Group Risk

Personal Statement

July 2019

Emplus, a division of AMG Super
ABN 300 993 205 83
PO Box 3528, Tingalpa DC QLD 4173

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

Important notice

OnePath Life is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you, and you wish to apply for more than $1,000,000 of Death only or Death and TPD cover, Group Salary Continuance cover of more than $4,000 per month and/or Group Salary Continuance cover with to age 65 benefit period, or where specifically requested by OnePath Life, and:

- you are proposing to become an insured member under the policy and your insurance cover is subject to assessment by OnePath Life
- you are an existing insured member and your insurance cover (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 in the Product Disclosure Statement. You may wish to seal it in an envelope and send it to:

Emplus, PO Box 3528, Tingalpa DC QLD 4173

The Trustee's 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.

You must disclose relevant information
You must tell the Insurer anything you know, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms. If you do not do so, this may be treated as a failure by the Trustee to tell the Insurer something that the Trustee must tell the Insurer.

If you provide relevant information to the Trustee rather than the Insurer, The Trustee will provide the information you give the Trustee to the Insurer. The Trustee will do this so that you comply with your obligation to provide relevant information to the Insurer.

If the Trustee does 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 the Trustee does not tell the Insurer anything the Trustee is required to, and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if the Trustee had told the Insurer, the Insurer may avoid the contract within 3 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 the Trustee had told the Insurer everything it should have. However, if the contract provides cover on death, the Insurer may only exercise this right within 3 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 the Trustee had told the Insurer everything it 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.

Postal address
Emplus
PO Box 3528, Tingalpa DC QLD 4173
Tel 1800 336 911
Fax 07 3899 7299

Website
www.emplus.com.au

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OnePath

Type of Fund/Plan

Please tick the appropriate box ☐ Group Life ☐ Group Salary Continuance

Policy number (if known)

Name of Fund/Plan

Type of Cover **Amount of required benefit/cover**

☐ Death Only $, ,

☐ Death and Total and Permanent Disablement (TPD) $, ,

☐ Group Salary Continuance (monthly benefit) $, ,

Details of Group Salary Continuance Cover:

Waiting period ☐ 30 days ☐ 60 days ☐ 90 days

Fixed term periods (if applicable) ☐ 2 years ☐ 5 years

1. PERSONAL DETAILS

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

Surname

Given name(s)

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

Residential address (cannot be a PO Box)

Street

Suburb State Postcode

Country

Home Phone Work Phone Mobile Phone

Email

May one of our underwriting staff or OnePath authorised service providers contact you by phone if we require more information? ☐ Yes ☐ No

If yes, when is the most convenient day(s) and time and on which phone number?

Days Time From To Phone ☐ H ☐ W ☐ M

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) (Countries/cities)

Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other (please specify)

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) | Max. depth (m) | Dives p.a

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 Crew	Passenger	Future annual average 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.). ☐ Yes ☐ No

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 above, please complete the relevant questionnaire in Section 13.

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, 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. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment?) ... ☐ 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. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ... ☐ Yes ☐ No
30. 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

31.a. Is the combined total of your existing insurance(s) detailed in section 3 Question 1, and any new insurance you are applying for with OnePath Life, more than any one of the following; $500,000 Death; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? ... ☐ Yes ☐ No

If you answered **yes** to question 31(A) please proceed to 31(B), otherwise continue to question 32.

31.b. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (please do not include any test conducted solely for the purpose of medical research study where the result of the test has not been or will not be, provided to you)... ☐ 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 22.

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 | 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 | 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 | Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

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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 | 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 | 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 | 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 signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- 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 arrangements 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 have read and understand the Duty of Disclosure section above, and I have not withheld any information that may affect the Insurer's decision as to whether to accept my application. I understand that the Duty of Disclosure continues after I have completed this form until my application has been accepted by the Insurer and confirmation is issued in writing.
- I have read the Emplus Super's Privacy statement contained in the Member guide and OnePath Life's Privacy statement in this form, and authorize the collection, use, storage and disclosure of my personal information (including health and other sensitive information) for the purpose of this application as described in OnePath Life's Privacy Policy which is available at OnePath Life's website onepath.com.au/insurance/privacy-policy or by calling Customer Services on 133 667. If I have provided information about another person in this application (for example a beneficiary or life insured), I declare that I have the consent of that person to do so. I understand that OnePath Life require me to inform the person concerned that I have done so and direct them to the Privacy Policy which is located at onepath.com.au/insurance/privacy-policy.
- 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 , that I have received, read and understood a copy of the Emplus Super's Disclosure Statement(s) (PDS) and information on for the type (s) of cover for which I am applying.
- I acknowledge that insurance cover will not commence until I am notified of acceptance in writing.
- I acknowledge that if this application is accepted by OnePath Life, any exclusion or loading imposed as part of the acceptance of this application will be confirmed in writing and will apply to the amount of cover accepted by OnePath Life.
- I acknowledge that if this application is declined, any of my existing cover on the date of this application will continue on same terms, including but not limited to any pre-existing condition exclusion(s).
- I acknowledge that any information received by OnePath Life in relation to this application may be used when assessing my existing or future claim, and may operate as an exclusion to my claim. This is irrespective of whether this application is accepted or declined.
- I understand that I may cancel my existing cover at any time.

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

11. AUTHORISATIONS

Doctor's authorisation

To be completed and signed by the life insured.

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 life insured

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

Signature of life insured

Date (dd/mm/yyyy)

Address of life insured

Suburb/Town

State

Postcode

Policy number

Doctor's authorisation

To be completed and signed by the life insured.

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 life insured

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

Signature of life insured

Date (dd/mm/yyyy)

Address of life insured

Suburb/Town

State

Postcode

Policy number

12. PRIVACY STATEMENT

Privacy

In this section 'we', 'us' and 'our' refers to OnePath Life Limited. 'You' and 'your' refers to policy owners and life insureds.

Any reference to your personal information includes any health or other sensitive information we may hold about you.

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/insurance/privacy-policy

We may disclose your personal information to certain third parties as outlined below.

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 to detect and protect against consumer fraud
- 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 advisor)
- the policy owner (or parties acting on behalf of the policy owner)
- regulatory bodies, government agencies, law enforcement bodies and courts
- our related companies (members of Zurich Insurance Group Ltd group), including for carrying out any group business functions
- organisations, including those in an alliance with us or our related companies, to distribute, manage and administer our products and services, carry our business functions, enhance customer service and undertake analytics activities.

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
- the disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

We 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/insurance/privacy-policy

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 personal information about someone else, you must show them a copy of this document or our Privacy Policy available at onepath.com.au/insurance/privacy-policy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

Privacy Policy

Our Privacy Policy contains information about:

- when we 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 have breached the Privacy Act or an applicable code and how we 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: insuranceprivacy@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 13 36 67.

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

Overseas recipients

We may disclose your personal 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 OnePath Life's Privacy Policy at onepath.com.au/insurance/privacy-policy

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 did you have 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 the details.

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

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

Name of doctor/health professional

Address

Suburb/Town State

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 commenced (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) ..... Date (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

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

If **yes**, please provide details.

Tests performed	Date commenced (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 3 in Section 8.

1. When was your high cholesterol 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? ..... ☐ I'm on an insulin pump ☐ 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 commenced (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 bipolar 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. analgesics, anti-inflammatory drugs, immobilisation)

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