Personal Health Statement (Full Form)

Complete this form if you are applying for Death only, Death and TPD or Income Protection cover for amounts:

- *more than $6,000 per month for Income Protection cover; and/or*
- *more than $800,000 for Death only or Death and TPD cover; or*
- *Less than these amounts and you were unable to answer 'No' to each of the questions 1 to 4 and 6 to 10 of the Health Evidence section of your initial application.*

YOUR DUTY OF DISCLOSURE

Before MLC Limited (MLC) advises acceptance of cover on your life, you have a duty under the Insurance Contracts Act 1984 to inform MLC of every matter that you know, or could reasonably be expected to know, which may affect MLC's decision to insure you or the terms of that insurance cover. You have the same duty to inform MLC before cover is varied, extended or reinstated. This duty of disclosure does not apply to anything that reduces MLC's risk, that is common knowledge that MLC should know in the ordinary course of business or that MLC does not require you to disclose. Your duty of disclosure applies even after this Personal Health Statement is completed until MLC advises acceptance of the cover.

If you do not disclose relevant matters and MLC would not have granted cover at all, MLC may cancel cover within three years of granting it. If your non-disclosure was fraudulent, MLC may cancel cover at any time. If MLC is entitled to cancel the insurance cover or increase in insurance cover, it may within the first three years adjust the sum insured based on the premium charged, to the amount that would have applied had full disclosure been made.

All questions on this Personal Health Statement are relevant as to whether or not MLC accepts the risk and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dot or dash is not acceptable.

Part 1 – Personal details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Other

Surname ☐ Sex ☐ Male ☐ Female

Given names ☐ Date of birth / /

My height is ☐ cms OR ☐ ft ins My weight is ☐ kgs OR ☐ st lbs

Address ☐

Suburb ☐ Postcode ☐

Phone Home ☐ Work ☐ Mobile ☐

Email ☐

Occupational details

Current occupation ☐

(Please include details of all manual work)

Industry ☐

Number of hours worked per week ☐ *(must be regular and consistent hours every week)*

Annual income last financial year $ ☐ *(from your current occupation, net of expenses but before tax) DO NOT INCLUDE INVESTMENT INCOME*

Insurance benefit cover requirements

Death only ☐ ***OR*** Death & TPD ☐

(max. $10 million) *(max. $10 million death, $3 million TPD)*

Income protection ☐ per month ***OR*** ☐ of income

(max. $30,000 per month or 75% income + superannuation)

Waiting period 30 days ☐ 90 days ☐

Benefit payment period 2 years ☐ 5 years ☐ Age 65 ☐

Part 2 - Insurance history details

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? Yes ☐ No ☐

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

Insurance company name	Date	Terms offered and reason

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

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

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

Part 3 - Activities and pastime details

Do you currently engage in or intend to engage in any of the following sports or hazardous activities:

1. Flying (other than as a fare paying passenger on a commercial airline)? Yes ☐ No ☐
2. Underwater diving? Yes ☐ No ☐
3. Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing? Yes ☐ No ☐
4. Football of any code (including touch football or tag)? Yes ☐ No ☐
5. Any other sport or hazardous activities, eg. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports or recreations involving heights? Yes ☐ No ☐

If you have answered '**Yes**' to questions 1, 2 or 3 above, please complete a Pastimes Questionnaire. This is available from Client Services on 1300 654 720, your Adviser or can be downloaded from the Underwriting Forms section of Smartsave's website at smartsavesuper.com.

If you have answered '**Yes**' to questions 4 or 5 above, please provide full details below:
What are the activity/ies you engage in?

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

Recreational only (non-competition) ☐ Recreational with competition ☐ Semi-professional/professional ☐

Part 4 - Personal health details

1. Have you smoked tobacco or any other substance or used any nicotine - containing product at any time in the last twelve months? Yes ☐ No ☐

If '**Yes**', please indicate type (eg. cigarettes, gum, patch etc.) and average amount consumed in one of the following boxes.

Type	Per day	Per week	Per year

2. Do you drink alcohol? Yes ☐ No ☐

If '**Yes**', please provide the average number of standard drinks consumed in one of the following boxes

Per day	Per week	Per year

Part 5 - Family history

Have any of your immediate family (parents, brothers, sisters) suffered from or been diagnosed with any of the following:

Heart problems, stroke, high blood pressure, diabetes — *Unknown* ☐ *Yes* ☐ *No* ☐

Cancer — *(please specify type and site)*

*Any other inherited or hereditary disease ** — *(please specify type)*

** Huntington's disease, polycystic kidney, muscular dystrophy, familial polyposis, etc.*

Any of the following:

Kidney Disease, Rheumatoid Arthritis, Motor Neuron Disease or Multiple Sclerosis

*If '**Yes**', please complete the following table*

Family member	*Condition*	*approximate age of onset*	*Age at death (if applicable)*

Part 6 - Doctor Details

1. What is the name and address of the last doctor or medical centre you visited?

Full name of doctor

Address

Phone number ( ) *Fax number* ( )

2. How long have you been attending this practice? *Years* ☐ *Months* ☐

3. a. What was the date of your last consultation? / /

b. Reason for last consultation

c. What was the result/outcome from your last consultation? (please tick (✔) the appropriate box)

- *Referral to specialist/health professional* ☐
- *Tests conducted – results pending* ☐
- *Not fully recovered yet* ☐
- *Ongoing treatment (eg. 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)* ☐

4. Is the doctor/medical centre mentioned above your usual doctor/medical centre? *Yes* ☐ *No* ☐

*If **No**, please provide details of your usual doctor or medical centre*

Doctor's Name or Medical Centre

Address

Phone Number

Part 7 - Medical History

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

1.	***Asthma***	Yes ☐	No ☐
2.	***Cysts, moles, sunspots*** *or skin lesions?*	Yes ☐	No ☐
3.	***Arthritis, gout, osteoporosis,*** *fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome?*	Yes ☐	No ☐
4.	***Back, neck, shoulder, knee, elbow complaints****, sciatica, disc or spine complaints, or injury of the joints, bones or muscles?*	Yes ☐	No ☐
5.	***Depression or mental disorder*** *(including but not limited to stress, anxiety, panic attacks, behavioural or nervous disorder)?*	Yes ☐	No ☐
6.	***High blood pressure*** *or* ***high cholesterol*** *.*	Yes ☐	No ☐
7.	*Heart condition*	Yes ☐	No ☐
8.	*Epilepsy or any neurological disease*	Yes ☐	No ☐
9.	*Stroke or vascular disorder*	Yes ☐	No ☐
10.	*Lung complaint*	Yes ☐	No ☐
11.	*Diabetes, bowel, kidney or bladder disorder*	Yes ☐	No ☐
12.	*Alcohol or drug dependence*	Yes ☐	No ☐
13.	*Professional advice to reduce alcohol consumption*	Yes ☐	No ☐
14.	*Migraine, persistent headache or chronic fatigue*	Yes ☐	No ☐
15.	*Disorder of the productive system (eg prostrate, ovary)or sexually transmitted disease*	Yes ☐	No ☐
16.	*Cancer or leukaemia*	Yes ☐	No ☐
17.	*Haemophilia or blood disorder*	Yes ☐	No ☐
18.	*Liver disorder, hepatitis or test indicating past or present hepatitis infection*	Yes ☐	No ☐
19.	*Any allergies, skin disorder or disorder of the eyes, ears, nose or throat*	Yes ☐	No ☐
20.	*Any other operation, disability, illness, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned*	Yes ☐	No ☐
21.	*Other than already stated, have you, in the last 5 years:*		
	i. *Taken any prescribed medication on a regular or ongoing basis? (other than for colds or flu)*	Yes ☐	No ☐
	ii. *Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?*	Yes ☐	No ☐
22.	*Do you NOW have any other disability, illness, injury or symptoms not already mentioned?*	Yes ☐	No ☐
23.	*Do you contemplate seeking any advice, test, investigation or treatment?*	Yes ☐	No ☐

Females Only

24.	*Are you currently pregnant?*	Yes ☐	*Date Due*	/ /	No ☐
25.	*Have you had any complications of pregnancy or childbirth?*			Yes ☐	No ☐
26.	*Have you ever had an abnormal pap smear*			Yes ☐	No ☐

If you have answered 'Yes' to questions 1 to 6 above, please complete the following Underwriting Questionnaires:

1. *Yes to question 1 – Asthma Questionnaire*
2. *Yes to question 2 – Cyst Questionnaire*
3. *Yes to question 3 – Musculoskeletal Questionnaire*
4. *Yes to question 4- If you are applying for Total and Permanent Disablement or Income Protection insurance – Back & Neck Questionnaire*
5. *Yes to question 5 – Mental Health Questionnaire*
6. *Yes to question 6 – Blood Pressure Questionnaire*

All of these Questionnaires are available from Client Services on 1300 654 720, your Adviser or can be downloaded from the Underwriting Forms section of Smartsave's website at smartsavesuper.com.

Part 8 - General health questionnaire

*If you have answered '**Yes**' to any part of questions 7 to 26 in **Part 7**, please complete the table below. Please ensure you write the question number in the brackets above each column.*

	Question ( )	Question ( )	Question ( )
1. Name of condition	1.	2.	3.
2. Date symptoms first started	/ /	/ /	/ /
3. Date symptoms ceased (if ongoing please state)	/ /	/ /	/ /
Ongoing	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4 How often do/did you have symptoms? Please choose one of the following **daily, weekly, monthly, quarterly, half yearly, yearly, one off, other (please specify)**			
5 Severity of condition Please choose from one of the following **mild, moderate, severe, never had symptoms, symptoms ceased**			
6. Did you take medication or have you had any other treatment (eg. physiotherapy or an operation) for this condition? (please tick box)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If '**Yes**', name the treatment/condition	Details	Details	Details
7. Are you still on treatment, including medication? (please tick box)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Have you ever been off work due to this condition? (please tick box)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If there is insufficient space please attach an additional sheet	Details	Details	Details
If '**Yes**', please state the total time off work in days, months and years	Days	Days	Days
	Months	Months	Months
	Years	Years	Years
9. Have you had any residual, ongoing effects or restrictions as a result of this condition? (please circle answer)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If '**Yes**', please provide details and dates	Details	Details	Details

Part 9 - Lifestyle declaration

1. *Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition .* Yes ☐ No ☐
2. *In the past three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? Note – HIV risk situations are situations in which you have been potentially exposed to HIV infection. These situations include but are not limited to, intercourse with someone you know or suspect to be HIV positive, intravenous drug use, or unprotected anal intercourse (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).* Yes ☐ No ☐

If you have answered Yes to either of these questions, a confidential questionnaire will be sent to you for completion by MLC's Chief Underwriter.

Part 10 - Declaration

I agree that this Personal Health Statement and any other medical evidence obtained shall be the basis on which MLC grants cover on my life under the Smartsave 'Member's Choice' Superannuation Master Plan. I understand that all questions asked on this Personal Health Statement are relevant to MLC's decision whether to accept the risk and, if so, on what terms. I also understand that I must advise MLC of any change in my health between now and when MLC actually accepts the cover being sought.

I authorise:

- *MLC 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);*
- *MLC and any person appointed by MLC to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me; and*
- *any hospital, doctor or other person who has treated or examined me to give to MLC any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.*

I hereby declare that I have read and understood the general nature and effect of a member's Duty of Disclosure, shown on page 1 of this Personal Health Statement. I have also read the Privacy Statement in the PDS. Please note that a copy of the PDS is available at www.smartsavesuper.com or on request from the Administrator on 1300 654 720.

I further declare that all the answers shown on this Personal Health Statement are true and that I have not withheld any information which might be material to MLC accepting cover on my life. To the extent that any answers are not in my own handwriting, they have been checked by me and I certify that they are correct.

I understand that cover to which this Personal Health Statement relates will not commence until MLC accepts in writing my application for insurance on standard terms or I accept in writing any non-standard terms offered to me and MLC receives a sufficient contribution to meet the required premium. A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Full Name ☐

Signature of person to be insured ☐ *Date* / /

MEDICAL AUTHORITY
Please sign & date both Medical Authorities

Authority to obtain a report from a medical practitioner or hospital – MLC will complete the appropriate doctor's details in the space below

☐

I request and authorise you to supply MLC and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer this information to another State, Territory or jurisdiction.

A photocopy of this authorisation shall be as valid as the original.

If married, what is your maiden name? ☐

Signature of Person to be insured

☐

Date / /

MEDICAL AUTHORITY
Please sign & date both Medical Authorities

Authority to obtain a report from a medical practitioner or hospital – MLC will complete the appropriate doctor's details in the space below

☐

I request and authorise you to supply MLC and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer this information to another State, Territory or jurisdiction.

A photocopy of this authorisation shall be as valid as the original.

If married, what is your maiden name? ☐

Signature of Person to be insured

☐

Date / /

Please return this completed form to:

Smartsave
PO Box R173
Royal Exchange
NSW 1225