Insurance Application Form with Personal Statement

Please complete this form if you are applying for or increasing Death only, Death and Total & Permanent Disablement (TPD) or Income Protection (IP) insurance cover within RBF. If you would like to reduce or cancel your insurance, change your occupational category or are applying to transfer your insurance from another fund, please contact us on **1800 622 631**.

Full terms and conditions relating to Insurance are contained in the 'Fact Sheet – Insurance in your super' available on the RBF website.

Section A – Personal and occupational details

RBF membership number

Date of birth / /

☐ Female ☐ Male

Surname

Given name(s)

Postal address

State Postcode

Email address

Telephone number ( )

Mobile number

Employer

Job title/occupation

Average number of hours worked (per week)

Risk category questions

1. Are the duties of your occupation with your Tasmanian public sector employer limited to managerial, administrative, clerical, secretarial or similar 'white collar' nature tasks which do not involve manual work or teaching and are undertaken entirely within an office environment (excluding travel time from one office environment to another)?
   ☐ No ☐ Yes
2. Are you earning in excess of $100,000 per annum from your profession?
   ☐ No ☐ Yes
3. Do you hold a tertiary qualification or are you a member of a professional institute or registered by a government body?
   ☐ No ☐ Yes
4. Are you in a management role?
   ☐ No ☐ Yes

Section B – Insurance cover

This application, if accepted by the insurer, will be added to any existing level and type of insurance cover you currently hold in RBF.

If you are applying for:

- more than $1,500,000 in total of Death only or Death and TPD cover
- more than $12,000 of total IP cover
- a shorter waiting period or longer benefit payment period for IP cover,

the insurer may require you to undertake a blood test and/or attend a medical examination at the insurer's expense.

Death and TPD insurance cover

Please note: that you can select either Unitised or Fixed cover and only one type of cover is applicable at any one time. You may select a different amount of Death cover to TPD cover but any TPD cover amount requested cannot exceed your Death cover.

☐ **Unitised cover** provide the additional (not inclusive of existing cover) units of cover required (where applicable)

Death cover – additional units required units

TPD cover – additional units required units

☐ **Fixed cover** provide the additional (not inclusive of existing cover) amount of cover required (where applicable)

Death cover – additional amount required $

TPD cover – additional amount required $

Section B – Insurance cover (continued)

Income Protection insurance cover

Please note: The maximum amount of Income Protection you can apply for is up to 84% of your gross monthly Income (inclusive of a 9% Super Contribution being allocated to your RBF Investment Account).

Select your insured percentage (one of the following 4 options)

☐ 50% of salary ☐ 59% of salary (including a 9% Super Contribution being allocated into your RBF Investment Account)

☐ 75% of salary ☐ 84% of salary (including a 9% Super Contribution being allocated into your RBF Investment Account)

Select your waiting period: ☐ 30 days ☐ 60 days **Or** ☐ 90 days

Select your benefit payment period: ☐ 2 years ☐ 5 years **Or** ☐ to age 65

Voluntary Income Protection

1. Are you applying for Voluntary Income Protection Cover on top of your Basic Income Protection cover (if any)

No ☐ Yes ☐ ▸ If **'yes'**, proceed to question 2, if **'no'** proceed to Section C - Personal Statement.

2. What is the monthly amount of Voluntary Income Protection cover you wish to apply for? $

Section C – Personal statement

What is your: **Height** cm **or** ft/in **Weight** kg **or** st/lb

Have you smoked in the last 12 months?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate what you smoke

What is your average? per day per week **or** per year

Do you drink alcohol? No ☐ Yes ☐ ▸ If **'yes'**, please provide the average number of standard drinks consumed:

per day per week **or** per year

1. Do you engage in any hazardous pastimes or pursuits such as, but not limited to, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than a fare paying passenger), scuba diving or any sport(s) in a professional capacity?	No ☐ Yes ☐	**A**
2. Have you:		
a) Recently applied for or do you have a policy for life, total and permanent disability, trauma or salary continuance (excluding this application)?	No ☐ Yes ☐	**B**
b) Ever had an application for life, disability, trauma, accident or sickness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms?	No ☐ Yes ☐	**B**
c) Ever claimed a lump sum or accident or sickness benefit from any insurance policy, including but not limited to superannuation, workers' compensation, disability pension or Veterans Affairs?	No ☐ Yes ☐	**B**
3. Have you ever received medical advice, been treated for or diagnosed with back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, injury of any joint, bones or muscle, arthritis, gout or repetitive strain injury (RSI)?	No ☐ Yes ☐	**C**
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental disorder, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, myalgia or fibromyalgia or chronic fatigue syndrome?	No ☐ Yes ☐	**D**
5. Have you received medical advice, undergone any treatment, investigation or operation for, or had:		
a) High blood pressure or raised cholesterol?	No ☐ Yes ☐	**E**
b) Cyst, mole, sunspots or melanoma?	No ☐ Yes ☐	**F**
c) Asthma (other than childhood), bronchitis or any other lung complaint requiring hospitalisation?	No ☐ Yes ☐	**G**
d) Heart complaint, stroke or neurological disorder, including multiple sclerosis?	No ☐ Yes ☐	**G**
e) Cancer, leukaemia, diabetes or chronic kidney complaint?	No ☐ Yes ☐	**G**
6. Have you:		
a) Taken any illegal drugs in the last five years?	No ☐ Yes* ☐	
b) Been advised or received counselling or treatment for alcohol or substance abuse?	No ☐ Yes* ☐	
c) Been infected with or tested positive for HIV/AIDS, Hepatitis B and/or C?	No ☐ Yes* ☐	
d) In the last five years, ever engaged in unprotected male to male sexual intercourse or worked as or engaged the services of a prostitute?	No ☐ Yes* ☐	
7. Apart from anything already stated:		
a) Are you considering seeking medical advice, treatment, tests or surgery in the future?	No ☐ Yes ☐	**G**
b) Have you, in the last five years, received any medical advice, any medical treatment, investigation or had any operation not mentioned above (apart from colds, flu, contraceptive advice)?	No ☐ Yes ☐	**G**
8. To the best of your knowledge, have any of your natural parents, brothers or sisters suffered from or been diagnosed with:		
a) Heart or circulatory problems, stroke, high blood pressure, diabetes?	No ☐ Yes ☐	**H**
b) Depression or any other mental illness?	No ☐ Yes ☐	**H**
c) Cancer of any type?	No ☐ Yes ☐	**H**
d) Huntington's disease, muscular dystrophy, polycystic kidney disease or any other hereditary disease?	No ☐ Yes ☐	**H**

*If you have answered `yes' to question 6, a confidential questionnaire will be sent to you.

Have you answered 'yes' to any questions (1 to 5) or (7 and 8) in Section C?

No ☐ ▸ **Go straight to Section F on page 9. Do not complete Section D or E.**

Yes ☐ ▸ **For each 'yes' answer you must complete a corresponding questionnaire, as noted in the column beside your 'yes' answer above. Proceed to relevant questionnaire in Section D.**

Section D – Questionnaire A – Pastimes questionnaire

Only complete if you answered **'yes'** to **question 1** of **Section C – Personal statement**

1. Do you engage in any of the following hazardous pastimes or pursuits?	
a) Flying? (other than as a fare paying passenger on a commercial airline)	No ☐ Yes ☐
b) Underwater diving (scuba)	
If **'yes'** (i) do you dive more than 40 metres in depth?	No ☐ Yes ☐
(ii) do you dive alone?	No ☐ Yes ☐
c) Football of any code (other than touch or Oztag)	No ☐ Yes ☐
d) Motor sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing	No ☐ Yes ☐
e) Trail bike riding	No ☐ Yes ☐
f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports or recreations involving heights?	No ☐ Yes ☐

If you have answered 'yes' to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

At what level do you participate? (**tick (✔) the appropriate box)**

Recreational only (non competition) ☐

Recreational with competition ☐

Semi-professional/professional ☐

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)?

No ☐ Yes ☐

Questionnaire B – Insurance history questionnaire

Only complete if you answered **'yes'** to any part of **Question 2** of **Section C – Personal statement**

1. Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance on your life with CommInsure, or any other insurance company? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	Type of cover	Insurance benefit	To be replaced?	Date commenced
		$	No ☐ Yes ☐	/ /
		$	No ☐ Yes ☐	/ /
		$	No ☐ Yes ☐	/ /

2. Has an application for life, total and permanent disability, trauma, or salary continuance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

3. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, from any superannuation fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits? No ☐ Yes ☐

If **'yes'**, please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
	/ /	$	/ /
	/ /	$	/ /
	/ /	$	/ /

Questionnaire C – Joint/musculoskeletal questionnaire

Only complete if you answered **'yes'** to **question 3** of **Section C – Personal statement**

1. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

5. Was an x-ray or scan taken?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Date of most recent test / /

Details of results of tests taken:

6. Is the nature of the condition degenerative or a disc problem?

No ☐ Yes ☐

7. Are you still undergoing treatment or experiencing symptoms?

No ☐ ▸ If **'no'**, please complete the details below:

Yes ☐

Date symptoms ceased / /

Date treatment ceased / /

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire D – Mental health questionnaire

Only complete if you answered **'yes'** to **question 4** of **Section C – Personal statement**

1. Please provide details of the condition (doctor's diagnosis):

2. Please indicate the reason or cause by ticking the appropriate box(es):

Bereavement/family illness ☐

Marital problems ☐

Post natal ☐

Work related ☐

Other (please specify) ☐

3. Date symptoms first commenced:

/ /

4. Have the symptoms ceased?

No ☐ Yes ☐ ▸ If **'yes'**, please provide the date symptoms ceased:

5. Have you taken or are you taking medication?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)

6. Have you attempted suicide or had suicidal thoughts?

No ☐ Yes ☐

7. Have you ever been hospitalised?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number

Fax number ( )

Questionnaire E – High blood pressure/ Raised cholesterol questionnaire

Only complete if you answered **'yes'** to **Question 5a** of **Section C – Personal statement**

1. Name of condition
High blood pressure ☐ Raised cholesterol ☐

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain?
No ☐ Yes ☐ ▸ If **'yes'**, please provide details:

4. Are you taking regular medication for this condition?
No ☐
Yes ☐ ▸ If **'yes'**, please provide details, including dosage:

5. Blood pressure
When was your last blood pressure reading?

Was it considered to be well controlled, e.g. less than 140/90?
No ☐ Yes ☐
Don't know ☐

Cholesterol
When was your last cholesterol reading?

What was the result of your last cholesterol reading?
2.0 to 6.5 mmol ☐
6.6 to 7.5 mmol ☐
7.6 or above ☐
Don't know ☐

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire F – Cysts, moles, sunspots or skin lesion questionnaire

Only complete if you answered **'yes'** to **Question 5b** of **Section C – Personal statement**

1. Please provide type:
Cyst ☐ Mole ☐ Sunspot ☐ Skin lesion ☐
Melanoma ☐ Basal cell carcinoma ☐
Other ☐ ▸ please specify:

2. Location of growth(s)
Face/head ☐ Back/shoulder ☐ Chest/front ☐
Arm/leg ☐

3. When was this?

4. Was/were the growth(s) removed?
No ☐ Yes ☐ ▸ If **'yes'**, please complete below:
When was it removed?

How many growths were removed?

Method of removal:
Frozen/burnt off ☐ Surgical/cut out ☐

5. Was/were the growth(s) reported as cancerous (malignant)?
No ☐ Yes ☐ ▸ If **'yes'**, were any further tests, investigations, treatments, follow up or re-excision required?
No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details of further tests, investigations, treatments, follow up or re-excision:

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Only complete if you answered **'yes'** to any part of **Question 5 C, D & E and/or 7** of **Section C – Personal statement**

1. When did you last consult a doctor?

Within the last month ☐ 1 to 3 months ago ☐ 3 to 6 months ago ☐

6 to 12 months ago ☐ 12 months to 2 years ago ☐ Over 2 years ago ☐

a) What was the reason for this consultation?

b) What was the result/outcome from your last consultation? **(tick (✔) the appropriate box)**

Referral to specialist/health professional ☐ Tests conducted – results pending ☐

Ongoing treatment e.g. Ventolin inhaler ☐ Routine tests conducted – results all clear/normal ☐

All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication) ☐ Not fully recovered yet ☐

c) Was the doctor/medical centre consulted, your usual doctor/medical centre?

No ☐ Yes ☐

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

2. This question is for females only, otherwise please continue to question 3.

a) Are you currently pregnant?

No ☐ Yes ☐ ▸ If **'yes'**, what is the due date for your baby?

b) Have you ever had any complications with pregnancy or childbirth? (e.g. diabetes, ectopic pregnancy)

No ☐ Yes ☐ ▸ If **'yes'**, please provide details and dates below

c) Have you ever had an abnormal result for any of the following tests?

i) Pap smear No ☐ Yes ☐

ii) Breast ultrasound No ☐ Yes ☐

iii) Mammogram No ☐ Yes ☐

If **'yes'**, please provide details and dates below

d) Have you ever had a breast lump or breast cyst (even if you have not consulted a doctor)?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details including dates and results of treatments.

▸ Please continue to question 3 overpage...

Questionnaire G – Personal and medical details questionnaire (continued)

3. Have you ever had, or sought advice or treatment, experienced symptoms or suffered from any of the following:

a)	Chest pains, heart complaint, heart murmur, palpitations or rheumatic fever	No ☐ Yes ☐
b)	Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder	No ☐ Yes ☐
c)	Cancer, tumour or melanoma	No ☐ Yes ☐
d)	Thyroid, glandular or pancreatic disorder	No ☐ Yes ☐
e)	Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder	No ☐ Yes ☐
f)	Diabetes or abnormal blood sugar	No ☐ Yes ☐
g)	Any disorder of the gall bladder or liver, including hepatitis B, C or raised liver function	No ☐ Yes ☐
h)	Varicose veins, haemorrhoids or hernia	No ☐ Yes ☐
i)	Disorder of the kidney, bladder or prostate, blood in urine or kidney stones	No ☐ Yes ☐
j)	Epilepsy, fits of any kind, fainting episodes or recurring headaches or migraines	No ☐ Yes ☐
k)	Asthma (other than childhood), bronchitis or any other lung complaint requiring hospitalisation in the last 5 years?	No ☐ Yes ☐
l)	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder	No ☐ Yes ☐
m)	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome	No ☐ Yes ☐
n)	Eczema, dermatitis, psoriasis or any other skin disorder	No ☐ Yes ☐
o)	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder	No ☐ Yes ☐
p)	Any impairment of sight (other than corrected by glasses or lenses) or blurred vision	No ☐ Yes ☐
q)	Any impairment of hearing or speech including tinnitus	No ☐ Yes ☐
r)	Any sexually transmitted diseases	No ☐ Yes ☐
s)	Any other illness, injury, disease or disorder not mentioned above	No ☐ Yes ☐
t)	Other than those conditions mentioned above, are you taking any regular prescribed medication	No ☐ Yes ☐
u)	Within the last three years, have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results, a genetic test or an ultrasound (other than for pregnancy)?	No ☐ Yes ☐
v)	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No ☐ Yes ☐

If you have answered **'yes'** to any **of the above questions**, please provide full details of each **'yes'** answer in **Section E – General health questionnaire on page 8.**

Questionnaire H – Family history questionnaire

Only complete if you answered **'yes'** to any part **Question 8** of **Section C – Personal statement**

1. Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

2. Have you had or do you intend on having a genetic test?

No ☐ Yes ☐

3. What was the result of the genetic test? (please mark the appropriate box)?

Have not been tested yet ☐ Positive (I have the gene) ☐ Negative (I do not have the gene) ☐ Unsure ☐

Section E – General health questionnaire

If you have answered **'yes'** to any part of **Question 3 a to v** in **questionnaire G**, please complete the table below:

Details for question number:	Question ( )	Question ( )	Question ( )
1. Name of condition?			
2. Date symptoms first started?			
3. Date symptoms ceased (if applicable)?			
4. Are these symptoms ongoing?			
5. How often do/did you have symptoms? Please choose one of the following: **daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).**			
6. Severity of symptoms? Please choose one of the following: **mild, moderate, severe, never had symptoms, symptoms ceased.**			
7. Did you take medication or have any other treatment for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'** please give details of the medication/treatment.			
8. Are you still on treatment, including medication?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
9. Have you ever been off work as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please indicate the total time off work.			
10. Have you had any residual, ongoing effects or restrictions as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
11. Have you ever had an x-ray, scan or blood test for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
12. Is your treating doctor different from your usual doctor?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please provide the doctor's name and contact details.			

Section F – Duty of disclosure

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 those matters to the insurer before you 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 your 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.

Section G – Privacy of your personal information

How we handle your personal information

Personal information is information or opinion that allows others to identify you. It includes your name, age, gender, contact details as well as your health and financial information. CommInsure are part of the Commonwealth Bank Group.

We will act to protect your personal information in accordance with the National Privacy Principles or an industry privacy code.

The Group is a collection of related organisations that provide banking, finance, insurance, funds management, financial planning and advice, superannuation, stockbroking and other services.

The protection of your personal information is a vital part of our service. It is supported by our long experience of keeping personal information confidential.

We collect personal information to provide you with the products and services you request and the law may also require us to collect personal information. We will tell you who collects the personal information, advise you of their contact details, your right of access to that information and what will happen if you choose not to provide the information.

Personal information may be used and disclosed within the Group to administer our products and services, as well as for prudential and risk management purposes. We also use the information we hold to help detect and prevent illegal activity. We co-operate with police and other enforcement bodies as required or allowed by law.

We disclose relevant personal information to external organisations that help us provide services. These organisations are bound by confidentiality arrangements. They may include overseas organisations.

You can seek access to the personal information we hold about you. If the information we hold about you is inaccurate, incomplete or outdated, please inform us so that we can correct it. If we deny access to your personal information, we will let you know why.

For example, we may give an explanation of a commercially sensitive decision, rather than direct access to evaluative information connected with it.

Further information and feedback

If you have any questions or would like further information on our privacy and information handling practices, please contact us by:

E-mail at **CustomerRelations@cba.com.au**

Telephone **1800 805 605***, or writing to the address below:

Privacy Officer
Customer Relations
Commonwealth Bank Group
Reply Paid 41
Sydney NSW 2001

* A free call unless made from a mobile phone, which will be charged at the applicable mobile rate.

These sections must be completed in all circumstances

Section H – Telephone underwriting

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion. I permit the insurer (CommInsure) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my duty of disclosure as described in Section F.

No ☐ Yes ☐ ▸ If **'yes'**, I am contactable on the following number

between the hours of ____ am ☐ pm ☐ and ____ am ☐ pm ☐

(note they must be usual business hours eastern standard time)

Section I – Doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Phone number ( )

Fax number ( )

Doctor's address

State Postcode

Section J – Declaration

I have read the duty of disclosure in this Personal statement 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.
- any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

I declare that:

- the answers to all the questions and the declarations on this Personal Statement 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 privacy of your personal information in Section G on page 9. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.
- I have read and understand the obligations outlined in the duty of disclosure in Section F on page 9.

A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Full name

Signature of life to be insured

✗

Date

/ /

Please ensure that you initial any amendments or changes made throughout this form

Please return the completed form to RBF, Reply Paid 446, Hobart TAS 7001. Free call: 1800 622 631