Insurance Application / Personal Statement

IMPORTANT NOTICES – PLEASE READ

Privacy

The *Privacy Act 1988* ("the Act") sets out a number of principles that we must comply with in the collection, security, storage, use and disclosure of personal information. These principles are known as the Australian Privacy Principles.

The following information is provided to you in accordance with these Principles.

The organisation collecting information about you is Hannover Life Re of Australasia Ltd. ("HLRA"). Our contact details are shown below.

The information we collect will be used to assess and process your application for life insurance. We may also use or disclose the information to assess and process a claim if a claim is submitted by you, or by someone acting on your behalf.

The information we collect may be disclosed to other organisations, including but not limited to, medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, the trustees of a superannuation fund you belong to, an organisation that is duly appointed to manage the administration of such fund and interpreters.

If you fail to provide us with all or part of the information we require, we will be unable to assess and process your application.

If you would like further information, please refer to our Privacy Policy Document available on request or found on our website **www.hannoverlifere.com.au** about:

- how we collect, use and disclose your personal information;
- how you may request access to, or correction of, your personal information that is held by HLRA; and
- making a privacy complaint about the handling of your personal information and how your complaint will be dealt with by HLRA.

Duty of Disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the *Insurance 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 insurance and if so, on what terms. You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of life 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 your insurer knows, or, in the ordinary course of its 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 premium that would have been payable if you had disclosed all relevant matters to the insurer.

Your Duty of Disclosure continues until the contract of life insurance has been accepted by the insurer and confirmation is issued in writing. Please ensure all applicable questions are fully answered.

All questions on this Personal Statement are relevant as to whether or not HLRA accepts the risk 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.

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A Member of the Hannover Re Group
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Section A. Fund / Plan name & type of cover

Name of Fund / Plan

Type of Cover: (please tick appropriate box)		**Amount of Benefit / Cover:**
Death Only	☐	$
Death and Total and Permanent Disablement (TPD)	☐	$
Group Income Protection (GIP)	☐	$ (monthly benefit)
Trauma Cover	☐	$

Section B. Member Details and Insurance History

1. **Member Details:**

Surname

Given Name(s)

Sex: Male ☐ Female ☐

Date of Birth / /

Home Address

State

Postcode

2. Occupation

3. Annual Salary $

4. Telephone Number: (home/work/mobile)

Most convenient time to contact you: **am** ☐ / **pm** ☐

Please tick No or Yes to each of the following:

5. Has Life, Disability, Accident and Sickness or Superannuation cover on your life ever been declined, deferred to 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:

6. Have you ever made a claim for disability benefits under an Insurance, Superannuation or Worker's 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:

7. Other than this application, do you have or are you applying for any Life, 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 C. 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 give full details:*

4. Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's visa? **No** ☐ **Yes** ☐
   Please provide full details:

5. Do you intend travelling overseas in the immediate future (i.e. next 2 years)? **No** ☐ **Yes** ☐
   *If **'Yes'** please give full details (where, when, duration and reason):*

Section D. Occupation Details

1. Employer's Name | Telephone
   Employer's Address | 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 details*
   How long? years / months | % of business you own? %
   Business/ Company Name
   Business/ Company Address | State | Postcode
   How many employees do you have? (*excluding yourself*)

Section D. Occupation Details (cont.)

4. What are the main duties of your occupation?

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

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

If 'Yes', please provide 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 details:

Previous Occupation	Employer	Employment Status*	Date from	Date to
				/ /

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

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 E. Financial Details*

**** Only complete this section if applying for Group Income Protection – otherwise go to Section F.***

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?
(*e.g., sick leave, other disability income policies, pension, investment, rental, company profit share, etc.*) **No** ☐ **Yes** ☐

*If **'Yes'** please provide full details:*

2. **Employees only** (*i.e., no ownership in employer's business*)

In respect of your principal occupation, what has been the total value of remuneration paid by your employer of 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 is	Commission/Bonus/Overtime component this amount is
	$

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

2. **Self-Employed only** (*i.e., sole trader, employed by/director of own company or trust, partnership*)

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

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

NB: any amounts received as wages/salary/drawings/director's fees must not be paid from past profits, capital or loans.

Section F. Medical Statement

1. Name and Address of your Doctor

Doctor's Name _____ Telephone _____

Doctor's Address _____

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, physiotherapist or other health care professional (*naturopath, etc.*) or been in a 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 revealed an abnormality, eg 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 and address of Doctor or Hospital, Clinic, etc.	Conditions, Medications Treatment and Time off Work	Recovery %
/ / to / /			
/ / to / /			
/ / to / /			

Section F. Medical Statement (cont.)

*Please tick **No** or **Yes** to each of the following:*

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 prostate 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 (eg 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 above (if more space is required, please go to Section I).

Specific Condition	Question No. _____	Question No. _____	Question No. _____
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 G. 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** ☐

*If '**Yes**' please provide full details (including age at diagnosis and age at death (if applicable):*

Section H. Questions in relation to Aids

*Please tick **No** or **Yes** to each of the following:*

1. Have you **EVER** been infected by the virus which causes AIDS (the Human Immunodeficiency Virus)? No ☐ Yes ☐
2. Have you **EVER** sought or are 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** shared a needle or syringe for the injection of any drug, engaged in male to male anal sexual activity or worked as or engaged in sexual activity with a prostitute or someone you know or suspect to be HIV positive? No ☐ Yes ☐

NB – if any of these questions are answered "yes", we will send you a separate questionnaire.

Section I. Additional Information (to assist with clarification of any issue)

Please ensure you have read and signed the last page.

Section I. Consent, Declaration & Doctor's Authority

IMPORTANT - PLEASE READ & SIGN

Consent

I understand that in order to assess and process my application, HLRA may need health and employment information about me. I consent to HLRA obtaining information about me from any medical practitioner or health professional that I have or may consult in the future, or that HLRA appoints to examine me, and from my employers.

I further understand that if I apply for increased or different insurance cover, HLRA may require further information about me. I now consent to HLRA obtaining such further information as and when required, from any medical practitioner or health professional that I have consulted or may consult in the future, or that HLRA appoints to examine me, and from my employers.

I understand that if I or anyone else on my behalf, makes a claim for a benefit, HLRA will need information about me in order to assess and process the claim. I hereby consent to HLRA obtaining information about me from any of the following:

Medical practitioners that I have consulted at any time and any that HLRA wishes to appoint to examine me, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers and interpreters.

For the purpose of this application and any future application and any claim for a benefit, I also consent to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for HLRA to perform its functions.

Declaration

I have read and carefully considered the questions on this Insurance Application / Personal Statement. I have also read the Duty of Disclosure and all my answers on the Insurance Application / Personal Statement are true and correct.

I acknowledge:

a. This Declaration is part of an application for Life, TPD, GIP, Trauma (where this benefit applies), and the making of a false statement or failure to comply with my duty of disclosure may invalidate my application.

b. That, if I fail to provide all or part of the information required, or consent to HLRA obtaining such information, as it requires, this application will not be assessed and processed.

c. That at the date of this application I am not absent from work for reasons of illness or injury and I am performing all of the duties of my usual occupation.

Member's Signature _____ Date / /

Disclosure of Information (Doctor's Authority)

For the purposes of assessing my eligibility for insurance, I authorise my current medical practitioner, and any other medical practitioner or health professional I have consulted or may consult in the future, or that Hannover Life Re of Australasia Ltd (HLRA) appoints to examine me, to disclose information about my health and related matters to HLRA. A photocopy of this authorisation will be as valid as the original.

Member's Signature _____ Date / /