Optimum Corporate Super Insurance application form for employees or family account members

Issued 1 January 2014

Asteron Life

Part of the Suncorp Group

Please read the Optimum Corporate Super Product Disclosure Statement (PDS) and Product Guide before completing this form. The form should be completed in a blue or black pen, using BLOCK letters and cross (✗) to mark answer boxes.

Any questions? If you have any questions in regards to completing this form, please contact your adviser or the Customer Service team, Monday to Friday, between 8am and 6pm (Sydney time), on 1800 819 499. Additional copies of this form can be obtained from our website via www.asteronlife.com.au

Your duty of disclosure

To be read by the Policy Owner and Person to be Insured before completing the application.

Before you enter into a contract of life insurance with an insurer or become a member of this Fund, you have a duty, under the Insurance Contracts Act 1984 or under the terms of your membership, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

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

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows, or in the ordinary course of their business, ought to know;
- as to which compliance with your duty is waived by the insurer.

Non-disclosure – If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the insurance fee that would have been payable if you had disclosed all relevant matters to the insurer.

This duty continues to apply until the insurer notifies you that the risk has been accepted. It also applies when you extend, vary or reinstate a contract of life insurance.

A. Details of Person to be Insured

Title | Sex: Male ☐ Female ☐

Single ☐ Married ☐ De-facto ☐ | Smoker ☐ Non-smoker ☐

Given name(s)

Surname

Date of birth d d / m m / y y y y | Age next birthday

Home address

Street address

Suburb/Town

State | Postcode

Phone (home) | (work)

Mobile | Fax

Email

Postal address (if different from above)

Street address
PO Box

Suburb/Town

State | Postcode

Occupation

Member No. (existing members only)

B. Insurance details

Under the MySuper regulations, employees under corporate plans must be provided with at least a minimum level of Death and TPD Insurance. For new members joining a corporate plan, they will be automatically provided the greater of the employer plan default (if applicable) or MySuper Trustee minimum. Members are free to keep the MySuper Trustee minimum, choose their own level of cover or to opt out of insurance. More information can be found in the PDS or Product Guide.

1. New or amendment to existing cover

Please tick the appropriate box

☐ New application cover

☐ Amendment to existing cover

2. Insurance cover

Please select the insurance cover option that suits you, and complete the details (please note TPD cover amount cannot be more than the amount of Death cover).

Option 1	Option 2	Option 3	Option 4	Option 5
☐ **MySuper Trustee Minimum**	☐ **Death/TPD** Insert Death cover amount $ Insert TPD cover amount $	☐ **Death/TPD** Insert Death cover amount $ Insert TPD cover amount $ **& Income Protection** Monthly income benefit amount $ Superannuation contribution amount up to 10% of salary (if required) $ Waiting period (please tick) ☐ 30 days ☐ 60 days ☐ 90 days	☐ **Income Protection only** Monthly income benefit amount $ Superannuation contribution amount up to 10% of salary (if required) $ Waiting period (please tick) ☐ 30 days ☐ 60 days ☐ 90 days	☐ **No Insurance Cover**

C. Occupational details (Must be completed)

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

   Occupation

   Industry No. of years

2. What are the principal duties of your occupation? (include % of time spend in each)

   %

   %

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

   Date of change d d / m m / y y y y

4. What has been your insurable income over the past 12 months? Insurable income is the income earned by your own personal exertion (less expenses insured in earning that income) before tax, which will cease if you are unable to work.
   $ pa

5. Occupation class quoted by your Adviser (if completed)

D. Insurance history (Must be completed)

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

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

Name of company	Type of insurance	Insured benefit	Date commenced	Is policy to be discontinued/ replaced?
		$	/ /	Yes* ☐ No ☐
		$	/ /	Yes* ☐ No ☐

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

2. Has any application for insurance ever been refused, postponed, accepted with an increased insurance fee or on modified terms? ..... Yes ☐ No ☐
   If 'yes', please provide details:

3. Are you claiming or have you ever claimed benefits from any source eg, an insurance policy, workers compensation, social security (including unemployment benefits), veterans affairs, sickness benefits, invalid pension, third party, etc? ..... Yes ☐ No ☐
   If 'yes', please provide:

Date	Source	Reason	Has the claim been settled/ benefits ceased?	Date ceased
/ /			Yes ☐ No ☐	/ /
/ /			Yes ☐ No ☐	/ /

E. Residence and travel (Must be completed)

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1. Were you born in Australia? ..... Yes ☐ No ☐
   If 'yes', please go straight to question 3
2. Are you an Australian citizen or do you hold an Australian Permanent resident visa? ..... Yes ☐ No ☐

   How long have you lived in Australia? ☐ Country of birth ☐ Visa type ☐

3. Do you travel overseas in your job? ..... Yes ☐ No ☐

   Countries ☐ Purpose ☐

   Duration ☐ Frequency ☐

4. Do you have definite plans to live or travel overseas in the future? ..... Yes ☐ No ☐

   If 'yes', please advise Date leaving d d / m m / y y y y Date returning d d / m m / y y y y

   Countries to be visited ☐ Reason for trip ☐

F. Medical history (Must be completed, except when a medical examination is required)

1. What is your height and weight? Height ☐ cm Weight ☐ kgs
2. Are you left handed or right handed? Left ☐ Right ☐
3. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:

	Yes	No
a. Heart attack, angina, chest pain or stroke?	☐	☐
b. Asthma, bronchitis, emphysema?	☐	☐
c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder?	☐	☐
d. Epilepsy, fainting attacks or fits of any kind?	☐	☐
e. Recurrent indigestion, ulcer, Hepatitis (A, B, C or D)?	☐	☐
f. Cancer, tumour, lump or growth of any kind or breast lumps (even if you have not seen a doctor)?	☐	☐
g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses)	☐	☐
h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs?	☐	☐
i. Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI or any regional pain syndrome or chronic fatigue?	☐	☐
j. Diabetes or abnormal blood sugar?	☐	☐
k. Psoriasis, eczema or any other disorder of the skin, or any allergic or chemical sensitivity reaction?	☐	☐

If you answered 'yes' to any of the conditions above, please also complete a Special health questionnaire (on pages 6 and 7) for each condition.

4. Other than those conditions stated in question 3, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:

a. High blood pressure, heart murmur or any other heart or blood vessel disorder?	☐	☐
b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder?	☐	☐
c. Tuberculosis or any other lung or respiratory system disorder?	☐	☐
d. Paralysis, Multiple Sclerosis, recurrent headaches or any other disorder of the nervous system?	☐	☐
e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancreas?	☐	☐
f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs?	☐	☐
g. Sleep apnoea or any sleeping disorder?	☐	☐
h. Thyroid disorder or any other glandular disorder?	☐	☐
i. Any sickness, injury or physical impairment not previously mentioned?	☐	☐
5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)?	☐	☐
6. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result?	☐	☐
7. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation?	☐	☐

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

If you answered 'yes' to 4, 5, 6, 7 or 8 please provide details on the next page.

9. Has your mother or father, or any brother or sister had breast, ovarian, colon or other cancer, diabetes, high blood pressure, heart problems, stroke, mental disorder, haemochromatosis, Huntington's disease, muscular dystrophy, Familial Adenomatous Polyposis, polycystic kidney or any other hereditary disease? Yes ☐ No ☐
   If 'yes', please provide details in the following table.

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

10. Females only
    a. Have you ever had an abnormal pap smear or breast ultrasound or mammogram? Yes ☐ No ☐
       If 'yes', please provide details of test(s), result(s) and date(s). ☐
    b. Are you currently pregnant? Yes ☐ No ☐
       (i) If 'yes', due date ☐ / /
       (ii) Have there been or are there expected to be any complications? Yes ☐ No ☐
       If 'yes', please provide details ☐

If you answered 'yes' to any question in 4, 5, 6, 7 or 8 please provide details.

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. ☐ Sickness, injury or tests

Test results

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Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

G. Special health questionnaires

(Must be completed if you answered 'yes' in Section F question 3)

Asthma

1. Date asthma first diagnosed / /
2. How often do you experience symptoms? eg, wheezing, breathlessness, chest tightness.
3. When did you last experience symptoms? / /
4. Are you woken during the night with symptoms? Yes ☐ No ☐
   If 'yes', how often and date of last occurrence.
5. Have you ever been off work due to your asthma? Yes ☐ No ☐
   If 'yes', please advise when and for how long.
6. What is your current treatment? Include type of medication and dosage.
7. Have you ever required use of oral steroids? ..... Yes ☐ No ☐
   If 'yes', please advise when and for how long.
8. Have you ever been in hospital or received emergency treatment for asthma? ..... Yes ☐ No ☐
   If 'yes', please advise when, for how long and where.
9. Do you ever measure your peak flow? ..... Yes ☐ No ☐
   If 'yes', please advise your highest and lowest readings in the past 6 months.
10. Have you ever consulted a specialist for this condition? ..... Yes ☐ No ☐
    If 'yes', please advise name and address of doctor and date of last consultation.
11. Does your usual doctor have details of this condition? ..... Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.
12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Anxiety/Depression/Nervous disorder

1. Nature of condition and underlying cause.
2. Describe your symptoms.
3. Date symptoms commenced. / /
   i) Are you still experiencing symptoms? ..... Yes ☐ No ☐
   ii) If 'no', when did you last experience symptoms? / /
4. Have you taken regular or occasional medication for this condition? ..... Yes ☐ No ☐
   If 'yes', please advise type, dosage and frequency.
5. Are you still taking this medication? ..... Yes ☐ No ☐
   If 'no', please advise date ceased. / /
6. Have you had any other treatment (eg, counselling, hospitalisation, ECT)? ..... Yes ☐ No ☐
   If 'yes', please advise type, dates, hospital and name and address of treating doctor.
7. Have you ever been off work or had your normal daily activities restricted in any way due to this condition? Yes ☐ No ☐
   If 'yes', please advise when and for how long.
8. Have you any ongoing effects or restriction in your activities of any kind? ..... Yes ☐ No ☐
   If 'yes', please provide details.
9. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? ..... Yes ☐ No ☐
   If 'yes', please advise dates and name and address of all persons consulted.
10. Please provide details of your most recent visit for this condition. Include date and name and address of doctor consulted.
11. Does your usual doctor have details of this condition? ..... Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

G. Special health questionnaires

(Must be completed if you answered 'yes' in Section F question 3)

Back/Neck

1. Area of spine affected? Neck, upper or lower back?

2. Date of first symptoms / /

3. What was the cause?

4. Have you had any diagnostic investigations eg, CT Scans, x-rays etc? ..... Yes ☐ No ☐
   If 'yes', please provide details of test(s), result(s) and date(s).

5. Are you still experiencing symptoms?..... Yes ☐ No ☐
   If 'no', please provide date of last experienced symptoms? / /

6. How often do/did you have symptoms?

7. Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ..... Yes ☐ No ☐

8. Have you ever been off work due to your spinal symptoms or unable to perform your normal day to day activities? ..... Yes ☐ No ☐
   If 'yes', when and for how long?

9. What is the nature of the treatment (eg, spinal manipulation, deep tissue massage etc)?

   i) Are you still receiving treatment? ..... Yes ☐ No ☐

   ii) If 'no', when did you cease treatment? / /

10. Have you ever consulted a specialist for this condition? ..... Yes ☐ No ☐
    If 'yes', provide name and address of specialist and date of last consultation.

11. Please provide details of your most recent visit to any other doctor or therapist for this condition. Include date, name and address of doctor or therapist consulted.

12. Have you had any ongoing effects of any kind?
    Eg, pain, discomfort or limitations of movement etc? Yes ☐ No ☐
    If 'yes', please provide details.

13. Is it necessary to avoid lifting or to restrict your daily activities in any way? ..... Yes ☐ No ☐
    If 'yes', please provide details.

14. Does your usual doctor have details of this condition? Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

Any other condition

1. Name of condition (exact diagnosis)

2. The cause

3 a. Describe symptoms

   b. Date symptoms commenced / /

   Date symptoms ceased / /

   c. How often do/did you have symptoms?

4. Have you ever been off work or had your normal daily activities restricted in any way because of this condition?..... Yes ☐ No ☐

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		

5. Have you any residual, on-going effects or restriction in your daily activities?..... Yes ☐ No ☐
   If 'yes', please provide details.

6. Have you taken regular or occasional medication for this condition?..... Yes ☐ No ☐
   If 'yes', please advise names of medication(s), dosage(s) and frequency.

   Are you still taking this medication? ..... Yes ☐ No ☐

7. Have you had any other treatment for this condition (eg, physiotherapy, operation, alternative remedies)? Yes ☐ No ☐

8. Have you had any diagnostic investigations (eg, scope, scan, x-rays, EEG, ECG etc)? ..... Yes ☐ No ☐

9. Have you ever been in hospital or received emergency treatment for anything related to this condition? Yes ☐ No ☐

10. If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.

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

Date	Reason for consultation, investigations, findings, advice
/ /	

Doctor/Therapist name and specialty

12. Has further treatment been recommended for this condition? ..... Yes ☐ No ☐
    If 'yes', please provide details.

13. Does your usual doctor have details of this condition? ..... Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

H. Habits (Must be completed, except when a medical examination is required)

12

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

   If 'yes', type (eg, cigarettes, gum, patches)? _____ Daily quantity? _____

   How many years? _____ Date ceased? if applicable / /

   Other _____

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

   If 'yes', please advise number of standard drinks per week? _____ Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

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

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

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

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

I. Doctor's details (Must be completed)

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If you do not have a usual doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your usual doctor _____

   Address _____ Postcode

   Phone Work ( ) Fax ( )

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

   Reason and outcome of last consultation _____

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

   Name of previous doctor/medical centre _____

   Address _____ Postcode

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

J. HIV (Must be completed)

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

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

K. Activities (Must be completed)

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

   If 'yes', please answer the activities questionnaire on page 9.

2. Type of activity _____

3. Do you want to be considered for cover while taking part in this activity?

☐ Yes, If 'yes', please complete the Activities questionnaire on page 9.

☐ No, If 'no', please complete the Sports and activities exclusion acknowledgement on page 10.

(Please note that the activity will usually be excluded for disability type coverages).

L. Activities questionnaire
(Must be completed if you indicated 'yes' in Section K question 1)

Underwater diving

a. Type (scuba, hookah etc) | b. What are your qualifications for this activity?

c. How long have you been doing this? | d. How often do you do this?

e. Are you professional or amateur?

f. Maximum depth of dives (Metres) | g. Average depth of dives (Metres)

h. Geographical location

i. Do you dive in wrecks, potholes or caves? ..... Yes ☐ No ☐

j. Have you ever had a diving accident or diving sickness? (eg, blackout, needed decompression etc) ..... Yes ☐ No ☐

k. Do you intend to change the scope of your license/participation? ..... Yes ☐ No ☐

If 'yes' to i or k, please provide details.

Motor sports

a. Type (car, bike etc) | b. Events (speedway, off road etc)

c. How long have you been doing this? | d. How often do you do this?

e. Are you professional or amateur?

f.

Category (eg, touring cars)	Class (eg, AA/D)	Vehicle & type of fuel	Engine capacity	No. of vehicles in event	Max speed km/hour

k. Do you intend to change the scope of your license/participation? ..... Yes ☐ No ☐

If 'yes', please provide details.

Flying – power-driven aircraft or conventional glider

a. What type of flying do you do (private, agricultural, ultralight etc)?

b. Total number of hours flown as a pilot? (Hrs) Number of hours in the past 12 months? Fixed Wing (Hrs) Helicopter (Hrs)

c. Number of hours expected in the next year? Fixed Wing (Hrs) Helicopter (Hrs)

d. Geographical location

e. What class license do you hold?

f. Do you intend to change the scope of your license? ..... Yes ☐ No ☐

If 'yes', please provide details.

Abseiling, caving, mountaineering, rock climbing

a. Activity

b. How long have you been doing this? | c. How often do you do this?

d. Geographical location

e. Maximum altitude/depth | f. Equipment used

g. Maximum grade of climb | h. Type (top roping etc)

Other activity

a. Describe activity | b. What are your qualifications for this?

c. How long have you been doing this? | d. How often do you do this?

e. Geographical location | f. Are you professional or amateur?

M. Sports and activities exclusion acknowledgement

Please complete this section if you answered 'no' to question 3 in section K on page 8.

To be completed by the proposed Person to be Insured

This form applies to the following activities only:

- Abseiling
- Aviation (includes conventional gliding)
- Caving
- Diving
- Football (all codes)
- Martial arts (incl boxing)
- Motor boat racing
- Motor car racing
- Motor cycle racing
- Mountaineering
- Parachuting
- Rock climbing
- Sports aviation (eg, hang gliding)

Is the type of activity you noted in section K on page 8 listed above?

Yes ☐ If 'yes', please complete this acknowledgment form.

No ☐ If 'no', you do not need to complete this form. We will send you a separate sports and activities exclusion acknowledgment form for you to complete and return to us.

Death

No benefit will be paid if death or terminal illness results directly or indirectly from _____

Name of Person to be Insured

engaging in _____

Insert key words from list below

Income Protection/Total and Permanent Disability

No benefit will be paid for any disablement which results directly or indirectly from _____

Name of Person to be Insured

engaging in _____

Insert key words from list below

Key word	Exclusion wording
Abseiling, mountaineering, rock climbing, caving	Participation in or preparation for abseiling, caving, pot holing, rock climbing or any form of mountaineering.
Aviation (includes conventional gliding)	Participation in aviation activities, other than as a fare paying passenger in a fully licensed standard type of aircraft operated by a recognised airline over an established air route.
Diving	Participating in or preparation or practice for diving activities using scuba or any other form of diving equipment.
Football (eg. rugby union, rugby league, Australian rules and soccer)	**This wording will be included as a special condition if you are applying for Income Protection and/or Total and Permanent Disabilty.** Amateur – Occupation classes O1, O2 • Participation in or preparation or practice for football activities during the first 30 days that the Insured Person is unable to work. Amateur – Occupation classes 3, 4, 5 • Participation in or preparation or practice for football activities during the first 90 days that the Insured Person is unable to work.
Sports aviation (eg hang gliding)	Participation in or preparation or practice for hang gliding, ballooning, paragliding, para ascending activities or any other form of flight by any means other than aeroplane.
Martial arts (including boxing)	Participation in or practice for boxing, wrestling or any martial arts activities.
Motor boat and power boat racing	Participation in or preparation or practice for motor boat or power boat-racing activities.
Motor car racing	Participation in or preparation or practice for motor racing activities.
Motor cycle racing	Participation in or preparation or practice for motor cycle racing activities.
Parachuting	Participation in or preparation for making a parachute descent or any happening in or to an aircraft in connection with parachuting.

Declaration

- I/We have read the full exclusion wording that applies to each activity that I/we wish to exclude, and
- I/We understand and accept the limits this places on the insurance cover, and
- I/We accept that the exclusion wording for each activity that I/We wish to exclude will be included as a special condition in my/our policy.

Signature of Policy Owner(s) (if applicable) ✗ _____ Date d d / m m / y y y y

Signature of Person to be Insured ✗ _____ Date d d / m m / y y y y

N. Consent and declaration by the Person to be Insured

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This must be completed in ALL instances

I acknowledge that:

- I have read this application form and confirm that the answers given are my true and complete answers, even if the answers either in this form or any attachment, are not in my handwriting, I declare that they have been correctly written down at my dictation.
- I have read my Duty of Disclosure and have not withheld any material information from the Insurer or the Trustee and understand that this duty continues to apply and that the insurance applied for will not become effective until Suncorp Life & Superannuation Limited advises the risk has been accepted.
- I have read, understood and signed the Medical History Authorisation which enables Suncorp Life & Superannuation Limited, at its discretion, to obtain full details of my medical records and I understand that Suncorp Life & Superannuation Limited may obtain a report from my usual doctor or any doctor whom I have consulted.
- Any statements I have made on or with an application to another insurer and which I have presented to Suncorp Life & Superannuation Limited are intended by me as declarations and representations to Suncorp Life & Superannuation Limited and I acknowledge that Suncorp Life & Superannuation Limited will use them in assessing this application for insurance.

I acknowledge that:

- I have read and understood the Privacy Statement contained within the Product Disclosure Statement.
- I may request access to my personal information by contacting you, although I may in some circumstances not be granted access to it. Also, I acknowledge that if the personal information requested from me is not provided to you, then you may not be able to provide services covered in the Privacy Statement.
- I acknowledge that for TPD and Income Protection cover, this policy contains a specific exclusion if the event giving rise to claim is caused directly or indirectly by war or an act of war.
- I understand that the insurance applied for will not become effective until this application is accepted in writing.
- I have received and read the current Product Disclosure Statement.
- My Death and TPD cover will stop if I commence active duty with the armed forces of any country (excluding regular activities of the Navy, Army or Air Force Reserves).

I consent to:

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

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

Signature of the Person to be Insured ✗

Date d d / m m / y y y y

O. Adviser details (Your adviser will be able to complete this information for you)

Adviser number

Adviser name

Adviser's signature ✗

Date d d / m m / y y y y

Please send the completed form and any required attachments to:

Customer Service team
Optimum
GPO Box 1576
Sydney NSW 2001

P. Medical history authorisation by the Person to be Insured

(Must be completed)

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To Doctor

I authorise any doctor, hospital, clinic and other medical or related facility, or any other person who has attended me, to provide Suncorp Life & Superannuation Limited with any information with respect to any sickness, injury, consultation, tests (including genetic test(s)), prescriptions or treatment and copies of all hospital records.

I authorise the Medicare Australia to release to Suncorp Life & Superannuation Limited, at their request, a copy of my medical history records.

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

Name of Person(s) to be Insured

Maiden name (if applicable)

Signature ✗

Date / /

Signature of Person to be Insured