Insurance Cover Application Form

All questions on this form are relevant as to whether or not Hannover Life Re of Australasia Ltd (HLRA) offers you insurance and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dash is not acceptable. Please use Section I, or attach additional pages, if there is insufficient room to provide full information for any question.

Where the words "we", "us" and "our" appear they refer to the insurer, Hannover Life Re of Australasia Ltd (ABN 37 062 395 484).

Before signing this Insurance Cover Application Form, please ensure that you have read the relevant Product Disclosure Statement and current Emplus Personal Super Insurance Guide.

Your duty of disclosure

Before you enter into a life insurance contract with us, whether on your own behalf or on behalf of another person, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure and the terms of that insurance.

This duty of disclosure continues after you have completed this statement until the cover has been issued by us.

The same duty applies before you extend, vary or reinstate the contract.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If the insurance is for the life of another person and that person does not tell us everything he or she should have, this may be treated as a failure by you to disclose.

If you or the person who becomes the life insured under the policy do not tell us something

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

If you or the life insured does not tell us something that you or they are required to tell us, and we would not have insured you on the same terms if we had been told, we may avoid your cover within 3 years of issuing it.

If we choose not to avoid your cover, we may, at any time, reduce the amount for which you or the life insured have been insured. This would be worked out using a formula that takes into account the premium that would have been payable if you and the life insured had told us everything you should have. However, for death cover, we may only exercise this right within 3 years of issuing the cover.

If we choose not to avoid the cover or reduce the amount for which you or the life insured have been insured, we may, at any time vary the cover in a way that places us in the same position we would have been in if we had been told everything we should have been told. However, this right does not apply to death cover.

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

AMOUNT OF COVER

Please select the application type: ☐ New application ☐ Increase to existing cover

Amount of cover (including existing cover) you are applying for:

Death Cover $

Total & Permanent Disablement (TPD) $

Please note that the amount of TPD cannot exceed that of Death Cover

Group Income Insurance (GIP) $ per month

Benefit Period: ☐ 2 years ☐ 5 years ☐ To age 65

Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days

Emplus, a division of AMG Super
ABN 300 993 205 83
PO Box 3528, Tingalpa DC Qld 4173
Phone: 1800 336 911 or 07 3899 7200 | Fax: 07 3899 7299 | Email: info@emplus.com.au

Issued by the trustee:
Equity Trustees Superannuation Limited
ABN 50 055 641 757
AFS Licence No 229757
RSE Licence No L0001458

Section A: PERSONAL DETAILS AND INSURANCE HISTORY

1. Full Name:

Sex: ☐ Male ☐ Female Date of Birth:

Address (H):

Suburb: State: Postcode:

Phone (H): Mobile:

Email:

Please tick your preferred contact method and most convenient time to contact you:

☐ Phone ☐ Mobile ☐ Email ☐ AM ☐ PM

2. Occupation:

3. Annual Salary: $

Please tick No or Yes to each of the following:

4. Has Death, TPD, GIP, Disability, Accident and Sickness or Superannuation cover on your life ever been declined, deferred or withdrawn from any insurance Company or accepted with a loading, exclusion or other than as applied? No ☐ Yes ☐

Please provide full details *(including dates, name of company and reason)*:

5. Have you ever made a claim for disability benefits under an Insurance, Superannuation or Workers' Compensation policy, Veteran's Affairs or under Social Security (including CTP and public liability)? No ☐ Yes ☐

Please provide full details *(including dates, cause of claim, type of benefit and amount paid, claim number and insurance company)*:

6. Other than this application, do you have or are you applying for any Death, TPD, Disability Income or GIP with any other company? No ☐ Yes ☐

Please provide full details:

Company	Type of Policy	Benefit Amount	Owner	To be Replaced
				No ☐ Yes ☐
				No ☐ Yes ☐
				No ☐ Yes ☐

Section B: HABITS, ACTIVITIES AND RESIDENCE

Please tick No or Yes to each of the following:

1. Do you drink alcohol?

☐ No ☐ Yes > If Yes, please state type and weekly quantity

2. Have you smoked in the past 12 months?

☐ No ☐ Yes > If Yes, please state form and daily quantity

3. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a recognised airline), motor racing of any kind, diving, football, parachuting, hang gliding, etc.?

☐ No ☐ Yes > If Yes, please provide full details

4. Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's visa?

☐ No ☐ Yes > If No, please provide full details

5. Do you intend travelling overseas in the immediate future (i.e. next 2 years)?

☐ No ☐ Yes > If Yes, please provide full details (where, when, duration and reason)

Section C: MEDICAL STATEMENT

1. Your Doctor's Details

Name:

Address:

Suburb: State: Postcode:

Phone:

2. Details of last medical consultation, including doctors, physiotherapists, chiropractors or ANY other health professional.

Date	Health Professional	Address	Reason	Outcome/Result

3. Please state your height cm weight kg

Please tick No or Yes to each of the following:

4. Within the **LAST THREE YEARS** have you, other than advised above:

a. Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, psychotherapist or other health care professional (naturopath, etc) or been in hospital or been advised to have an operation? No ☐ Yes ☐

b. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection? No ☐ Yes ☐

5. Have you EVER had an ECG, x-ray, transfusion, mammogram, surgery or any other investigation? No ☐ Yes ☐

6. Have you EVER had any blood tests which reveal an abnormality, e.g. raised blood sugar, liver function or renal function results, or anaemia, etc? No ☐ Yes ☐

7. Do you contemplate seeking any medical examination, advice, treatment or surgery in the future? No ☐ Yes ☐

Please provide full details for all YES answers above (if more space is required, please go to section I).

Dates From	To	Name & address of Doctor or Hospital, Clinic, etc	Conditions. Medications. Treatment & Time off Work	Recovery %
	to			
	to			
	to			

8. Have you **EVER** received any advice or treatment for:

a.	High blood pressure, raised cholesterol, stroke or circulatory disorder?	No ☐	Yes ☐
b.	Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?	No ☐	Yes ☐
c.	Asthma, bronchitis or other lung complaint?	No ☐	Yes ☐
d.	Diabetes?	No ☐	Yes ☐
e.	Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?	No ☐	Yes ☐
f.	Hepatitis or other liver or gall bladder disease?	No ☐	Yes ☐
g.	Back, neck or knee complaint or any disorder of the joints, bones or muscles (e.g. gout, arthritis)?	No ☐	Yes ☐
h.	Kidney or bladder disease, renal colic, stones or blood in the urine?	No ☐	Yes ☐
i.	Depression, anxiety, stress, mental or nervous condition, or chronic fatigue?	No ☐	Yes ☐
j.	Cancer, tumour, melanoma, sunspots or growth of any kind?	No ☐	Yes ☐
k.	Eczema, dermatitis, psoriasis or any other skin condition?	No ☐	Yes ☐
l.	Tinnitus, hearing loss or any defect in hearing, sight or speech?	No ☐	Yes ☐
m.	Anaemia, leukaemia, haemophilia or other blood disorder?	No ☐	Yes ☐
n.	Thyroid or prostrate disorder, any disorder of the reproductive organs, or sexually transmitted disease?	No ☐	Yes ☐
o.	Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	No ☐	Yes ☐
p.	Multiple sclerosis, epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks?	No ☐	Yes ☐
q.	Any other physical impairment, congenital abnormality, deformity or symptoms of ill health, illness or injury?	No ☐	Yes ☐

Females only:

r.	Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal pap smear, etc.)?	No ☐	Yes ☐
s.	Have you ever had any complications of pregnancy or childbirth?	No ☐	Yes ☐
t.	Are you currently pregnant?	No ☐	Yes ☐
	If Yes, what is the expected delivery date? ☐ / ☐ / ☐		
u.	Have you ever had a breast lump (even if you have not seen a doctor about it)?	No ☐	Yes ☐

Please provide full details for all YES answers below (if more space is required, please go to Section I).

Specific Condition	Question Number___	Question Number ___	Question Number ___
1. Date symptoms first started and description of symptoms?			
2. What was the condition and which part of the body was affected?			
3. What was the medical diagnosis including results of x-rays and investigations?			
4. What was the frequency (daily, weekly, etc) of attacks or symptoms?			
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			

6. How long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide date and duration of your stay.			
8. What advice/treatment did you receive?			
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
10. When did you last suffer from any symptoms?			
11. Degree of recovery (%).			
12. Please supply name and address of all doctors or hospitals or other consultants.			

Section D: FAMILY HISTORY

Please tick No or Yes

1. Have any of your parents, brothers or sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer, Huntington's Disease or any other hereditary disease? No ☐ Yes ☐
   Please provide full details (including age at diagnosis and age at death (if applicable)):

Section E: QUESTIONS IN RELATION TO AIDS

Please tick No or Yes to each of the following:

1. Have you EVER been infected with the virus which causes AIDS (Human Immunodeficiency Virus)? No ☐ Yes ☐
2. Have you EVER sought or are you expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV? No ☐ Yes ☐
3. Have you EVER:
   i. Injected yourself with any drug not prescribed by a medical practitioner? No ☐ Yes ☐
   ii. Worked as or engaged in sexual activity with a sex worker? No ☐ Yes ☐
   iii. Engaged in sexual activity with someone you know or suspect to be HIV positive? No ☐ Yes ☐
4. Have you engaged in male to male anal sexual intercourse (except in a relationship between you and only one other person where neither of you had sex with anyone else in the past 5 years)? No ☐ Yes ☐

Please note – if any of these questions are answered 'Yes', we will send you a separate questionnaire.

Section F: QUESTIONS IN RELATION TO COVID-19

Please tick No or Yes to each of the following:

1. Have you returned from overseas in the last 2 weeks? No ☐ Yes ☐
2. Have you had close contact with a person confirmed or suspected to have COVID-19 in the last 14 days? No ☐ Yes ☐
3. Have you been diagnosed with COVID-19 or is it likely that you have this disease? No ☐ Yes ☐
4. Have you suffered from one of the following symptoms in the last 14 days: sore throat, runny nose, fever of 38° celsius or above, cough, shortness of breath, difficulty breathing, chest pain or unexplained fatigue, aches and pains? No ☐ Yes ☐
5. Have you been advised to undergo a test for COVID-19 or do you currently await the result from a test for COVID-19? No ☐ Yes ☐

If 'Yes' to any of the above, please provide further details:

Section G: OCCUPATION DETAILS

1. Name of Employer: Phone number:

Employer's Address:

Suburb: State: Postcode:

2. How long have you been in your current occupation? years months

Are you a Permanent or Casual employee?

How many hours do you work per week?

3. Are you self-employed *(this means shareholder or employee of own company, sole trader or partner)*? No Yes

If Yes, please provide full details:

How long have you been self-employed? years months

What percent of the business do you own? %

Name of business:

Address of business:

Suburb: State: Postcode:

How many employees do you have (excluding yourself)?

4. What are the main duties of your occupation?

Duties (e.g. office work, sales, supervision, manual)	% of Time	Location (e.g. office, on-site, travel, at home)	% of Time
	100%		100%

5. Do you hold any professional/trade qualifications? No Yes

If Yes, please provide full details:

Type	Name of Institution where Obtained

6. Has your main occupation, employer or employment status changed in the last 3 years? No Yes

If Yes, please provide full details:

Previous occupation	Employer	Employment Status*	Date from	Date to

**Employment Status (e.g. unemployed, employed, employed by own company, self employed, partnership etc.)*

7. Do you have any other occupation? No ☐ Yes ☐

If Yes, please complete the following:

Type of occupation:

Name of your employer:

How many hours per week do you work in this other occupation?

How long have you been doing this other occupation? years months

What is your monthly income from this other occupation? $

Section H: FINANCIAL DETAILS

Only complete this section if applying for Group Income Protection - otherwise continue to Section H

Please note that based on the financial information provided below, additional financial information may be required.

1. If disabled, would all or part of your income continue? No ☐ Yes ☐

If Yes, please advise income that would continue, for how long and source (e.g. sick leave, other disability income policies, pension, company profit share, investment, rental, etc):

2. **Employees Only** – No ownership in employer's business

In respect of your principal occupation, what has been the total value of remuneration paid by your employer over the last two years? This should be determined by calculating the amount you could be expected to receive if your total remuneration was received as a salary or wage (before income tax is deducted).

Current Tax Year		$	Last Tax Year		$
Commission/Bonus/Overtime component of this amount is		$	Commission/Bonus/Overtime component of this amount is		$

3. **Self-Employed Only** – Sole trader, employed by/director of own company or trust, or partnership

Last Tax Year		$	Previous Tax Year		$
	Business $	Your Share $		Business $	Your Share $
Gross Income	$	$	Gross Income	$	$
LESS Business Expenses	$	$	LESS Business Expenses	$	$
Net Income (Loss)	$	$	**Net Income (Loss)**	$	$
PLUS the following paid to you:			PLUS the following paid to you:		
Wages/Salary/Drawings/Director's Fees		$	Wages/Salary/Drawings/Director's Fees		$
Superannuation Costs		$	Superannuation Costs		$
Total		$	**Total**		$

Please note – Any amounts received as wages/salary/drawings/director's fees must not be paid from past profits, capital or loans.

Section I: INSURANCE ELECTION

☐ I elect to maintain all my insurance cover in Emplus even if:

a. my account has not received any contributions or other amounts for a continuous 16 month period; and/or
b. my account has a balance of less than $6,000; and/or
c. I am under 25 years old

Section J: ADDITIONAL INFORMATION

(To assist with clarification of any issue)

Section K: PRIVACY COLLECTION NOTICE

This Privacy Collection Notice outlines how Hannover Life Re of Australasia Ltd ("Hannover", "we", "us" or "our") collects and handles your personal information in compliance with the Privacy Act 1988 (Cth).

Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may on occasions collect it from a third party such as our related bodies corporate, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance / reinsurance companies, legal practitioners, medical practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law..

Overseas disclosure

We may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

Access

Our Privacy Policy which is available at https://www.hannover-re.com/1094181/australia_lh_privacy (or, by contacting us using the details set out in the 'Contact Us' section below) outlines our personal information handling practices, including details on how you can seek access or correction of the personal information that we hold about you, how to complain if you believe we have breached the Australian privacy laws and our complaint handling processes.

Contact

You may contact Hannover as follows:

The Privacy Officer. Hannover Life Re of Australasia Ltd. Tower 1, Level 33, 100 Barangaroo Avenue SYDNEY NSW 2000

Telephone: (02) 9251 6911 Facsimile: (02) 9251 6862 Email: privacyofficer@hlra.com.au

Section L: CONSENT FOR ACCESSING HEALTH INFORMATION

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, Hannover Life Re of Australasia Ltd., collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent. Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent. Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below

Authority 1 explanatory notes - through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or;
- releasing correspondence with other health providers.

Authority 2 explanatory notes - through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority 1 - to release to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Hannover Life Re of Australasia Ltd. ("HLRA"), or to third parties they engage.

☐ By ticking this box I _____ whose date of birth is set out below agree to the following:

- My health information can be released in the form HLRA asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- HLRA can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while HLRA is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally. I accept that this electronic authority replaces the need for a personally signed Authority.

Date of Birth: _____ Date: _____

Authority 2 - to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

☐ By ticking this box I _____ whose date of birth is set out below authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to HLRA, or to third parties they engage, only if HLRA has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- HLRA can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while HLRA is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally. I accept that this electronic authority replaces the need for a personally signed Authority.

Date of Birth: _____ Date: _____

Section M: DECLARATION

☐ By ticking this box I _____ whose date of birth is set out below,

by continuing with my application (and, any variation, extension or reinstatement of my application) or application for different insurance cover I agree that:

- I have read, understand and agree to the terms of our Duty of Disclosure and all my answers are correct. In particular, I give HLRA a general authority to obtain information they reasonably believe is relevant to my application unless I tell them otherwise (e.g. where I request they only obtain particular information from particular sources or I have not consented for my health provider to release my health information to them) which may delay or invalidate my application and, if I fail to comply with my duty of disclosure, HLRA may avoid my cover or reduce the amount of cover if it is within a 3 year period.
- I have read, understand and agree to the terms of HLRA's Privacy Collection Notice. In particular, I consent to HLRA collecting and where required disclosing certain personal information and sensitive information (including medical and health information) from or to third parties (the details of which can be found in HLRA's Privacy Collection Notice https://www.hannover-re.com/1094181/australia_lh_privacy) who may contact me and provide information to me about HLRA or their services.
- As at the date of this application I am not absent from work for reason of illness or injury and I am performing all duties I would ordinarily perform in my occupation.
- I accept that this electronic authority replaces the need for a personally signed Consent, Declaration and Authority to Provide Information.

Member's Signature: On completion of this form, please print and sign by hand

Date: _____

Date of Birth _____

Please return this completed form to Emplus PO Box 3528, Tingalpa DC Qld 4173 or email to info@emplus.com.au
Phone: 1800 336 911 Fax: (07) 3899 7299 Website: www.emplus.com.au

We are committed to respecting the privacy of the personal information you give us.
Our formal Privacy Statement sets out how we do this. If you would like a copy of Emplus' Privacy Statement, please let us know. We have published our Privacy Statement on our website at www.emplus.com.au