

Insurance Cover Form



ALL SECTIONS MUST BE COMPLETED

PLEASE ☒ NOT ☒

PLEASE USE BLOCK LETTERS



ABOUT THIS FORM

Complete this form if you wish to apply for Death and TPD insurance cover or increase your existing Death and TPD cover with Club Super. Return your completed form to Club Super.

If you would like to reinstate your Income Protection insurance (SalarySafe) or nominate a waiting period for your Income Protection insurance then download the *Application to change Income Protection Insurance (SalarySafe)* Form available at clubsuper.com.au/forms-and-resources/forms.

If you would like to cancel your Death, TPD or Income Protection insurance then download the *Request to Cancel Insurance Cover Form* available at clubsuper.com.au/forms-and-resources/forms.

PERSONAL DETAILS

ARE YOU A MEMBER OF CLUB SUPER?

☐ YES ☐ NO If YES, Member No:

Note: if you have changed your name since first becoming a member please attach a certified copy of your Marriage Certificate, Deed Poll or a Statutory Declaration as proof.

DATE OF BIRTH

GENDER

/ /

☐ MALE ☐ FEMALE

TITLE

SPECIFY IF OTHER

☐ MR ☐ MRS ☐ MISS ☐ OTHER

FIRST NAME

MIDDLE NAME

FAMILY NAME

EMAIL ADDRESS

PHONE NUMBER

MOBILE NUMBER

RESIDENTIAL ADDRESS

STREET NUMBER

STREET NAME

SUBURB/TOWN

STATE POSTCODE

POSTCODE

POSTAL ADDRESS (If same as above, write "as above")

PO BOX

SUBURB/TOWN

STATE POSTCODE

POSTCODE

SECTION A: PERSONAL DETAILS (continued)

Club Super automatically provides you with Income Protection insurance for up to 90% of your salary, for the first 26 weeks of your claim (tapering applies thereafter). If you're aged 24 or under, you automatically receive 1 unit of Death cover and 2 units of Total Permanent Disablement (TPD) cover. If you're aged 25 or over you automatically receive 2 units of Death cover and 2 units of TPD cover. This is the 'default' number of units.

If eligible, you can elect to have up to 3 additional units of Death and TPD cover. To receive up to 3 additional units of Death and TPD cover, please complete the *Short Form Underwriting Form* available at clubsuper.com.au/forms-and-resources/forms.

If you require more than 3 additional units, please complete this *Insurance Cover Form*, including the Personal Statement section.

The value of unit based cover decreases as you get older. As an alternative, you may apply for fixed cover (with premiums then increasing as you get older). However, the minimum amount of 'fixed' cover you must have is equivalent to the value of 1 unit (based on your current age).

NOTE: Fixed TPD cover tapers at older ages.

Please refer to the *Club Super Additional Information - Insurance in your super* available at clubsuper.com.au

The maximum amount of Death insurance cover available is \$5,000,000. The maximum amount of TPD insurance cover available is \$2,500,000. If you require more than \$2,500,000 in Death insurance cover, your TPD insurance cover will be limited to \$2,500,000, subject to approval by the insurer.

WORK STATUS Are you currently working and actively performing your normal duties?

☐ YES ☐ NO

DEATH AND TPD INSURANCE

UNIT BASED COVER

Death and TPD cover

I would like the following units of Death and TPD cover:

Total number of Death units required

Total number of TPD units required

OR

FIXED AMOUNT COVER

(must be at least the value of 1 unit based on your current age)

Death and TPD cover

I would like to fix my Death cover at an amount of

\$.00

I would like to fix my TPD cover at an amount of

\$.00

PLEASE COMPLETE RELEVANT SECTIONS



YOUR PRIVACY IS IMPORTANT TO US

We only collect information that is essential for the administration of your superannuation benefits, including providing you with insurance cover. The information we ask for is for the purpose of identifying you, and in order to properly administer your superannuation benefits. If you do not provide all of the information we may be unable to action your request.

Information we hold about members may be provided to third parties including our insurers, your employer/s, advisers and other service providers, where the information needs to be shared in relation to your active or potential insurance claims. Personal information collected will not be used or disclosed for any other purpose without your consent, except where required by superannuation, taxation or other relevant law. You are entitled to access information that Club Super holds about you – contact us by telephone on 1300 369 330 or in writing.

Club Super's full Privacy Policy, is available on the website - clubsuper.com.au or by calling us on 1300 369 330. You may also wish to read a copy of the insurer's Privacy Policy in conjunction with our Privacy Policy. The insurer's Privacy Policy can be found at www.commbank.com.au or by calling 13 10 56.

DECLARATION

In signing this application, I:

- acknowledge I have read and understood the terms of the current Club Super Product Disclosure Statement; including the section on Insurance, and acknowledge it does not constitute personal advice;
- agree to be bound by the terms and conditions contained in the trust deed and current Product Disclosure Statement;
- declare that the information in this form is true and correct to the best of my knowledge and belief;

SIGNATURE

DATE



PERSONAL STATEMENT

You are applying to enter into a contract of insurance.

As such, you have a duty to disclose all relevant information. Failing to provide the insurer with full and accurate information could result in your insurance cover being cancelled and any claim for benefits could be denied, so it is vital you answer all questions fully and accurately.

Although we ask you specific questions via a personal statement, you should also tell us about any other information that will impact on the insurer's decision to offer you insurance cover, regardless of whether you deem it to be material or important. This includes current medical issues that require investigation, medication or treatment, even if a diagnosis has not been made.

This obligation applies to all insurance cover relating to this application, including amounts transferred from another fund or insurance arrangement. This means you could be placed in a position where you have no insurance cover if we later find you have not answered all questions fully and accurately.

Your Duty of Disclosure continues until you receive written confirmation your application has been accepted. You must contact the insurer if there is any change in your health or circumstances that are relevant to the insurer's decision on your application.

The full Duty of Disclosure is contained within this document and it is important you read it carefully. Having read the above, I declare the information I am about to provide is honest, true and complete.

SIGNATURE

DATE

 / /

SECTION A: YOUR DETAILS

EMPLOYER

OCCUPATION

SALARY (or remuneration earned in the last 12 months)

1) What is your:

Height: cm or ft/in

Weight kg or st/lb

2) Have you smoked tobacco, e-cigarettes or any other substance in the last 12 months?

No ☐ Yes ☐

If 'yes', please indicate what you smoked:

What is your average?

per day per week or per year

3) Do you drink alcohol?

No ☐ Yes ☐

If 'yes', please provide the average number of standard drinks consumed:

per day per week or per year

PLEASE COMPLETE RELEVANT SECTIONS

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SECTION B: PERSONAL STATEMENT

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 <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	B
3. Have you ever experienced symptoms, received medical advice, been treated for or diagnosed with any back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, or an injury, complaint or disorder of any joint, bones or muscle, including arthritis, gout or repetitive strain injury (RSI)?	No <input type="checkbox"/> Yes <input type="checkbox"/>	C
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental illness, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, attention deficit disorder or aspergers syndrome, myalgia or fibromyalgia or Chronic Fatigue Syndrome?	No <input type="checkbox"/> Yes <input type="checkbox"/>	D
5. Have you received medical advice, undergone any treatment, investigation or operation for, or had:		
a) High blood pressure or raised cholesterol?	No <input type="checkbox"/> Yes <input type="checkbox"/>	E
b) Cyst, mole, sunspots, skin lesions, skin cancer or melanoma?	No <input type="checkbox"/> Yes <input type="checkbox"/>	F
c) Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint requiring hospitalisation?	No <input type="checkbox"/> Yes <input type="checkbox"/>	G
d) Chest pain, heart complaint, cardiomyopathy, stroke, neurological disorder, multiple sclerosis, muscular dystrophy or blood disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>	G
e) Cancer, leukaemia, diabetes or chronic kidney complaint?	No <input type="checkbox"/> Yes <input type="checkbox"/>	G
6. Have you:		
a) Taken any illegal or non prescribed drugs (other than over the counter medications) in the last ten years?	No <input type="checkbox"/> Yes* <input type="checkbox"/>	
b) Ever been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?	No <input type="checkbox"/> Yes* <input type="checkbox"/>	
c) Ever been infected with or tested positive for HIV/AIDS, Hepatitis B and/or C or are you awaiting the results of such a test?	No <input type="checkbox"/> Yes* <input type="checkbox"/>	
d) In the last five years, ever engaged in unprotected anal intercourse (except in a relationship between you and one other person only where that person is not known or suspected to be HIV positive and/or injects non-prescribed drugs) or worked as or engaged the services of a prostitute?	No <input type="checkbox"/> Yes* <input type="checkbox"/>	
7. Apart from anything already stated:		
a) Are you considering seeking medical advice, treatment, tests or surgery in the future?	No <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	H
b) Depression or any other mental illness?	No <input type="checkbox"/> Yes <input type="checkbox"/>	H
c) Cancer of any type?	No <input type="checkbox"/> Yes <input type="checkbox"/>	H
d) Huntington's disease, muscular dystrophy, multiple sclerosis, polycystic kidney disease or any other hereditary disease?	No <input type="checkbox"/> Yes <input type="checkbox"/>	H
9. a) In the next twelve months do you plan to travel to another country?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
b) In the last six months have you been in another country?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
If yes to either or both question(s), please provide details below:		
Country/Destination	Date of Departure from Australia (if applicable)	Date of return/ arrival in Australia

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

No ☐ Go straight to Section E on page 13. Do not complete Section C or D.

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 C.

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

PLEASE COMPLETE RELEVANT SECTIONS

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SECTION C: QUESTIONNAIRE A - PASTIMES QUESTIONNAIRE

Only complete if you answered 'yes' to Question 1 of Section B – Personal statement

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

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 (X) 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 B – 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 <input type="checkbox"/> Yes <input type="checkbox"/>	/ /
		\$	No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /
		\$	No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /

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
	/ /	\$	/ /
	/ /	\$	/ /
	/ /	\$	/ /

PLEASE COMPLETE RELEVANT SECTIONS

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QUESTIONNAIRE C – JOINT/MUSCULOSKELETAL QUESTIONNAIRE

Only complete if you answered 'yes' to Question 3 of Section B – 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 ☐ Yes ☐ If 'no', please complete the details below:

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 ()

PLEASE COMPLETE RELEVANT SECTIONS



QUESTIONNAIRE D – MENTAL HEALTH QUESTIONNAIRE

Only complete if you answered 'yes' to Question 4 of Section B – 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)
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

PLEASE COMPLETE RELEVANT SECTIONS

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QUESTIONNAIRE E – HIGH BLOOD PRESSURE/RAISED CHOLESTEROL QUESTIONNAIRE

Only complete if you answered 'yes' to Question 5a of Section B – 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 5.9 mmol
☐ 6.0 to 6.9 mmol
☐ 7.0 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 B – 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. What date did you first notice this growth?

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

When was it removed?

 / /

Number of growths removed:

One ☐ Two ☐ Three ☐ More ☐

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?

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 ()

PLEASE COMPLETE RELEVANT SECTIONS

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QUESTIONNAIRE G – PERSONAL AND MEDICAL DETAILS QUESTIONNAIRE

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

☐ 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) Will you be returning to work in the same capacity as your current occupation, eg: back to the same or greater hours within or at the end of your 12 month maximum maternity leave?

No ☐ Yes ☐

c) Have you ever had any complications with pregnancy or childbirth? (e.g. diabetes, ectopic pregnancy, pre-eclampsia & excluding elective caesarian or miscarriage in the first 15 weeks)

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

d) 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

e) Have you ever had a breast lump or breast cyst or any other type of breast abnormality (even if you have not consulted a doctor)?

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

f) Have you ever sought treatment for any condition of the ovary, uterus, endometrium or perineum?

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

PLEASE COMPLETE RELEVANT SECTIONS

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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)	Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint requiring hospitalisation	No <input type="checkbox"/> Yes <input type="checkbox"/>
b)	Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever	No <input type="checkbox"/> Yes <input type="checkbox"/>
c)	Stroke, paralysis, neurological disorder, multiple sclerosis, muscular dystrophy or blood vessel disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
d)	Alzheimer's, Parkinson's dementia or any other disorder of the brain	No <input type="checkbox"/> Yes <input type="checkbox"/>
e)	Cancer, tumour or melanoma	No <input type="checkbox"/> Yes <input type="checkbox"/>
f)	Thyroid, glandular, pituitary or pancreatic disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
g)	Gastric or duodenal ulcer, persistent indigestion, gastro oesophageal reflux disease, Barrett's oesophagitis, irritable bowel or other bowel disorder (eg: polyps, ulcerative colitis and Crohn's disease)	No <input type="checkbox"/> Yes <input type="checkbox"/>
h)	Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar	No <input type="checkbox"/> Yes <input type="checkbox"/>
i)	Any disorder of the gall bladder or liver, including hepatitis B, C or fatty liver/raised liver function	No <input type="checkbox"/> Yes <input type="checkbox"/>
j)	Varicose veins, haemorrhoids or hernia	No <input type="checkbox"/> Yes <input type="checkbox"/>
k)	Disorder of the kidney, bladder or prostate (including raised PSA), blood in urine or kidney stones	No <input type="checkbox"/> Yes <input type="checkbox"/>
l)	Epilepsy, fits of any kind, fainting episodes, dizziness or vertigo or recurring headaches or migraines	No <input type="checkbox"/> Yes <input type="checkbox"/>
m)	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder including insomnia	No <input type="checkbox"/> Yes <input type="checkbox"/>
n)	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome	No <input type="checkbox"/> Yes <input type="checkbox"/>
o)	Eczema, dermatitis, psoriasis or any other skin disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
p)	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder, embolism, thrombosis (DVT) or Factor V Leiden	No <input type="checkbox"/> Yes <input type="checkbox"/>
q)	Any impairment of sight (other than corrected by glasses or lenses) or blurred vision	No <input type="checkbox"/> Yes <input type="checkbox"/>
r)	Any impairment of hearing (including tinnitus, deafness, high frequency hearing loss) or speech	No <input type="checkbox"/> Yes <input type="checkbox"/>
s)	Any sexually transmitted diseases	No <input type="checkbox"/> Yes <input type="checkbox"/>
t)	Any other illness, injury, disease or disorder not mentioned above	No <input type="checkbox"/> Yes <input type="checkbox"/>
u)	Other than those conditions mentioned above, are you taking any regular prescribed medication	No <input type="checkbox"/> Yes <input type="checkbox"/>
v)	Have you undergone screening for diseases or conditions such as, but not limited to, bowel cancer or have you had a genetic test?	No <input type="checkbox"/> Yes <input type="checkbox"/>
w)	Within the last three years, have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results or an ultrasound (other than for pregnancy)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
x)	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No <input type="checkbox"/> Yes <input type="checkbox"/>

If you have answered 'yes' to any of the above questions, please provide full details of each 'yes' answer in Section D – General health questionnaire on page 12.

QUESTIONNAIRE H - FAMILY HISTORY QUESTIONNAIRE

Only complete if you answered 'yes' to any part of Question 8 of Section B – 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. If 'yes', 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

PLEASE COMPLETE RELEVANT SECTIONS



SECTION D: GENERAL HEALTH QUESTIONNAIRE

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

Details for question number:	Question ()	Question ()	Question ()
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started?			
3. Date symptoms ceased (if applicable)?			
4. Are these symptoms singular, recurrent or 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? If 'yes' please give details of the medication/treatment.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
8. Are you still on treatment, including medication?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
9. Have you ever been off work as a result of this condition? If 'yes', please indicate the total time off work.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
11. Have you ever had an x-ray, scan or blood test for this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
12. Is your treating doctor different from your usual doctor? If 'yes', please provide the doctor's name and contact details.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

PLEASE COMPLETE RELEVANT SECTIONS

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SECTION E: DUTY OF DISCLOSURE

Duty of disclosure

Before a person enters into a life insurance contract in respect of their life or the life of another person, they have a duty to tell the insurer anything that they know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms.

The person entering into the contract has this duty of disclosure until the insurance is provided.

The person who has entered into the contract has the same duty before they extend, vary or reinstate the contract.

The person entering into the contract does not need to tell the insurer anything that:

- reduces the risk of the insurance; or
- is common knowledge; or
- the insurer knows or should know as an insurer; or
- the insurer waives the duty to tell the insurer about.

If the insurance is for the life of another person and that person does not tell the insurer something that they know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to comply with their duty of disclosure.

If the person entering into the contract does not tell us something

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

If the person entering into the contract does not tell the insurer anything they are required to, and the insurer would not have provided the insurance if they had been told, the insurer may avoid the contract within 3 years of entering into it.

If the insurer chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the person entering the contract had told the insurer everything they should have. However, if the contract has a surrender value or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time, vary the contract in a way that places the insurer in the same position it would have been in if the person entering the contract had told the insurer everything they should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to comply with the duty of disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

SECTION F: PRIVACY OF YOUR PERSONAL INFORMATION

How we handle your personal information

Personal information we collect about you can include information such as your identity, contact details, gender, marital status, medical, life style and financial information. We collect information directly from you and from others such as, trustees, employers, service providers, family members or anyone that holds information relevant to your application or claim. We may be required by law to identify you or people who act on your behalf and we may verify the information provided. When we do so we may disclose your personal information. This collection and verification helps us to protect against fraud and other illegal activities. It's important you provide us with accurate and complete information. If you don't, we may not be able to provide you with the product or service that you are seeking such as processing your application or claim.

We collect, use and exchange your information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services
- administer our products and services, including managing your application, cover and claims
- manage our relationship with you and to contact you, including by electronic means
- manage our risks (including by reinsurance) and help identify and investigate illegal activity, such as fraud
- conduct and improve our businesses and improve the customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you.

We may also collect, use and exchange your information in other ways permitted by law.

We may exchange your information with other members of the Commonwealth Bank group (CBA), so that the group may adopt an integrated approach to its customers. CBA members may use this information in the same way we use your information. We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information. Third parties include:

- trustees of superannuation funds and their administrators, your employer and former employers
- brokers, agents, advisers, attorneys and persons acting on your behalf,
- medical and healthcare practitioners, claims-related providers such as assessors and investigators, insurance reference agencies, reinsurers, auditors and other insurers
- organisations to whom we may outsource certain functions eg IT
- any one that we reasonably believe may hold information relevant to your application, cover or claim.

Where we exchange your personal information with our service providers or agents confidentiality arrangements apply and they can use this personal information in the same way as we do. We may be required to disclose information by law, e.g. under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to illegal activities, fraud, sanctions, anti-money laundering or counter terrorism financing.

We may send your information overseas. Overseas parties can include CBA companies or other parties who operate or hold data outside Australia. Where we send it to these parties, we make sure that appropriate data handling and security arrangements are in place. Information may be sent overseas to complete assessment or to manage your application or claim (such as when we are required to send information under reinsurance arrangements) or where this is required by law and regulation of Australia or another country. As well as reinsurers, overseas parties can include medical or rehabilitation practitioners or other parties. Australian law may not apply to some of these overseas parties. Information about what countries your information may be sent to by us is included in our Privacy Policy.

The law generally allows you to access your personal information and to have any inaccurate information corrected. Our information handling practices, information on how to make a complaint and how we deal with your complaint is described in our Privacy Policy which is available at www.commbank.com.au or upon request at any CBA branch.

PLEASE COMPLETE RELEVANT SECTIONS

Insurance Cover Form



SECTION G: 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 E.

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 H: 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

Doctor's address

State Postcode Phone number () Fax number ()

SECTION I: 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 agree to provide further medical authorities if requested.

I declare that:

- the answers to all the questions and the declarations in 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 F. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.
- I have read and understand the obligations outlined in the "Duty of disclosure" in Section E.

I agree that a photocopy or electronically transmitted image of this authorisation is as effective and valid as the original signed authorisation.

FULL NAME

SIGNATURE OF LIFE TO BE INSURED

DATE

PLEASE ENSURE THAT YOU INITIAL ANY AMENDMENTS OR CHANGES MADE THROUGHOUT THIS FORM.
RETURN THE COMPLETED FORM, WITH ATTACHMENTS, TO CLUB SUPER PO BOX 10726 BRISBANE ADELAIDE STREET QLD 4000

RETURN COMPLETED FORM TO: CLUB SUPER PO BOX 10726 BRISBANE ADELAIDE STREET QLD 4000
OR EMAIL A SCANNED COPY OF THE COMPLETED FORM TO: info@clubsuper.com.au

Club Plus Qld. Pty. Ltd. (ABN 30 010 892 396), the Trustee of Club Super (ABN 12 737 334 298) is Corporate Authorised Representative No. 268814 under AFSL No. 238507.
Club MySuper Product Unique Identifier 12737334298988.

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