If Yes, please complete below:

   When was it removed?

   / /

   How many growths were removed?

   Method of removal:

   Frozen/burnt off

   Surgical/cut out

C Questionnaire E – High blood pressure/ Raised cholesterol (continued)

6. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

( )

Fax Number

( )

C Questionnaire F – Cysts, moles, sunspots or skin lesion (continued)

5. Was/were the growth(s) reported as cancerous (malignant)? Yes No

If Yes, were any further tests, investigations, treatments, follow up or re-excision required? Yes No

If Yes, please provide dates and details of further tests, investigations, treatments, follow up or re-excision: Yes No

6. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

( )

Fax Number

( )

D General health

ⓘ If you have answered **Yes** to any part of **Section B**, please complete the table below:

Details for question number:	Question ( )		Question ( )		Question ( )	
1. Name of injury, illness, condition or tests?						
2. Date symptoms first started?						
3. Date symptoms ceased (if applicable)?						
4. Are these symptoms singular, recurrent or ongoing?						
5. How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).						
6. Severity of symptoms? Please choose one of the following: mild, moderate, severe, never had symptoms, symptoms ceased.						
7. Did you take medication or have any other treatment for this condition? If Yes please give details of the medication/treatment.	Yes	No	Yes	No	Yes	No
8. Are you still on treatment, including medication?	Yes	No	Yes	No	Yes	No
9. Have you ever been off work as a result of this condition? If Yes, please indicate the total time off work.	Yes	No	Yes	No	Yes	No
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	Yes	No	Yes	No	Yes	No
11. Have you ever had an x-ray, scan or blood test for this condition?	Yes	No	Yes	No	Yes	No
12. Is your treating doctor different from your usual doctor? If Yes, please provide the doctor's name and contact details.	Yes	No	Yes	No	Yes	No

E Your personal information privacy

Your privacy as a member of Prime Super

The information you provide in this form is collected by and held for Prime Super by the fund Administrator, in accordance with the Australian Privacy Principles of the Privacy Act. Such information is usually disclosed to third parties, including the Insurer or medical consultant who may be involved with the assessment of this application, and is held by the fund Administrator and the Insurer. For further information about privacy or to obtain a free copy of our Privacy Policy, please visit our website primesuper.com.au or by contacting customer service on **1800 675 839**, write to us at Locked Bag 5103, Parramatta, NSW 2124 or email us at administration@primesuper.com.au.

Your privacy and the Insurer

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which TAL collects, uses, secures and discloses your personal and sensitive information is set out in the TAL Privacy Policy available at tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1300 209 088.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following.

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

! These sections must be completed in all circumstances

F Your personal information privacy

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion.

I permit the insurer (TAL) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my Duty of Disclosure as described in Section 1.

Yes No If Yes, I am contactable on the following number ____________

G Your doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Doctor's Address

Town/Suburb/City

State

Postcode

Phone number

Fax number

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's Address

Town/Suburb/City

State

Postcode

8 Member declaration

I have read the duty to take reasonable care in this Personal Statement and I am aware of the consequences of non-disclosure.

I understand that the duty to take reasonable care continues after I have completed this statement until my application for cover has been accepted by TAL Life Limited ABN 70 050 109 450 (TAL) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers)
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me

I agree to provide further medical authorities if requested.

I declare that:

- the answers to all the questions and the declarations in this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect TAL's decision to provide insurance
- I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance
- Being a Prime Super or Prime Super Health Division member, I acknowledge that if I am increasing my cover through a change in occupation category, then my cover is Limited Cover for the increased amount for 24 months and will remain until I have been in Active Employment for 30 consecutive days after the end of the initial 24 month period
- I agree to be bound by the terms and conditions set out in the Insurance Policy Document (between Prime Super and the Insurer)
- I have read and understood the "Your personal information privacy" in Section E. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section
- I have read and understand the obligations outlined in the "Your Duty to take reasonable care" in Section 1.
- I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Full name

Member signature

Date / /

Return this form to us via by mail or email

mail: Prime Super
Reply Paid 85860
PARRAMATTA NSW 2124
No stamp required

email: administration@primesuper.com.au
visit: primesuper.com.au
call: 1800 675 839

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