Personal Statement

Group risk insurance – ANZ Australia Staff Superannuation Scheme

31 October 2016

OnePath Life Limited (OnePath Life)
ABN 33 009 657 176 AFSL 238341
GPO Box 4129, Sydney NSW 2001

Group Risk Insurance Administration
Phone 1800 199 414
Email groupriskuw@onepath.com.au
Website onepath.com.au

Important notice

OnePath Life is the insurer in respect of a group insurance arrangement. You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by OnePath Life; or
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by OnePath Life.

OnePath Life requires this personal statement and other health information to assist us in making a decision on your proposed insurance cover.

This Personal Statement is confidential. Please refer to the Privacy Statement on page 10.

When fully completed, please seal in an envelope and send it to:

ANZ Staff Super, GPO Box 4303, Melbourne, VIC 3001.

Policy owner's duty of disclosure

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

The policy owner has this duty until OnePath Life agrees to provide the insurance.

The policy owner entering into the contract has the same duty before they extend, vary or reinstate the contract. The policy owner entering into the contract does not need to tell OnePath Life anything that:

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

If you do not tell OnePath Life something that you know, or could reasonably be expected to know, may affect OnePath Life's decision to provide the insurance and on what terms, this may be treated as a failure by the policy owner to tell OnePath Life something that it must tell OnePath Life.

If the policy owner does not tell OnePath Life something

In exercising the following rights, OnePath Life may consider whether different types of cover can constitute separate contracts of life insurance. If it does, OnePath Life may apply the following rights separately to each type of cover.

If the policy owner entering into the contract does not tell OnePath Life anything the policy owner is required to, and OnePath Life would not have provided the insurance or entered into the same contract with the policy owner if they had told OnePath Life, OnePath Life may avoid the contract within 3 years of entering into it.

If OnePath Life chooses not to avoid the contract, it 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 the policy owner had told OnePath Life everything they should have. However, if the contract provides cover on death, OnePath Life may only exercise this right within 3 years of entering into the contract.

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

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

Please ensure all applicable questions are fully answered. Your duty of disclosure applies even after your application is completed and until the insurer has assessed and accepted your application for insurance cover or an increase in cover.

Type of Fund/Plan – Voluntary Group Salary Continuance Plan

☐ I want to apply to buy voluntary salary continuance insurance in this Plan. I understand that premiums will be deducted from my Superannuation Guaranteed Contribution account.

☐ I confirm that I am currently working more that 20 hours per week, which is the eligibility requirement to apply for this insurance cover.

Name of Fund/Plan: ANZ Australian Staff Superannuation Scheme

Name of Intermediary: Mercer Australia

Type of cover

☐ Voluntary Group Salary Continuance (Monthly Benefit)

Amount of benefit/cover

$

1. Personal details

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other ☐

Surname

First names(s)

Date of birth (dd/mm/yyyy) / / Male ☐ Female ☐

Occupation

Occupation duties (time spent each duty)

Member No. Work Phone No.

Salary No.

2. 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**

3. 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.

4. Occupation details

1. What is your usual occupation?

2. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed.
Sedentary/administration (e.g. filing, computer work, answering telephone, reception duties, etc.)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)		
Manual work – heavy (e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)		

3. How many hours (on average) do you work per week?

4. What is your current annual income earned through personal exertion, before tax, and including superannuation contributions, but after deduction of business expenses? .....$ ☐☐,☐☐☐,☐☐☐

5. Do you have more than one occupation? ☐ Yes ☐ No

If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s):

5. 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

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,** give details.

_____

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

6. Personal statement

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.

If you are required to a have a full medical examination, go to Section 9 on page 9.

7. 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).

8. 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 the conditions in bold above, please complete the relevant questionnaire on pages 11 to 19.

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

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

36. In the past 5 years have you:

- had sex without using a condom with a person you know or suspect to be either HIV positive or who uses non prescribed drugs intravenously
- had sex without using a condom with a sex worker or as a sex worker
- had anal intercourse without using a condom (except with someone whom you have been in a monogamous relationship for five years or more)? ☐ Yes ☐ No

If you answered **yes** to question 36 a private and confidential questionnaire will be sent to you.

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 20.

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	

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

9. 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.
	/ /		
	/ /		
	/ /		
	/ /		

10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement (including all questionnaires in this form that appear after this declaration) signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- I have read the Privacy Statement at part 12 of this form (below). (OnePath's Privacy Policy details how we manage personal information. It is available free of charge by calling 02 9234 8111 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 Privacy Statement on this form (see Section 12).
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I understand my duty of disclosure and the remedies available to OnePath Life if I fail to comply with my duty of disclosure under the Insurance Contracts Act 1984. I understand that my duty of disclosure continues after I have completed this application until I am notified in writing that my application for insurance has been accepted.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to OnePath Life in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Product Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.
- 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 OnePath Life.

Signature of life insured/applicant ✗ Date (dd/mm/yyyy) / /

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) or any organisation duly appointed by OnePath Australia.

A photocopy (or similar) of this authorisation shall be as valid as the original.

My name:

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

Signature of applicant:

✗

Date (dd/mm/yyyy) / /

Address:

State Postcode

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) or any organisation duly appointed by OnePath Australia.

A photocopy (or similar) of this authorisation shall be as valid as the original.

My name:

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

Signature of applicant:

✗

Date (dd/mm/yyyy) / /

Address:

State Postcode

The Insurer's Privacy Statement

In this section 'we', 'us' and 'our' refers to OnePath Life Limited and other members of the ANZ Group. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information. Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/privacy-policy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information to certain third parties.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information include:

- an organisation that assists us and/or ANZ to detect and protect against consumer fraud;
- any related company of ANZ which will use the information for the same purposes as ANZ and will act under ANZ's Privacy Policy;
- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner;
- regulatory bodies, government agencies, law enforcement bodies and courts.

We will also disclose your personal information in circumstances where we are required by law to do so.

Examples of such laws are:

- The *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- There are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

ANZ may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/privacy-policy

Life risk – sensitive information

For life risk products, where applicable, we may collect health information with your consent. Your health information will only be disclosed to service providers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us or ANZ personal information about someone else, please show them a copy of this document so that they may understand the manner in which their personal information may be used or disclosed by us or ANZ in connection with your dealings with us or ANZ.

Privacy Policy

Our Privacy Policy contains information about:

- when we or ANZ may collect information from a third party;
- how you may access and seek correction of the personal information we hold about you; and
- how you can raise concerns that we or ANZ has breached the Privacy Act or an applicable code and how we and/or ANZ will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing:

GPO Box 75
Sydney NSW 2001
Email: privacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667.

More information can be found in our Privacy Policy onepath.com.au/privacy-policy

Overseas recipients

We or ANZ may disclose information to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in ANZ's Privacy Policy at anz.com/privacy

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13. Supplementary questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in Section 8.

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
/ /	
/ /	
/ /	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in Section 8.

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.

Tests performed	Date (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) / /

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) / /

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in Section 8.

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

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

HDL Cholesterol ____ LDL Cholesterol ____

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

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	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? ..... Date (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) / /

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in Section 8.

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

If **yes**, please provide details.

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) / /

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in section 8.

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.

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

If **yes**, please provide details.

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

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in Section 8.

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? ..... ☐ Yes ☐ No

If **yes**, please provide details.

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

6. Have you had recurrent or multiple episodes of the back/neck condition? ..... ☐ Yes ☐ No

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? ..... ☐ Yes ☐ No

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

9. Are your work duties or activities limited/affected by the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ..... ☐ Yes ☐ No

If **yes**, please provide details.

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) / /

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in Section 8.

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. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

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

8. Do you have any residual pain, limitation of movement or restriction of any kind? ..... ☐ Yes ☐ No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? ..... ☐ Yes ☐ No

If **yes**, please provide details.

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) / /

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in Section 8.

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 (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) / /

Additional information/comments