

Insurance application form

PLEASE COMPLETE FORM IN BLOCK LETTERS IN BLACK INK

Complete this form if you are applying for Death and Total & Permanent Disablement cover for total amounts less than and including \$800,000. If you wish to apply for cover higher than this amount, please complete a *Personal statement*, which is available to download from our website, www.accountants-super.com, or request one to be posted by calling 1300 651 331.

1. Your Accountants Super membership details (You must complete all details in this section)

Your Accountants Super member number (if known)

Male

Female

Surname (mandatory*)

Title

Date of birth (DDMMYYYY mandatory*)

Given name (mandatory*)

Previous surname (if different)

Unit / street number

Street Name

Suburb / town

State

Postcode

Email address** (Please **do not** leave any spaces empty, continue word on next line if necessary)

Phone (after hours)

Mobile**

Phone (business hours)

Fax

* If these fields are not completed, we may not be able to complete your request.

** Providing your mobile number/email address means you are willing to receive important information about your Accountants Super account and other benefits and services by SMS or email.

Do you spend at least 90% of your working hours in an office environment, without doing manual work?

Yes

No

2. Insurance

Eligible members are automatically covered by AutoCover, as described in the Product Disclosure Statement and on our website.

If you are not eligible for AutoCover, or AutoCover is insufficient for your needs, then you may apply for cover by completing this section of the form.

Total units required (Maximum \$3 million of cover)

Your Duty of Disclosure

Before you enter into, or become insured under a contract of life insurance with an insurer, you have a duty under the INSURANCE CONTRACTS ACT 1984, 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. You have the same duty to disclose these matters to the insurer before you renew, extend, vary or reinstate your insurance. 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 the insurer knows, or in the ordinary course of its business, ought to know; or
- 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 covered you on any terms if the failure had not occurred, the insurer may avoid the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may avoid your cover at any time.

An insurer who is entitled to avoid your cover may, within three years of issuing 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 premium that would have been payable if you had disclosed all relevant matters to the insurer.

3. Privacy statement

The information requested on this form is required in order to administer your membership. Your personal information may be provided to a financial adviser nominated by you and/or your employer. It may also be provided to specific organisations to provide services to you on our behalf. Your personal information will not be used or disclosed for any other purpose without your consent. If you do not provide the information requested, Accountants Super may not be able to administer your account. You may have access to the information Accountants Super holds about you. If you would like a copy of our Privacy Statement, please visit our website or call 1300 651 331.



4. Personal health details (Please mark Yes or No to every question)

If you answer 'Yes' to any of the questions below, please DO NOT continue completing this form. Instead, you will need to complete a *Personal statement*, which is available to download from our website, www.accountants-super.com, or request one to be posted by calling 1300 651 331.

	Yes	No
1 Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?	<input type="checkbox"/>	<input type="checkbox"/>
2 Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit from any superannuation fund, worker's compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you at the date of this application, due to injury, accident or illness; <ul style="list-style-type: none"> • off work? • restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even though your actual employment can be on a full-time, part-time or casual basis? 	<input type="checkbox"/>	<input type="checkbox"/>
4 Have you lost the sight of an eye or the total and permanent loss of the use of a limb ('limb' includes whole hand or whole foot)?	<input type="checkbox"/>	<input type="checkbox"/>
5 Please provide the following details: Height <input type="text"/> <input type="text"/> <input type="text"/> cm Weight <input type="text"/> <input type="text"/> <input type="text"/> kgs		
6 Excluding the contraceptive pill and inhaled asthma medication, have you been advised to take, or been given prescribed medication by a medical practitioner that has intended to be used for three months or longer within the last year (including but not limited to blood pressure, diabetes, oral steroids for asthma or depression medication)?	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you been unable to work because of sickness or injury for more than two consecutive weeks in the last three years?	<input type="checkbox"/>	<input type="checkbox"/>
8 Have you undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any illness or injury that would affect your long-term health and require ongoing medical supervision. This includes, but is not limited to: <ul style="list-style-type: none"> • Cancer or diabetes • High blood pressure, cholesterol or any heart complaint • Alcohol or drug abuse • Stroke, paralysis, neurological disorder or multiple sclerosis? 	<input type="checkbox"/>	<input type="checkbox"/>
9 Have you been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or Hepatitis B and C?	<input type="checkbox"/>	<input type="checkbox"/>
10 Have you received any medical advice or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any of the following: <ul style="list-style-type: none"> • Any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last 12 months AND/OR any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints? • Depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder)? • Chest pain, asthma, bronchitis or any other lung complaint requiring hospitalisation within the last five years? • Disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel, or liver? • Epilepsy? 	<input type="checkbox"/>	<input type="checkbox"/>

5. Declaration **This section must be completed in all circumstances.**

I have read the Duty of Disclosure in Section 2 and I am aware of the consequences of non-disclosure.

I understand that the Duty of Disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers);
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me.

I declare that:

- the answers to all the questions and the declarations on this form are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance.

I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.

I have read and understood the Privacy Statement in Section 3. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.

Full Name

Signature of life to be insured

Date

6. Please return this form to:

Accountants Super
GPO Box 3607
Melbourne Vic 3001

For further information:

Phone: 1300 651 331
Fax: 1300 655 490
Email: info@accountants-super.com
Website: www.accountants-super.com

Professional Associations Superannuation Limited
(ABN 14 056 917 303 AFSL 222590 RSE L0000352)
as Trustee of Professional Associations Superannuation Fund (PASF) (ABN 78 984 178 687 RSE R1000429).
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