

Individual insurance application



Connelly Temple Super Savings Plan
Issued 11 March 2004

Asteron Portfolio Services Limited ABN 61 063 427 958
AFS Licence No 237905
Level 23 2 Market Street Sydney NSW 2000

Personal details

Please use block letters

Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other <input type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname	<input type="text"/>				Smoker <input type="checkbox"/>	Non-smoker <input type="checkbox"/>
Given name(s)	<input type="text"/>					
Date of birth	Day <input type="text"/>	Month <input type="text"/>	Year <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address	<input type="text"/>					
	<input type="text"/>					
	Postcode					
Phone	Home (<input type="text"/>)			Work (<input type="text"/>)		
Details	<input type="checkbox"/> New	<input type="checkbox"/> Death only	Amount	<input type="text"/>	\$ (If greater than \$500,000 a HIV test will be required)	
	<input type="checkbox"/> Increase	<input type="checkbox"/> Death and TPD	Amount	<input type="text"/>	\$ (If greater than \$500,000 a HIV test will be required)	
		<input type="checkbox"/> Income Replacement	Amount	<input type="text"/>	\$ pa (Up to 75% of salary)	
			Amount	<input type="text"/>	\$ pa (Up to 10% of salary for super contributions)	
Waiting period	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days				
Date joined SSP	<input type="text"/>					
Member number	<input type="text"/>					

How to complete this form

This form is designed to provide us with information concerning your health, occupation and pastimes so that a proper assessment can be made of the application for insurance on your life. In this regard:

- Each question in this form must be answered honestly and accurately with all relevant details being provided. If there is insufficient space then answers can be completed on another sheet of paper. The question number should be noted and you must sign and date this additional sheet of paper and attach it to the Application.
- Questions should be answered, including the details given, bearing in mind the notes on duty of disclosure and non-disclosure set out below. Any other information which could be relevant to our assessment of the application for insurance on your life should be disclosed.

All sections of this form must be completed

Insurance Contracts Act, 1984 (Please read carefully)

Duty of Disclosure

Before life insurance cover is provided on your life, you have a duty to disclose to the insurer every matter that you know or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to the Insurer before your cover is extended, varied or reinstated.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the Insurer;
- that is of common knowledge;
- that the Insurer knows or, in the ordinary course of its business, ought to know; and
- the requirement for disclosure of which is waived by the Insurer.

Please note that your Duty of Disclosure continues until we advise you of our decision in relation to the application for insurance on your life.

Non-Disclosure

If you fail to comply with your duty of disclosure and the Insurer would not have provided the insurance cover on your life on any terms if the failure had not occurred, the Insurer may avoid the cover within 3 years of the commencement of cover. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

Where the Insurer is entitled to avoid the cover, the Insurer may, within 3 years of entering into the cover, elect not to avoid it but to reduce the sum insured in respect of your life. The reduction in sum insured shall be calculated in accordance with a formula that takes into account the premium that would have been payable, if you had disclosed all relevant matters to the insurer.

Please note that the insurance described in this brochure is considered to be life insurance business for the purposes of the Insurance Contracts Act, 1984.

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1. Occupation details

1. Please give details of your current occupation, industry and length of time in this occupation.

Occupation Industry No. of years

2. What are the principal duties of your occupation to include % of time spent in each.

3. Do you intend to change your occupation or duties, employment status or take extended leave within the next 12 months?..... Yes No

If yes, details of change Date of change / /

4. What has been your insurable income over the past 12 months?

\$

Insurable income is the income earned by your own personal exertion (less expenses incurred in earning that income) before tax, which will cease if you are unable to work.

2. Insurance history

If you have existing insurance providing benefits similar to that being applied for, we will take this existing insurance cover into account when considering whether or not to accept this application.

1. Do you have, with us or any other company, or are currently applying for, any type of life, superannuation, sickness, accident, trauma, lump sum disablement or disability insurance? Yes No

If yes, provide details below:

Name of company	Type of insurance	Insured benefit	Date commenced	Is this policy to be discontinued/replaced?*
				* Yes <input type="checkbox"/> No <input type="checkbox"/>
				* Yes <input type="checkbox"/> No <input type="checkbox"/>
				* Yes <input type="checkbox"/> No <input type="checkbox"/>

* If you have indicated that it is your intention to replace insurance you currently have with the cover you are now applying for, the replacement cover under any policy we issue will only start when the insurance which is to be replaced is cancelled.

2. Has any application for insurance ever been refused, postponed, accepted with an increased premium or on modified terms? Yes No

If yes, please provide details.

3. Are you claiming or have you ever claimed benefits from any source eg an insurance policy, workers compensation, Social Security (including unemployment benefits), veterans affairs, sickness benefits, invalid pension, third party, etc..... Yes No

If yes please provide details below:

Date	Source	Reason	Outcome	Has this claim been settled/benefits ceased?
/ /				Yes <input type="checkbox"/> No <input type="checkbox"/>
/ /				Yes <input type="checkbox"/> No <input type="checkbox"/>
/ /				Yes <input type="checkbox"/> No <input type="checkbox"/>

3. Medical history

1. What is your height and weight? Height cm Weight kgs
2. Are you left handed or right handed? Left Right
3. Have you ever had any symptoms of, or treatment for, or received a diagnosis for:
- a. Heart attack, angina, chest pain or stroke?..... Yes No
 - b. Asthma, bronchitis, emphysema? Yes No
 - c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder?..... Yes No
 - d. Epilepsy, fainting attacks or fits of any kind? Yes No
 - e. Recurrent indigestion, ulcer, hepatitis (A,B,C or D)?..... Yes No
 - f. Cancer, tumour or growth of any kind or breast lumps (even if you have not seen a doctor)?..... Yes No
 - g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short-sightedness corrected by glasses) Yes No
 - h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs? Yes No
 - i. Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI or any regional pain syndrome or chronic fatigue? Yes No
 - j. Diabetes or abnormal blood sugar? Yes No
 - k. Psoriasis, eczema or any other disorder of the skin, or any allergic or chemical sensitivity reaction? Yes No
- If you answered yes to any of the conditions above please also complete a SPECIAL HEALTH QUESTIONNAIRE for each condition.
4. Other than those conditions stated in question 3, have you ever had any investigation or treatment for, or received a diagnosis for:
- a. High blood pressure, heart murmur or any other heart or blood vessel disorder?..... Yes No
 - b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder?..... Yes No
 - c. Tuberculosis or any other lung or respiratory system disorder?..... Yes No
 - d. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? Yes No
 - e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancreas?..... Yes No
 - f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? Yes No
 - g. Allergic or chemical sensitivity reaction? Yes No
 - h. Thyroid disorder or any other glandular disorder? Yes No
 - i. Any illness, injury or physical impairment not previously mentioned? Yes No
5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)? Yes No
6. Have you ever had or are you considering having a genetic test? Yes No
7. Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?..... Yes No

continued over ...

3. Medical history (continued)

If you answered yes, to any question in 4,5,6 or 7 please provide details in the following table:

Question number	Sickness, injury or tests	Test results	Date commenced	Time off work	Degree of recovery (%)	Date of last symptoms	Treatment received	Full name and address of doctor or hospital
			/ /			/ /		
			/ /			/ /		
			/ /			/ /		
			/ /			/ /		
			/ /			/ /		
			/ /			/ /		

8. Has your mother or father, or any brother or sister had breast, ovarian, colon or other cancer, diabetes, high blood pressure, heart problems, stroke, mental disorder, haemochromatosis, Huntington's disease, muscular dystrophy, Familial Adenomatous Polyposis, polycystic kidney or any other hereditary disease? Yes No

If you answered yes please provide details in the following table:

Family member (relationship to you)	Condition/illness (for cancer/heart disease, specify type)	Age of onset (approx)	Age of death (if applicable)

9. Females only
 a. Have you ever had an abnormal pap smear or breast ultrasound or mammogram? Yes No

If yes, please give details of test(s), result(s) and date(s)

- b. Are you currently pregnant? Yes No

If yes please advise due date

- Have there been or are there expected to be any complications? Yes No

If yes please provide details:

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4. Doctor's details

1. Name of your usual doctor

Postal address

Phone no. Fax number

2. How long have you been a patient of this doctor? Date of last consultation

Reason and outcome of last consultation

3. If you have been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address

Please provide date, reason and outcome of last consultation(s)

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4. Doctor's details (continued)

4. Other than already stated, during the last 3 years have you been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist or any other health care professional, been in hospital, had any operation or had any tests (eg x-ray ECG etc)? Yes No

If yes, please provide name and address of those consulted

Please provide date, reason and outcome of last consultation(s)

5. HIV

1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV? Yes No
2. In the last 3 years have you or do you intend to:
- a. Work as or engage in sexual intercourse with a prostitute? Yes No
- b. Engage in male to male anal sexual intercourse? Yes No
- c. Have sexual intercourse with an intravenous drug user? Yes No
- d. Have sexual intercourse with someone you suspect or know to be HIV positive? Yes No

If you have answered yes to any of the above, our underwriters will contact you for further information.

6. Special health questionnaire

1. Name of condition (exact diagnosis)
2. The cause
3. a. Describe symptoms
- b. Date symptoms commenced / / Date symptoms ceased / /
- c. How often do / did you have symptoms?

4. Have you ever been off work or your normal daily activities restricted in any way related to this condition? Yes No

Date	Duration	Reason/restriction
/ /		
/ /		
/ /		

5. Have you any residual, on-going effects or restriction in your daily activities? Yes No

If yes, please provide details

6. Have you taken regular or occasional medication for this condition? Yes No

If yes, advise names of medication(s), dosage(s), frequency

Name	Dosage	Frequency

- Are you still taking this medication? Yes No

continued over ...

6. Special health questionnaire (continued)

7. Have you had any other treatment for this condition? (eg physiotherapy, operation, alternative remedies) Yes No
8. Have you had any diagnostic investigations (eg scope, scan, x-rays, EEG, ECG etc)?..... Yes No
9. Have you ever been in hospital or received emergency treatment for anything related to this condition? Yes No
10. If yes to questions 7, 8 or 9 please advise details including date, type of treatment and tests

11. Details of your most recent visit to a doctor or other therapist for anything related to this condition.

Date	Doctor/therapist name & speciality	Reason for consultation, investigations, findings, advice
/ /		
/ /		
/ /		

12. Has further treatment been recommended for this condition? Yes No

If yes, please provide details

13. Does your usual doctor have details of this condition? Yes No

If no, please provide name and address of doctor who has full details.....

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7. Habits

1. Have you ever smoked tobacco or any other substance, or, in the last 12 months, used any nicotine replacement therapy product?..... Yes No

If yes, type (eg cigarettes, gum, patches?)

Daily quantity How many years? Date ceased? (if applicable)

Other

2. Do you drink alcohol?..... Yes No

Number of standard drinks per day Per week

Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? Yes No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol? Yes No

If you answered yes to question 3 or 4 please provide details in the following table.

Question no.	Date from	Date to	Type of usage (eg alcohol, heroin etc)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

8. Activities details

- In the last 12 months have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity eg, football, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (eg Qantas)?..... Yes No

If yes, please provide full details in the activities questionnaire below.

9. Activities questionnaire

1. Please describe the activity
2. How long have you been doing this activity? Yrs Mths
3. How many times per year/hours per week do you participate in this activity?
4. Give details of your experience and/or qualifications for this activity
5. What class of license do you hold?
6. Geographical location
7. Do you ever participate in this activity alone? Yes No
If yes give details

Underwater diving (please also complete questions 1 to 7 above)

- Type (scuba, hookah etc)
- Maximum depth of dives metres Average depth of dives metres
- Do you dive in wrecks, potholes or caves? Yes No
- Have you ever had a diving accident or diving sickness? (eg blackout, needed decompression etc) Yes No
- If yes, please give details:

Abseiling, caving, mountaineering, rock climbing

(please also complete questions 1 to 7 above)

- Activity
- Maximum altitude/depth Equipment used
- Maximum grade of climb Type (top roping etc)

continued over ...

10. Declaration

This must be completed in ALL instances.

I, the Life to be Insured, declare that all the answers to the questions and statements concerning myself set out in this form and any attachments, are true and complete and that I have provided details of all circumstances which might affect the risk of any insurance on my life. **If any answer or statement, either in this form or any attachment, is not in my handwriting, I declare that it has been correctly written down at my dictation.** Any company and any doctor who has been, or may hereafter be consulted by me, is authorised and directed by me to divulge at any time to Asteron Life Limited or any legal tribunal any information that may have been acquired with regard to myself.

I have read the duty of disclosure and the statement on non-disclosure set out in this Application Supplement and I understand the contents. I understand that the information contained in this form, and the application, is relied upon by Asteron Life Limited in assessing the risk of the insurance and that these forms, and any other forms I have completed form the basis of the contracts of insurance on the terms to be contained in the policy.

I consent to:

- the use of personal information about me by Asteron Life Limited and the Trustee (if I am applying for membership of The Connelly Temple Public Superannuation Fund) for the purposes of providing insurance whether to me or through my membership of the fund, including to assess and decide whether to agree to an application and on what terms (if any) or any amendment or increase of any insurance provided; to provide and manage the insurance cover relating to an application that has been accepted; to investigate and, if covered, manage and pay any claims made in relation to any insurance I have with you or other members of the Promina Group; and
- the disclosure of personal information about me by Asteron Life Limited and/ or the Trustee to, and obtaining personal information from, other parties for any of these purposes. These other parties include my adviser, other members of the Promina Group, loss assessors and claim investigators, other insurance companies and reinsurers, mailing houses, claims reference providers, research and telephone service providers, hospitals, medical and other health professionals, government departments, other trustees, legal and other professional advisers, and other service providers.

If I have disclosed personal information about any other person, I confirm that I am authorised to disclose personal information about that person and to consent to its use and disclosure (and obtaining of other personal information about that person) for the purposes above and from the parties above.

I acknowledge that I may request access to my personal information by contacting Asteron Life Limited or the Trustee (as may apply), although I may in some circumstance not be granted access to it.

Also, I acknowledge that if the personal information requested from me is not provided to you, then you may not be able to provide the insurance cover or pay any claims made.

Signature of the life
to be Insured

X

Date / /

11. Adviser's details

Adviser's name

Code no.

Do you expect that this insurance will replace all or part of an existing policy,
or one discontinued within the past 2 months?

Yes No

If yes please name the previous insurer(s)

Signature of
adviser

X

Date / /

12. Medical history authorisation by the Insured person

To Doctor

I authorise any doctor, hospital, clinic and other medical or related facility, or any other person who has attended me, to provide Asteron Life Limited with any and all information with respect to any sickness and injury, consultation, tests, prescriptions or treatment and copies of all hospital records.

I authorise the Health Insurance Commission to release to Asteron Life Limited, at their request, a copy of my medical history records.

I agree that a photocopy or fax of this authority should be considered as effective and valid as the original.

Name of Insured person

Signature of adviser

Date

Signature of Insured Person or their guardian (if under 18). ACT residents please note: If you are an ACT resident, this authority only authorises us to seek information from doctors and other medical personnel and facilities named in this form. You have the right to request a copy of any report we obtain from your doctor in the ACT under the Health Records (Privacy and Access) Act.

Forward form to: The Connelly Temple Super Savings Plan
GPO Box 1576 Sydney NSW 2001