Insurance Application and Full Personal Health Statement – OnePath Life

Corporate Super

18 December 2015

OnePath MasterFund (Fund)
ABN 53 789 980 697 RSE R1001525 SFN 2929 169 44
OnePath Custodians Pty Limited (OnePath Custodians)
ABN 12 008 508 496 AFSL 238346 RSE L0000673
OnePath Life Limited (Insurer/OnePath Life)
ABN 33 009 657 176 AFSL 238341
242 Pitt Street, Sydney NSW 2000

Customer Services
Phone 1800 627 625
Fax 02 9234 6668
Email corpsuper@onepath.com.au
Website onepath.com.au/member

Instructions

OnePath Life is the group life insurer to OnePath Custodians, the trustee of the Fund. Corporate Super is a division of the Fund.

Please complete this form if you:

- are a Personal Division member of Corporate Super; or
- are a member of an employer plan in Corporate Super insured by OnePath Life; and
- wish to apply to for Death only or Death and TPD cover for over $1,000,000 (including any existing cover) or GSC cover or where we specifically requested you to complete this form. Members in an employer plan should note that if GSC is available in the employer plan, you cannot elect a different benefit period or waiting period from that chosen by your Employer.

By completing this form, you are requesting OnePath Custodians to submit an application to OnePath Life to enable OnePath Life to assess your request for cover. Before proceeding with this application it is important that you have read and understood the Corporate Super Product Disclosure Statement (PDS).You will be required to complete some or all of the questions in this form. Please follow all instructions carefully. Complete and sign the form and return to:

Corporate Super
OnePath Custodians Pty Limited
GPO Box 5306
Sydney NSW 2001

1. Personal details

Member number ☐☐☐☐☐☐☐/☐☐☐☐☐☐

Employer plan name

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname

Given name(s)

Date of birth (dd/mm/yyyy) / / Male ☐ Female ☐ Age next birthday

Residential address (this cannot be a PO Box)

Suburb/Town State Postcode

Country

Email

Phone Home Business

Mobile Email

May one of our underwriters contact you by phone if we require more information? ☐ Yes ☐ No

If **yes**, when is the most convenient time and on what phone number? Days Time (from / to) /

2. Amount of cover

Types of cover required – Employer sponsored members | **Total amount of cover**

☐ Death Only (no maximum benefit limit applies) $☐☐☐,☐☐☐,☐☐☐.☐☐

☐ Death and Total & Permanent Disablement (TPD) (maximum insurance cover is $3 million) $☐☐☐,☐☐☐,☐☐☐.☐☐

☐ Group Salary Continuance (monthly benefit) (maximum insurance cover is $30,000 or 75% of salary, whichever is the lesser per month). $☐☐,☐☐☐.☐☐

Where your employer has not selected GSC as part of your plan's insurance arrangements you are able to nominate your benefit period and waiting period.

Please nominate the benefit period: ☐ to age 65 ☐ two year

Please nominate the waiting period: ☐ 30 days ☐ 60 days ☐ 90 days

Types of cover required – Corporate Super Personal members | **Total amount of cover**

☐ Death Only (maximum insurance cover is $5 million)† $☐☐☐,☐☐☐,☐☐☐.☐☐

☐ Death and TPD (maximum insurance cover is $3 million)† $☐☐☐,☐☐☐,☐☐☐.☐☐

☐ GSC (monthly benefit) (maximum insurance cover is $30,000 or 75% of salary, whichever is the lesser per month)†. $☐☐,☐☐☐.☐☐

Please nominate the benefit period: ☐ to age 65 ☐ two year

Please nominate the waiting period: ☐ 30 days ☐ 60 days ☐ 90 days

† Family members are restricted to Death Only or Death and TPD cover.

Important Notice

Duty of disclosure

The Trustee who enters into a life insurance contract in respect of your life has a duty, before entering into the contract, to tell the insurer, OnePath Life Limited (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 Trustee has this duty until the Insurer agrees to provide the insurance.

The Trustee has the same duty before they extend, vary or reinstate the contract.

The Trustee does not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is of common knowledge; or
- the Insurer knows or should know as an Insurer, or
- the Insurer waives your duty to tell the Insurer about.

In order for the Trustee to comply with the duty of disclosure, we require you to tell us [Trustee] and the Insurer, anything you know, or could reasonably be expected to know, that may affect the Insurer's decision to insure you and on what terms.

If you do not tell us and the Insurer something that you 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 Trustee entering into the contract to tell the Insurer something that they must tell the Insurer.

If you do not tell the Insurer something

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

If you do not tell us or the Insurer anything you are required to, and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if you had told the Insurer and the Trustee, the Insurer may avoid the contract within 3 years of entering into it.

If the Insurer chooses not to avoid the contract, the Insurer 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 you had told the Insurer and the Trustee everything you should have. However, if the contract 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, the Insurer may, at any time vary the contract in a way that places the Insurer in the same position it would have been in if you had told the Insurer and the Trustee everything you should have.

However this right does not apply if the contract provides cover on death.

If the failure to tell the Insurer is fraudulent, the Insurer may refuse to pay a claim and treat the contract as if it never existed.

3. Residence and travel details

a. Are you a permanent resident of Australia? ☐ Yes ☐ No

b. How long have you lived in Australia?

c. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

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

Date of departure (dd/mm/yyyy) / / Duration of stay

Destinations

d. Purpose of stay? ☐ Holiday ☐ Business ☐ Residing ☐ Other, please specify

4. Insurance details

1. Do you have, or have you previously applied for any life, TPD, or income protection cover with OnePath Life, through any other superannuation fund or any other company? (Note, this includes insurance through your superannuation fund and insurance your employer may have arranged for you.) ☐ Yes ☐ No

If **yes** to question 1, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No

If **yes,** please provide name of company, alteration, date and reason (if known):

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If **yes,** please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc:

5. Occupation details

a. Occupation Industry

b. When did your present job/employment situation commence? (dd/mm/yyyy) / / Years in industry

c. What is your current annual income net of business expenses but before tax? $ ☐☐☐,☐☐☐,☐☐☐.☐☐

d. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed. **Please note the examples below are to be used as a guide only.**
Sedentary/administration		(e.g. filing, computer work, answering telephone, reception duties, etc.)
Manual work – light		(e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)
Manual work – heavy		(e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)

e. How many hours (on average) do you work per week? .....

6. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No

2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? ☐ Yes ☐ No

3. aviation/flying, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Vehicle type | Races p.a.

Engine size | Max. speed (km/h)

Class | ☐ Recreational ☐ Amateur ☐ Professional

Scuba/skin diving

Average depth (m) | Maximum depth (m)

Dives p.a. | Do you use explosives?

Do you dive in caves or potholes? ☐ Yes ☐ No

If **yes,** give details:

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a. ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.?

If **yes,** provide amount and details:

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

If **yes,** provide frequency and details:

b. On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes,** state type and period held:

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

6. Pastimes – continued

Please complete the table below:

No. of hours flown	**Past 12 months** Crew	Passenger	**Future annual average** Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? ☐ Yes ☐ No

If **yes**, please provide frequency and details:

7. Personal health statement

1. What is your current height and weight? Height (cm) Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months? ☐ Yes ☐ No

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

3. During the last 12 months have you smoked tobacco or any other substance? ☐ Yes ☐ No

If **'yes'**, please state **type** and **quantity** per day:

4. During the last three months, have you used nicotine replacement treatment or anti-smoking medication? ☐ Yes ☐ No

If **'yes'**, please state **type** used and **duration** of use:

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No

If **'yes'**, please state **type**, **quantity** per day and date ceased:

6. Do you consume alcohol? ☐ Yes ☐ No

If **'yes',** please state how many standard drinks you consume **per** day (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop smoking or to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No

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

8. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, multiple sclerosis, cystic fibrosis, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to age 60 been diagnosed with diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, cervical cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table:

Relation	Condition/Disorder	Age diagnosed

9. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. Asthma? ☐ Yes ☐ No

2. High blood pressure? ☐ Yes ☐ No

3. High cholesterol? ☐ Yes ☐ No

4. Diabetes? ☐ Yes ☐ No

5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No

6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No

7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No

8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 13 to 20.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No

10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No

11. Thyroid or glandular trouble? ☐ Yes ☐ No

12. Ulcers, bowel trouble or recurring indigestion? ☐ Yes ☐ No

13. Epilepsy, fits or dizziness of any kind or persistent headaches? ☐ Yes ☐ No

14. Alzheimer's disease or dementia? ☐ Yes ☐ No

15. Kidney or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No

16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No

17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No

18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No

19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No

20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No

21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? ☐ Yes ☐ No

22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No

23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No

24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No

9. Medical history – continued

25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No

26. Due to injury or illness have you ever been off work for more than seven consecutive days **(if not already mentioned)**? ☐ Yes ☐ No

27. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No

28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc) ☐ Yes ☐ No

29. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result? ☐ Yes ☐ No

30. Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No

31. Have you **ever** used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No

32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No

33. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition? ☐ Yes ☐ No

34. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

35. In the past 5 years have you:

- had sex without using a condom with a person you know or suspect to be either HIV positive or who uses non prescribed drugs intravenously ☐ Yes ☐ No
- had sex without using a condom with a sex worker or as a sex worker ☐ Yes ☐ No
- had anal intercourse without using a condom (except with someone whom you have been in a monogamous relationship for five years or more)? ☐ Yes ☐ No

If you answered yes to question 35 a private and confidential questionnaire will be sent to you.

36. Females only

a. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date / / (dd/mm/yyyy) ☐ Yes ☐ No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered **yes** to any questions from 9 – 34 or 36, please complete the following questions in relation to each question that you answered yes to. If there is insufficient space, please provide further details on page 21 or photocopy this page and complete the questions. Please attach all pages to your application.

Question number	Disability, illness, injury or conditions	Investigation type(s) and results	Date started (dd/mm/yyyy)	Date ceased (dd/mm/yyyy)	Treatment and type, date provided and date ceased	Time off work	Have you fully recovered? Yes/No	Name and address of institution or health professional
			/ /	/ /				
			/ /	/ /				
			/ /	/ /				

10. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre

Doctor/Medical centre

Phone Fax

No. and street

Suburb/Town State Postcode

How many years have you been attending this doctor/medical centre?.....years months

2. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned?..... ☐ Yes ☐ No

If **yes**, please provide details:

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		
	/ /		
	/ /		

11. Declaration by the life insured

I declare that:

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the arrangements on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I have read and understand the Duty of Disclosure section above, and I have not withheld any information that may affect the Insurer's decision as to whether to accept my application. I understand that the Duty of Disclosure continues after I have completed this form until my application has been accepted by the Insurer and confirmation is issued in writing.
- I have read the Privacy Statement in this form, and authorise the collection, use, storage and disclosure of my personal information for the purposes of this application, as outlined in the Privacy Statement. If I have provided information about another person in this application (for example a beneficiary or life insured), I declare that I have the consent of that person to do so. I understand that OnePath Life require me to inform the person concerned that I have done so and direct them to the Privacy Policy which is located at onepath.com.au
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to OnePath Life in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis , that I have received, read and understood a copy of the Product Disclosure Statement(s) (PDS) and information on for the type (s) of cover for which I am applying.
- I acknowledge that insurance cover will not commence until I am notified of acceptance in writing.
- I acknowledge that if this application is declined, any of my existing cover on the date of this application will continue on same terms, including but not limited to any pre-existing condition exclusion(s).
- I acknowledge that any information received by OnePath Life in relation to this application may be used when assessing my existing or future claim, and may operate as an exclusion to my claim. This is irrespective of whether this application is accepted or declined.
- I understand that I may cancel my existing cover at any time.

Signature of life insured ✗ Date (dd/mm/yyyy) / /

This page has been left blank intentionally

12. Authorisations

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath.

A photocopy (or similar) of this authorisation shall be as valid as the original.

My name

Date of birth (dd/mm/yyyy) / /

Signature of applicant

✗

Dated this (dd/mm/yyyy) / /

Address of life insured

State Postcode

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath.

A photocopy (or similar) of this authorisation shall be as valid as the original.

My name

Date of birth (dd/mm/yyyy) / /

Signature of applicant

✗

Dated this (dd/mm/yyyy) / /

Address of life insured

State Postcode

13. Adviser to complete

First adviser

Name

Phone | Fax

Agency no. | Adviser reference no.

Second adviser

Name

Phone | Fax

Agency no. | Adviser reference no.

Do you expect that this Insurance will replace all or part of an existing insurance, or one discontinued within the past two months? ☐ Yes ☐ No

If **'Yes',** previous insurer:

Reminder: For quick processing, please ensure all applicable questions are fully answered.

Additional comments

14. Questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in section 9.

1. When did you have your first episode of asthma? ..... Date (dd/mm/yyyy) / /

2. When was your most recent episode of asthma? ..... Date (dd/mm/yyyy) / /

3. Approximately how many episodes have occurred in the last 12 months?

4. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ..... ☐ Yes ☐ No

If **yes**, please provide details:

6. Have you sought medical treatment or advice for asthma? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

7. How has your doctor described your asthma? ..... ☐ Mild ☐ Moderate ☐ Severe

8. Have you ever used any medication, including steroids? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

9. Have you ever been hospitalised due to asthma? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Date from (dd/mm/yyyy) / / Date to / /

Name and address of hospital:

10. Have you ever had lung function tests performed? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Date (dd/mm/yyyy)	Test results
/ /	
/ /	
/ /	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in section 9.

1. When was your high blood pressure first diagnosed? ..... Date (dd/mm/yyyy) / /

2. What was your blood pressure reading at that time? ..... Systolic ☐ Diastolic ☐

3. Have you ever been treated by medication? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Name ☐

Address ☐

Suburb/Town ☐ State ☐ Postcode ☐

Date of last consultation / / (dd/mm/yyyy)

6. What was the date of your last blood pressure check? (dd/mm/yyyy) ..... / /

7. What was your blood pressure reading at that time? ..... Systolic ☐ Diastolic ☐

8. How has your doctor described your blood pressure control? ..... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details:

☐

9. What is the date of your next blood pressure check-up? ..... Date (dd/mm/yyyy) / /

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in section 9.

1. When was your high cholesterol first diagnosed? ..... Date (dd/mm/yyyy) / /

2. What were your cholesterol readings at that time? ..... Cholesterol ☐ Triglycerides ☐

HDL Cholesterol ☐ LDL Cholesterol ☐

3. Did you undergo any tests or investigations? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

Cholesterol questionnaire continued

4a. Have you ever used any medication? ☐ Yes ☐ No

If **yes**, please provide details:

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ☐ Yes ☐ No

If **yes,** please provide date of when treatment changed and the reason(s) for change:

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town State Postcode

Date of last consultation / / (dd/mm/yyyy)

6. What was the date of your last cholesterol check? Date (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol Triglycerides

HDL Cholesterol LDL Cholesterol

8. How has your doctor described your cholesterol control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other,** please provide details:

9. What is the date of your next cholesterol check-up? Date (dd/mm/yyyy) / /

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in section 9.

1. When was your diabetes first diagnosed? Date (dd/mm/yyyy) / /

2. How is your diabetes controlled?

☐ Insulin – go to question 3 ☐ Diet only – go to question 4 ☐ Oral – list medications below and then go to question 4

3. How many times a day do you administer insulin? ☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

4. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details:

5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details:

Condition	Date (dd/mm/yyyy)	Treatment
	/ /	
	/ /	

Diabetes questionnaire continued

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details:

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details:

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

7. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town State Postcode

Date of last consultation / / (dd/mm/yyyy)

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in section 9.

1. Please tick the conditions you have had (or currently have), or received treatment for:

☐ Anxiety including generalised anxiety, panic or phobia disorder

☐ Eating disorder including anorexia nervosa or bulimia

☐ Depression including major depression or dysthymia

☐ Manic depressive illness or bi-polar disorder

☐ Alcohol or other substance abuse or addiction

☐ Post traumatic stress

☐ Schizophrenia or any other psychotic disorder

☐ Stress, sleeplessness or chronic tiredness

☐ Other

If **other**, please describe:

2. Please complete the table below for all described conditions:

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates:

4. Are you currently symptom free? ☐ Yes ☐ No

If **yes**, please provide date(s) of last symptoms:

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital:

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details:

7. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

8. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details:

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details:

10. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details:

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation / / (dd/mm/yyyy)

11. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details:

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation / / (dd/mm/yyyy) Doctor(s) consulted

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in section 9.

1. When did your back/neck condition first occur? ..... Date (dd/mm/yyyy) / /

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? ..... ☐ Yes ☐ No

If **yes**, please provide details:

Tests	Date of tests (dd/mm/yyyy)	Results
	/ /	
	/ /	

6. Have you had recurrent or multiple episodes of the back/neck condition? ..... ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

7. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

9. Are your work duties or activities limited/affected by the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details:

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details:

11. Overall do you feel that your back/neck condition is: ..... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? ..... Date (dd/mm/yyyy) / /

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in section 9.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	**Right**		**Left**	**Right**
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other	☐	☐
Knee	☐	☐	If **other**, state which joint		

2. When did this condition first occur? ..... Date (dd/mm/yyyy) / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known:

5. Have you had recurrent or multiple episodes of the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

6. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

8. Do you have any residual pain, limitation of movement or restriction of any kind? ..... ☐ Yes ☐ No

If **yes**, please provide details:

9. Are your work duties or activities limited/affected by the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details:

10. Are you still undergoing treatment? ..... ☐ Yes ☐ No

If **yes**, please provide details:

11. Overall do you feel that your condition is: ..... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? ..... Date (dd/mm/yyyy) / /

Privacy

In this section 'we', 'us' and 'our' refers to OnePath Custodians Pty Limited, OnePath Life Limited and other members of the ANZ Group. 'You' and 'your' refers to policy owners and life insured's.

We collect your personal information from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information. Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/privacy-policy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information to certain third parties.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information include:

- an organisation that assists us and/or ANZ to detect and protect against consumer fraud;
- any related company of ANZ which will use the information for the same purposes as ANZ and will act under ANZ's Privacy Policy;
- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner;
- regulatory bodies, government agencies, law enforcement bodies and courts.

We will also disclose your personal information in circumstances where we are required by law to do so. Examples of such laws are:

- The *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- There are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

ANZ may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/privacy-policy

Life risk – sensitive information

For life risk products, where applicable, we may collect health information with your consent. Your health information will only be disclosed to service providers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

Privacy consent

We and other members of the ANZ Group may send you information about our financial products and services from time to time. ANZ may also disclose your information to its related companies or alliance partners to enable them or ANZ to tell you about a product or service offered by them or a third party with whom they have an arrangement.

You may elect not to receive such information at any time by contacting Customer Services. Where you wish to authorise any other parties to act on your behalf, to receive information and/ or undertake transactions please notify us in writing.

If you give us or ANZ personal information about someone else, please show them a copy of this document so that they may understand the manner in which their personal information may be used or disclosed by us or ANZ in connection with your dealings with us or ANZ.

Privacy Policy

OnePath's Privacy policy contains information about:

- when we or ANZ may collect information from a third party;
- how you may access and seek correction of the personal information we hold about you; and
- how you can raise concerns that we or ANZ has breached the Privacy Act or an applicable code and how we and/or ANZ will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing:
GPO Box 75
Sydney NSW 2001
Email: privacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 1800 627 625.

More information can be found in our Privacy Policy which can be obtained from our website at onepath.com.au/privacy-policy

Overseas recipients

We or ANZ may disclose information to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in our Privacy Policy at onepath.com.au/privacy-policy

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in section 9.

1. Please provide details in the table below:

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each. Date of removal / /

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable:

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required:

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details:

Tests/Treatments/Investigations	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town State Postcode

Date of last consultation / / (dd/mm/yyyy)

Additional information/comments

Customer Services

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