ANZ Australian Staff Superannuation Scheme

ANZ Australian Staff Superannuation Scheme

Application for or to change Personal or Partner Section insurance cover over $1 million

When to use this form

Please complete this form if you would like to apply to:

- increase your death only or death and Total and Permanent Disablement (TPD) insurance cover to an amount of $1 million or more (please complete Steps 1, 2, 3 and 4); or
- decrease or cancel your death and TPD insurance cover or only your TPD cover (please complete Steps 1, 5 and 6)

in the Personal Section (Retained Benefit Account Section) or Partner (Spouse Contribution Account Section) of ANZ Staff Super.

If you would like to apply to increase your death only or death and TPD insurance cover to an amount less than $1 million, please complete the *Application for or to change Personal or Partner Section insurance cover up to $1 million* form available at **www.anzstaffsuper.com** or by calling ANZ Staff Super on **1800 000 086**.

Before making any changes to your insurance cover you should read the applicable Personal or Partner Section's Product Disclosure Statement (PDS) and In Detail booklets. You can download these documents at **www.anzstaffsuper.com** or request a copy by calling **1800 000 086.**

Please return your completed form to:
ANZ Staff Super
GPO Box 4303
Melbourne VIC 3001

If you need help

For assistance call ANZ Staff Super on **1800 000 086** or refer to **www.anzstaffsuper.com**.

Step 1 – Complete your personal details

Please print in black or blue pen, in uppercase, one character per box. A ✓

Title Mr ○ Mrs ○ Ms ○ Miss ○ Other ☐☐☐ Date of birth ☐☐ / ☐☐ / ☐☐☐☐

Given names

Surname

Postal address

Suburb State Postcode

Daytime Telephone Mobile

E-mail

Membership number Gender

Male ☐ Female ☐

☐ I authorise one of the Insurer's underwriting service representatives to contact me by phone if further information is required.

I can be contacted during the following times:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any business day

Between ☐☐ AM/PM and ☐☐ AM/PM

Please tick your preferred contact phone number: ☐ Home ☐ Work ☐ Mobile

Issued by ANZ Staff Superannuation (Australia) Pty Limited ABN 92 006 680 664 AFSL 238268 as Trustee for the ANZ Australian Staff Superannuation Scheme
ABN 83 810 127 567

Step 2 – Choose level of death only or death and TPD cover

I wish to: ✓ *(Select an option)*

- increase my death only insurance cover to $_____
- increase my death and TPD insurance cover to $_____

Please note:

1. **For Partner Section members, the minimum level of cover is $50,000. Please nominate your level of insurance cover in increments of $50,000.**
2. **You must complete the Personal Statement and Declaration (Steps 3 and 4) if you are applying for insurance cover or additional insurance cover in the Personal or Partner Section of ANZ Staff Super.**
3. Your application for insurance cover or additional insurance cover will not be effective until the Insurer has accepted your application.
4. The cost of your insurance cover is deducted from you account balance monthly or on exit from these Sections by redeeming some units.

Step 3 – Complete Personal Statement

Personal Statement

You are required to disclose in this Personal Statement every matter that you know or could reasonably be expected to know, which is relevant to the Insurer's decision whether to accept the risk of insuring your life on any terms.

Please answer all questions below.

1. Residence and travel details

1. Are you currently residing in Australia? ☐ Yes ☐ No

If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No

If **yes**, please proceed to question 3.

If **no**, please advise what type of visa you hold.

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

If yes, please complete the following:

Date of departure (dd/mm/yyyy)	Duration of stay	Destination(s) (country/cities)
/ /		

Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other Please specify if **other**

Step 3 – Complete Personal Statement (continued)

2. Insurance details

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including OnePath Life (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

If you have answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No

If **yes**, please provide name of company, alteration, date and reason (if known).

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

3. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? ☐ Yes ☐ No
3. aviation/flying, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Vehicle type Races p.a.

Engine size Max. speed (km/h) Class ☐ Recreational ☐ Amateur ☐ Professional

Step 3 – Complete Personal Statement (continued)

Scuba/skin diving

Average depth (m) Maximum depth (m) Dives per annum

Do you use explosives? Yes No Do you dive in caves or potholes? Yes No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a. Recreational Amateur Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.? Yes No

If **yes**, provide amount and details.

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? Yes No

If **yes**, state type and period held.

Do you intend to change the scope of your present licence? Yes No

Have you ever had an accident or been charged with violating CASA regulations? Yes No

Do you always use authorised landing areas? Yes No

Please complete the table below.

No. of hours flown	**Past 12 months**		**Future annual average**	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? Yes No

If **yes**, please provide frequency and details.

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.)..

b. On what basis do you partake in this activity? Recreational Amateur Professional

Step 3 – Complete Personal Statement (continued)

4. Personal details

1. What is your current height and weight? Height (cm) ☐☐☐ Weight (kg) ☐☐☐

2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance? ☐ Yes ☐ No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Chantix, etc.)? ☐ Yes ☐ No

If **yes**, please state **type(s)** used and **length of time** you have been using this.

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No

If **yes**, please state **type**, **quantity** per day and date ceased.

6. Do you consume alcohol? ☐ Yes ☐ No

If **yes**, please state how many standard drinks you consume **per** day (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No

If **yes**, please provide full details.

5. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, multiple sclerosis, cystic fibrosis, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to age 60 been diagnosed with diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, cervical cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).

Step 3 – Complete Personal Statement (continued)

6. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1.	Asthma?	Yes	No
2.	High blood pressure?	Yes	No
3.	High cholesterol?	Yes	No
4.	Diabetes?	Yes	No
5.	Stress, anxiety, depression or any other mental health condition?	Yes	No
6.	Back or neck pain, sciatica or any disorder of the spine or neck?	Yes	No
7.	Arthritis, shoulder or knee pain or any other disorder of the joints?	Yes	No
8.	Cyst, mole or skin lesion?	Yes	No

If you answered **yes** to any of questions 1 to 8 above, please complete the relevant questionnaire on pages 12 to 20.

9.	Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition?	Yes	No
10.	Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder?	Yes	No
11.	Thyroid or glandular trouble?	Yes	No
12.	Ulcers, bowel trouble or recurring indigestion?	Yes	No
13.	Epilepsy, fits or dizziness, fainting of any kind or persistent headaches?	Yes	No
14.	Alzheimer's disease or dementia?	Yes	No
15.	Kidney, liver, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis?	Yes	No
16.	Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?	Yes	No
17.	Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)?	Yes	No
18.	Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)?	Yes	No
19.	Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders?	Yes	No
20.	Any abnormality affecting eyesight, hearing or speech?	Yes	No
21.	Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment?)	Yes	No
22.	Anaemia, haemophilia or any other disease of the blood?	Yes	No
23.	Bowel, liver or gall bladder disease or hepatitis?	Yes	No
24.	Coughing of blood or passing of blood from the bowel or in the urine?	Yes	No
25.	Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason?	Yes	No
26.	Due to injury or illness have you ever been off work for more than seven consecutive days (**if not already mentioned**)?	Yes	No
27.	Do you now have any symptoms of ill health or disability?	Yes	No
28.	Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc)	Yes	No
29.	Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result?	Yes	No
30.	Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis?	Yes	No

Step 3 – Complete Personal Statement (continued)

31. Have you **ever** used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No

32. Females only

a. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No

b. Are you now pregnant? If yes, please advise due date (dd/mm/yyyy) / / ☐ Yes ☐ No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

33. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No

34. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition? ☐ Yes ☐ No

35. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

If you answered **yes** to any questions from 9–35, please complete the following table. If there is not enough space here, please provide details on page 21.

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Step 3 – Complete Personal Statement (continued)

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Step 3 – Complete Personal Statement (continued)

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Step 3 – Complete Personal Statement (continued)

7. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/medical centre

Phone Fax

No. and street

Suburb/town State Postcode

2. How many years have you been attending this doctor/medical centre? Years Months

a. When was your last visit to this doctor/medical centre?	b. Reason for check up or consultation?	c. Outcome including medication, treatment etc.	d. Degree of recovery?
			%

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? Yes No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		
	/ /		
	/ /		

Step 3 – Complete Personal Statement (continued)

8. Authorisations

Doctor's authorisation
To be completed and signed by the applicant.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of applicant

Date of birth (dd/mm/yyyy) / /

Signature of applicant

✗

Date (dd/mm/yyyy) / /

Address of applicant

Suburb/Town

State

Postcode

Membership number

Doctor's authorisation
To be completed and signed by the applicant.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of applicant

Date of birth (dd/mm/yyyy) / /

Signature of applicant

✗

Date (dd/mm/yyyy) / /

Address of applicant

Suburb/Town

State

Postcode

Membership number

Step 3 – Complete Personal Statement (continued)

9. Supplementary questionnaires

Asthma questionnaire
Only complete this questionnaire if you answered **yes** to question 1 in Section 5 of Step 3.

1. When did you have your first episode of asthma? Date (dd/mm/yyyy) / /
2. When was your most recent episode of asthma? Date (dd/mm/yyyy) / /
3. Approximately how many episodes have occurred in the last 12 months?
4. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ☐ Yes ☐ No

If **yes**, please provide details.

6. Have you sought medical treatment or advice for asthma? ☐ Yes ☐ No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

7. How has your doctor described your asthma? ☐ Mild ☐ Moderate ☐ Severe
8. Have you ever used any medication, including steroids? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

9. Have you ever been hospitalised due to asthma? ☐ Yes ☐ No

If **yes**, please provide details.

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Name and address of hospital.

10. Have you ever had lung function tests performed? ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	
/ /	

Step 3 – Complete Personal Statement (continued)

Blood pressure questionnaire
Only complete this questionnaire if you answered **yes** to question 2 in Section 5 of Step 3.

1. When was your high blood pressure first diagnosed? Date (dd/mm/yyyy) / /

2. What was your blood pressure reading at that time? Systolic Diastolic

3. Have you ever been treated by medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last blood pressure check? (dd/mm/yyyy) / /

7. What was your blood pressure reading at that time? Systolic Diastolic

8. How has your doctor described your blood pressure control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next blood pressure check-up? Date (dd/mm/yyyy) / /

Step 3 – Complete Personal Statement (continued)

Cholesterol questionnaire
Only complete this questionnaire if you answered **yes** to question 3 in Section 5 of Step 3.

1. When was your high cholesterol first diagnosed? Date (dd/mm/yyyy) / /

2. What were your cholesterol readings at that time? Cholesterol Triglycerides

3. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

4a. Have you ever used any medication? Yes No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? Yes No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last cholesterol check? (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol Triglycerides

HDL Cholesterol LDL Cholesterol

8. How has your doctor described your cholesterol control? Excellent Good Poor Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? Date (dd/mm/yyyy) / /

Step 3 – Complete Personal Statement (continued)

Diabetes questionnaire
Only complete this questionnaire if you answered **yes** to question 4 in Section 5 of Step 3.

1. When was your diabetes first diagnosed? Date (dd/mm/yyyy) / /

2. How is your diabetes controlled?

☐ Insulin – go to question 3

☐ Diet only – go to question 4

☐ Oral – list medications below and then go to question 4

3. How many times a day do you administer insulin?

☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

4. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details

5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

Condition	Date (dd/mm/yyyy)	Treatment
	/ /	
	/ /	

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

7. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

Step 3 – Complete Personal Statement (continued)

Mental health questionnaire
Only complete this questionnaire if you answered **yes** to question Section 5 of Step 3.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa or bulimia
- ☐ Depression including major depression or dysthymia
- ☐ Manic depressive illness or bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness
- ☐ Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

4. Are you currently symptom free? ☐ Yes ☐ No

If **yes**, please provide date(s) of last symptoms.

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details.

7. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

Step 3 – Complete Personal Statement (continued)

8. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details.

10. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details.

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

11. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details.

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / / Doctor(s) consulted

Step 3 – Complete Personal Statement (continued)

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in Section 5 of Step 3.

1. When did your back/neck condition first occur? Date (dd/mm/yyyy) / /

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed?

If **yes**, please provide details. ☐ Yes ☐ No

Tests	Date of tests (dd/mm/yyyy)	Results
	/ /	
	/ /	

6. Have you had recurrent or multiple episodes of the back/neck condition?

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition?

If **yes**, please provide details ☐ Yes ☐ No

9. Are your work duties or activities limited/affected by the condition?

If **yes**, please provide details ☐ Yes ☐ No

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind?

If **yes**, please provide details ☐ Yes ☐ No

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yyyy) / /

Step 3 – Complete Personal Statement (continued)

Arthritis/Joint questionnaire
Only complete this questionnaire if you answered **yes** to question 7 in Section 5 of Step 3.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other	☐	☐
Knee	☐	☐	If **other**, state which joint		

2. When did this condition first occur? Date (dd/mm/yyyy) / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? ☐ Yes ☐ No
If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition?
If **yes**, please provide the dates and duration. ☐ Yes ☐ No

8. Do you have any residual pain, limitation of movement or restriction of any kind?
If **yes**, please provide details ☐ Yes ☐ No

9. Are your work duties or activities limited/affected by the condition
If **yes**, please provide details ☐ Yes ☐ No

10. Are you still undergoing treatment
If **yes**, please provide details ☐ Yes ☐ No

11. Overall do you feel that your condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yyyy) / /

Step 3 – Complete Personal Statement (continued)

Cyst/Mole/Skin lesion questionnaire
Only complete this questionnaire if you answered **yes** to question 8 in Section 5 of Step 3.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each — Date of removal (dd/mm/yyyy) / /

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date of tests (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town — State — Postcode

Date of last consultation (dd/mm/yyyy) / /

Step 3 – Additional information/comments

About the Insurer

Insurance cover is provided by OnePath Life Limited ABN 33 009 657 176 AFSL 238 341 (the "Insurer") and subject to the terms and conditions of the insurance policy issued to ANZ Staff Superannuation (Australia) Pty Limited ABN 92 006 680 664 AFSL 238268 RSEL L0000543 (the Trustee of ANZ Staff Super) by the Insurer (the "Policy"). You should read the Product Disclosure Statement (PDS) for Personal or Partner Section members for a summary of the terms and conditions of the Policy. You can download your PDS from www.anzstaffsuper.com or contact ANZ Staff Super on 1800 000 086 if you would like a copy of the Policy.
Your application will be assessed by the Insurer and ANZ Staff Super will advise you of the outcome in writing.

The Insurer requires the information from this form to determine your application for cover or additional cover. The Insurer's Privacy Policy details how the Insurer manages personal information. It is available free of charge by calling OnePath Customer Services on 133 667 or may be downloaded from onepath.com.au/privacy-policy.

Duty of disclosure

The Trustee who enters into a life insurance contract in respect of your life has a duty, before entering into the contract, to tell the Insurer anything that it knows, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms.

The Trustee has this duty until the Insurer agrees to provide the insurance.

The Trustee has the same duty before it extends, varies or reinstates the contract.

The Trustee does not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is of common knowledge; or
- the Insurer knows or should know as an insurer; or
- the Insurer waives your duty to tell the Insurer about.

In order for the Trustee to comply with the duty of disclosure, we require you to tell us (the Trustee and Insurer) anything you know, or could reasonably be expected to know, that may affect the Insurer's decision to insure you and on what terms.

If you do not tell the Trustee and Insurer something that you know, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the Trustee entering into the contract to tell the Insurer something that we must tell the Insurer.

If you do not tell the Insurer something

If you do not tell the Insurer something

In exercising the following rights, the Insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, the Insurer may apply the following rights separately to each type of cover.

If you do not tell the Insurer or Trustee anything you are required to and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if you had told the Insurer and the Trustee, the Insurer may avoid the contract within three years of entering into it.

If the Insurer chooses not to avoid the contract, the Insurer may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if you had told the Insurer and the Trustee everything you should have. However, if the contract provides cover on death, the Insurer may only exercise this right within three years of entering into the contract.

If the Insurer chooses not to avoid the contract or reduce the amount of insurance provided, the Insurer may, at any time vary the contract in a way that places the Insurer in the same position it would have been in if you had told the Insurer and the Trustee everything you should have. However this right does not apply if the contract provides cover on death.

If the failure to tell the Insurer is fraudulent, the Insurer may refuse to pay a claim and treat the contract as if it never existed.

Step 4 – Declaration and consent

I have obtained, read and understand the insurance information in the PDS and In Detail booklets for Personal or Partner Section members (as applicable).

I have read and understand the questions in this Personal Statement.

I confirm the truth and accuracy of the responses given by me in this Personal Statement.

I understand and acknowledge that:

- this Personal Statement and any other evidence required by the Insurer will form the basis of my application for insurance cover or for an increased level of insurance cover; and
- the Insurer may require me to provide further additional medical or other evidence for the assessment of my application for insurance cover or for an increased level of insurance cover.

I have read the "Protecting members' privacy" statement on this form (see below).

I also I acknowledge that the Insurer's Privacy Policy details how the Insurer manages personal information and is available free of charge by calling 133 667 or may be downloaded from onepath.com.au/privacy-policy.

I consent to the collection, use, storage and disclosure of my personal information (including health information) as described in the "Protecting members' privacy" statement on this form and the Insurer's Privacy Policy.

I have read the "Duty of disclosure" and understand the consequences available to the Insurer if I fail to tell the Insurer any matter relevant to its decision to provide insurance. I understand that the duty of disclosure continues after I have completed this application until I am notified in writing that my application for insurance cover or additional insurance cover has been accepted.

I understand that if my application is accepted by the Insurer:

- the cover or additional cover I have applied for will not commence under the Policy until my application is accepted by the Insurer in writing and the increased premium for that cover will apply from that day;
- any existing cover will not be affected should my application be declined by the Insurer; and
- any insurance cover will be provided to me on the terms contained in the Policy as changed from time to time.

I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by the Insurer.

Signature

✗

Date

☐☐ / ☐☐ / ☐☐☐☐

Please return your completed form to: **ANZ Staff Super**
GPO Box 4303
Melbourne VIC 3001

Step 5 – Decrease or cancel insurance cover

I wish to: ✓ *(Select an option)*

- ◯ decrease my death only insurance cover to $_____
- ◯ decrease my death and TPD insurance cover to $_____
- ◯ cancel my death and TPD insurance cover
- ◯ cancel my TPD insurance cover but retain my death insurance cover.

Step 6 – Sign the form

Decrease or cancel insurance cover

I acknowledge that:

- I have read and understand the information provided in the PDS and In Detail booklets for the Personal and Partner Sections (as applicable) on insurance cover.
- I have read the "Protecting members' privacy" statement on this form (see below).
- I consent to the collection, use, storage and disclosure of my personal information as described in the "Protecting members' privacy" statement on this form.
- I understand that decreases in or cancellation of my cover will take effect when ANZ Staff Super receives this form (signed and dated) and premiums for my current level of cover will be deducted until that day. The reduced premium for any remaining cover will apply from that day.
- I understand that if I cancel or reduce my cover and wish to increase it in the future, I'll need to provide detailed health and other personal information which will be assessed by the Insurer and the cover or additional cover I have applied for will not commence under the Policy until my application is accepted by the Insurer.

Signature

✗

Date

☐☐ / ☐☐ / ☐☐☐☐

Please return your completed form to: ANZ Staff Super
GPO Box 4303
Melbourne VIC 3001

Protecting members' privacy

The Trustee, ANZ Staff Superannuation (Australia) Pty Limited, seeks to take all reasonable steps to protect members' privacy and the confidentiality of members' personal information.

ANZ Staff Super Administrator, Mercer, collects (on behalf of the Trustee) personal information directly from members and their employers. Sometimes information about you may be collected from other third parties such as a previous superannuation fund, your financial adviser or publicly available sources. We collect, use and disclose personal information about you to provide and manage your account in ANZ Staff Super and give you information about your super, or as required by super and tax laws.

If you do not provide the personal information requested or it is incomplete or inaccurate, we may not be able to manage your account properly and processing of transactions to, from or in relation to your account may be delayed.

Members' personal information is kept confidential, but may be disclosed by the Trustee or Scheme Administrator to third parties, such as ANZ Staff Super's actuary, Insurer, medical consultants, underwriter, legal adviser and auditor and other external service providers who are contracted to assist with administering members' benefits. It may also be disclosed where expressly authorised or required by law, for example to government agencies such as the Australian Taxation Office and Superannuation Complaints Tribunal. Members' personal information may also be disclosed to the Group Superannuation Department of ANZ for the purposes of administering members' benefits or resolving members' inquiries or complaints.

Members' personal information may be disclosed to related entities of ANZ Staff Super's Administrator located overseas (in particular, its wholly owned Global Operations Shared Services function in India) as part of the day-to-day provision of administration services.

The Trustee's Privacy Policy Statement contains more detail about how we deal with your personal information and information about how you can access and seek correction of information we hold about you. It also includes information about how you can lodge a complaint about how we've dealt with your personal information and how that complaint will be handled.

If you have any queries in relation to privacy issues, please contact:

ANZ Staff Super
GPO Box 4303
Melbourne VIC 3001
Telephone: 1800 000 086
Facsimile: 03 9245 5827
Email: anzstaffsuper@superfacts.com

The Trustee's Privacy Policy Statement is available on the ANZ Staff Super website www.anzstaffsuper.com or from ANZ Staff Super by calling 1800 000 086. You can also access ANZ Staff Super Administrator's privacy policy on the ANZ Staff Super website.

The Insurer's Privacy Policy details how the Insurer manages personal information. It is available free of charge by calling OnePath Customer Services on 133 667 or may be downloaded fron onepath.com.au/privacy-policy.

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