

Member's Personal Statement

Policy number

Member number

Plan administrator

YOUR DUTY OF DISCLOSURE

Before you enter into an insurance contract with us, you are required under the Insurance Contracts Act 1984 to provide us with the information we need to decide whether we'll accept your application for insurance, what terms will apply and what your premium will be.

You must comply with the Duty of Disclosure as described below.

Your Duty of Disclosure applies when applying for insurance cover and when varying or replacing any existing insurance cover. It applies from the moment you start completing the application questions and until we advise that we have accepted your application for cover, variation or replacement and issued confirmation.

You must answer all of our questions honestly and completely. You must tell us everything you know and everything that a reasonable person in the circumstances could be expected to know is relevant to our decision whether to insure you and whether any special conditions need to apply to the cover.

You do not need to tell us about any matter that diminishes our risk, is of common knowledge, that we know or should know as an insurer or that we tell you we do not need to know.

If you have not disclosed all relevant matters to us and we would not have entered into all or part of the cover on the same terms had we known about those matters, we may avoid all or part of the cover within three years of the commencement date. If your non-disclosure or misrepresentation is fraudulent and we would not have provided the cover on the same terms had we known about these matters, we may avoid all or part of the cover at any time. This means that we can treat the cover as if it never existed and we would not be liable to pay any claims.

Alternatively, instead of avoiding all or part of the cover we may decide:

- (a) to reduce the benefits for all or part of the cover in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to us, although any reduction to benefits payable in respect of your death can only occur within three years of the commencement date; or
- (b) for any benefits provided under the cover other than benefits payable in respect of your death, to vary the cover in such a way as to place you in the position you would have been in if you had disclosed all relevant matters to us.

If you have applied for cover via a financial adviser it is also your responsibility to ensure that the information provided to your adviser is accurate and complete and that the correct information is entered into the Application Form.

1. PERSONAL DETAILS

(please print answers clearly)

Name of plan Policy number

Title Mr Mrs Miss Ms Other

Surname Given name

Date of birth / / (DD/MM/YYYY) Gender M F

May TAL contact you directly to clarify or gather information in relation to this application? Yes No

If yes, preferred method of contact: Email Phone Contact time

Email address Phone No.

2. OCCUPATION DETAILS

1. Self employed Employee full-time OR Part-time hours p/week weeks p/year
2. Your occupation Industry
3. Duties performed, including % of time spent in each.
4. Annual salary (includes packaged items but excludes bonuses/commission) \$

3. INSURANCE APPLICATION

Death sum insured TPD sum insured

Monthly income benefit \$ Benefit period Waiting period

1. Is this an increase? Yes No
2. Have you ever held or applied for any life, disability, accident & sickness or trauma insurance, that was declined, postponed, had the premium increased or modified, or had a current policy cancelled or renewal refused? Yes No
3. Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? Yes No
4. Do you have, or are you applying for, any other life or disability cover? Yes No

If yes to 2, 3 and or 4, please provide full details below.

Name of company	Cover type	Sum insured /monthly benefit	Date of application or claim	State any loadings/ exclusions	Reason for decision/ claim	Duration of claim	Recovery %	Is cover to be replaced? Y/N
		\$	/ /					
		\$	/ /					
		\$	/ /					

4. HABITS AND ACTIVITIES

1. Do you drink alcohol? Yes No
 If yes, state type, number of standard drinks per day and number of days per week when alcohol is consumed.
 Standard drink = 1 nip spirits, 1 wine glass (100ml), 10oz/285ml beer.
2. Have you smoked in the past 12 months? Yes No
 If yes, state form and daily quantity.
3. Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? Yes No
 If yes, complete a drug use or alcohol consumption questionnaire.
4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or any other sport? Yes No
 If yes, please complete a sports and pastimes statement.
5. Do you intend travelling outside Australia within the next two years? Yes No
 If yes, please provide details below (where, when, duration and reason).

6. Are you an Australian or New Zealand citizen? Yes No
7. Do you hold an Australian Permanent Resident's Visa? Yes No

If no to 6 and 7, please advise type of visa, expiry date, plans for applying for permanent residency and nationality/current citizenship.

5. PERSONAL STATEMENT

1. Please state your: Height (cm) Weight (kg)
2. Name and address of your usual doctor or medical centre
- Surname Given name
- Address
- State Postcode
3. Details of last medical consultation with your usual doctor or medical centre
- Date (DD/MM/YYYY)
- Reason
- Outcome/results
4. If you have attended that doctor for less than 12 months, name and address of previous doctor
- Surname Given name
- Address
- State Postcode
5. A. Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquilisers? Yes No
- B. Have you EVER had an ECG, X-ray, transfusion, mammogram, ultrasound, surgery or any other investigation? Yes No
- C. Have you EVER had any blood tests which revealed an abnormality e.g. raised blood sugar, liver function, renal function results, or anaemia, etc? Yes No
- D. Do you contemplate seeking any medical examination, advice, treatment or surgery for any other current health condition, in the future? Yes No

Please provide full details for all 'Yes' answers.

Question	Dates (from /to)	Name / Address of doctor, hospital or clinic	Condition, medications, treatments & time off work	Recovery %

6. PERSONAL STATEMENT (GENERAL MEDICAL QUESTIONS)

Please provide details for all 'Yes' answers in General Medical Questionnaire at Section 7.

1. Have you ever had, been advised that you had, or received advice or treatment for any of the following:
 - A. High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? Yes No
 - B. Bowel, stomach or intestinal problem, gall bladder, hepatitis or liver disease? Yes No
 - C. Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks? Yes No
 - D. Depression, anxiety, panic attacks, stress, chronic fatigue, fibromyalgia or any mental or nervous condition? Yes No
 - E. Diabetes, sugar in urine, pancreatic or thyroid problem? Yes No
 - F. Cancer, tumour, melanoma, sunspots, mole or growth of any kind? Yes No
 - G. Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? Yes No
 - H. Impairment of sight, hearing or speech? Yes No
 - I. Asthma, bronchitis, sleep apnoea, or any lung complaint? Yes No
 - J. Leukaemia, haemochromatosis, anaemia, or any blood problems? Yes No
 - K. Kidney, prostate, or bladder problems? Yes No
 - L. Psoriasis, eczema, or any skin problem? Yes No
 - M. Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? Yes No
 - N. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No
 - O. Have you ever engaged in any activity/ies reasonably accepted to having an increased risk of exposure to the HIV/AIDS virus? Yes No

Females only

- P. Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal Pap smear, etc)? Yes No
 - Q. Have you ever had any complications of pregnancy or childbirth? Yes No
 - R. Are you currently pregnant? Yes No
- If yes, what is the expected delivery date?
- S. Have you ever had a breast lump (even if you have not seen a doctor about it)? Yes No

2. Family History

- Has any of your immediate family (mother, father, brother or sister), suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental health condition, haemophilia, Huntington's disease or any other hereditary disease? Yes No

3. If yes, please provide details in the table below.

Relationship to member	Medical condition (e.g. breast cancer, heart attack, type 2 diabetes)	Age when diagnosed	Age at death (if applicable)

7. GENERAL MEDICAL QUESTIONNAIRE

Please provide details for all 'Yes' answers in Section 6 A to S. Please complete on a separate sheet if required.

Question No.	Q.	Q.	Q.	Q.
Specific condition				
A. Date symptoms first started and description of symptoms.				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				
H. What advice/treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment.				
J. Date treatment/medication ceased.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%).				
M. Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

8. PRIVACY

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles. The way in which TAL collects, uses, secures and discloses your personal information is set out in the TAL Privacy Policy available at <http://www.tal.com.au/Privacy-Policy> or free of charge on request to TAL by telephoning 1800 666 136.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following:

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

9. DECLARATION

I acknowledge that I have read the notice of my duty of disclosure and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this Application and any supplementary application or personal statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Member, authorise and direct any medical or other practitioner to divulge at any time to TAL Life Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history, acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TAL Life Limited to its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information collected on this form or future forms in relation to this insurance.

Full name of Member

Signature of Member Date

10. MEDICAL AUTHORITY

I agree that any medical practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of Member

Signature of Member Date