

Application to change death and Total and Permanent Disablement insurance cover to over \$1 million – Employee Section

When to use this form

Please complete this form if you are an Employee Section member and you would like to apply to:

- increase your death and Total and Permanent Disablement (TPD) insurance cover to an amount over \$1 million (please complete Steps 1, 2, 3 and 4); or
- decrease or cancel your death and TPD insurance cover (please complete Steps 1, 5 and 6).

If you would like to apply to increase your death and TPD insurance cover to an amount less than \$1 million, please complete the Application for or to change death and Total and Permanent Disablement insurance cover up to \$1 million - Employee Section form available at anzstaffsuper.com or by calling ANZ Staff Super on **1800 000 086**.

Before making any changes to your insurance cover you should read the Employee Section’s Product Disclosure Statement (PDS) and In Detail booklet. You can download these documents at anzstaffsuper.com or request a copy by calling **1800 000 086**.

Please return your completed form to:
ANZ Staff Super
GPO Box 2139
Melbourne VIC 3001

If you need help

For assistance call ANZ Staff Super on **1800 000 086**, or go to anzstaffsuper.com.

Step 1 – Complete your personal details

Please print in black or blue pen, in uppercase, one character per box. A ✓

Title	Mr <input type="radio"/>	Mrs <input type="radio"/>	Ms <input type="radio"/>	Miss <input type="radio"/>	Other <input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Given names																
<input type="text"/>																
Surname																
<input type="text"/>																
Postal Address																
<input type="text"/>																
Suburb										State			Postcode			
<input type="text"/>										<input type="text"/>			<input type="text"/>			
Daytime Telephone								Mobile								
<input type="text"/>								<input type="text"/>								
E-mail																
<input type="text"/>																
Membership number										Gender						
<input type="text"/>										Male <input type="checkbox"/> Female <input type="checkbox"/>						

Continued over

Step 1 – Complete your personal details (continued)

I authorise one of the Insurer's underwriting service representatives to contact me by phone if further information is required.

I can be contacted during the following times:

- Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Any business day

Between

 AM PM

and

 AM PM

Please tick your preferred contact phone number:

- Home
 Work
 Mobile

Step 2 – Choose level of cover

I wish to change the number of blocks of insurance cover (in half block increments) I have in ANZ Staff Super:

Blocks of insurance cover (to a maximum of 7 blocks)

Please note:

- You must complete the Personal Statement (Step 3) and Declaration (Step 4) if you wish to increase your level of insurance cover.**
- The maximum amount of insurance cover available is \$5 million for death and \$3 million for TPD. These maximums will be applied even if the number of blocks you've elected would otherwise result in your insurance cover exceeding these limits.
- Your application to increase your insurance cover for death and Total and Permanent Disablement will not be effective until the Insurer has accepted your application.
- If you have previously received a Total and Permanent Disablement benefit from ANZ Staff Super:
 - if you were a member of ANZ Staff Super on 30 January 2003, you will not be eligible to increase your level of insurance cover for death and Total and Permanent Disablement; and
 - if you have become a member of ANZ Staff Super after 30 January 2003, you will not be eligible for any insurance cover for death and Total and Permanent Disablement.
- The cost of your insurance cover is deducted from your account balance monthly or on exit by redeeming some units.

Step 3 – Complete Personal Statement

Personal Statement

You are required to disclose in this Personal Statement every matter that you know or could reasonably be expected to know, which is relevant to the Insurer's decision whether to accept the risk of insuring your life on any terms.

Please answer all questions below.

1. Residence and travel details

1. Are you currently residing in Australia? Yes No

If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia? Yes No

If **yes**, please proceed to question 3.

If **no**, please advise what type of visa you hold.

3. 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

Destination(s) (country/cities)

 / /

Purpose of stay Holiday Business Residing Other Please specify if other

Step 3 – Complete Personal Statement (continued)

2. Insurance details

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including Zurich Australia (other than this application), including benefits under superannuation or insurance benefits by your employer? Yes No

If you have answered **yes**, 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)
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

3. 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

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 per annum

Do you use explosives? Yes No

Do you dive in caves or potholes? Yes No

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

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Step 3 – Complete Personal Statement (continued)

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.? Yes No

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

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

Please complete the table below.

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	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.

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.).

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

4. Personal details

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 (excluding pregnancy)? 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.

Step 3 – Complete Personal Statement (continued)

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Chantix, etc.)? Yes No

If **yes**, please state **type(s)** used and **length of time** you have been using this.

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 or reduce your alcohol intake due to a medical condition? Yes No

If **yes**, please provide full details.

5. Family history

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

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).

6. 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 questions 1 to 8 above, please complete the relevant questionnaire on pages 11 to 19.

Step 3 – Complete Personal Statement (continued)

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, fainting of any kind or persistent headaches? Yes No
14. Alzheimer's disease or dementia? Yes No
15. Kidney, liver, prostate 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
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. 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
33. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Yes No
34. 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
35. 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

If you answered **yes** to any questions from 9–35, please complete the following table.
If there is not enough space here, please provide details on page 20.

Step 3 – Complete Personal Statement (continued)

Question number Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work Have you completely recovered? Yes No

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

Name and address of medical facility and attending doctor

Question number Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work Have you completely recovered? Yes No

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

Name and address of medical facility and attending doctor

Question number Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work Have you completely recovered? Yes No

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

Name and address of medical facility and attending doctor

Step 3 – Complete Personal Statement (continued)

Question number	Disability, illness, injury or condition
<input type="text"/>	<input type="text"/>
Investigation type(s) and result(s)	
<input type="text"/>	
Date of first symptoms (dd/mm/yyyy)	Frequency of symptoms
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
Type of treatment	
<input type="text"/>	
Date treatment provided and ceased (dd/mm/yyyy): From <input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	
Has further treatment, referral or investigation(s) been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Time off work	Have you completely recovered?
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last symptoms (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name and address of medical facility and attending doctor	
<input type="text"/>	

Question number	Disability, illness, injury or condition
<input type="text"/>	<input type="text"/>
Investigation type(s) and result(s)	
<input type="text"/>	
Date of first symptoms (dd/mm/yyyy)	Frequency of symptoms
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
Type of treatment	
<input type="text"/>	
Date treatment provided and ceased (dd/mm/yyyy): From <input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	
Has further treatment, referral or investigation(s) been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Time off work	Have you completely recovered?
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last symptoms (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name and address of medical facility and attending doctor	
<input type="text"/>	

Question number	Disability, illness, injury or condition
<input type="text"/>	<input type="text"/>
Investigation type(s) and result(s)	
<input type="text"/>	
Date of first symptoms (dd/mm/yyyy)	Frequency of symptoms
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
Type of treatment	
<input type="text"/>	
Date treatment provided and ceased (dd/mm/yyyy): From <input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>	
Has further treatment, referral or investigation(s) been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Time off work	Have you completely recovered?
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last symptoms (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name and address of medical facility and attending doctor	
<input type="text"/>	

Step 3 – Complete Personal Statement (continued)

7. 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

2. How many years have you been attending this doctor/medical centre? Years Months

a. When was your last visit to this doctor/medical centre?	b. Reason for check up or consultation?	c. Outcome including medication, treatment etc	d. Degree of recovery?
			%

3. 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.
	/ /		
	/ /		
	/ /		
	/ /		

Step 3 – Complete Personal Statement (continued)

8. Authorisations

Doctor's authorisation

To be completed and signed by the applicant.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to Zurich Australia Limited ABN 92 000 010 195, or any organisation duly appointed by Zurich Australia. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of applicant

Date of birth (dd/mm/yyyy)

 / /

Signature

Date (dd/mm/yyyy)

 / /

Address of applicant

Suburb/town

State

Postcode

Member number

Doctor's authorisation

To be completed and signed by the applicant.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to Zurich Australia Limited ABN 92 000 010 195, or any organisation duly appointed by Zurich Australia. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of applicant

Date of birth (dd/mm/yyyy)

 / /

Signature

Date (dd/mm/yyyy)

 / /

Address of applicant

Suburb/town

State

Postcode

Membership number

Step 3 – Complete Personal Statement (continued)

9. Supplementary questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **YES** to question 1 in Section 6 of Step 3.

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 (dd/mm/yyyy) / /

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
/ /	
/ /	
/ /	

Step 3 – Complete Personal Statement (continued)

Blood pressure questionnaire

Only complete this questionnaire if you answered **YES** to question 2 in Section 6 of Step 3.

1. When was your high blood pressure first diagnosed? Date (dd/mm/yyyy) / /
2. When was your most recent episode of asthma? 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.

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

Step 3 – Complete Personal Statement (continued)

Cholesterol questionnaire

Only complete this questionnaire if you answered **YES** to question 3 in Section 6 of Step 3.

1. When was your high cholesterol first diagnosed? Date (dd/mm/yyyy) / /
2. What were your cholesterol readings at that time? Cholesterol Triglycerides
3. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details.

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

- 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? (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 blood pressure control? Excellent Good Poor Other

If **other**, please provide details.

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

Step 3 – Complete Personal Statement (continued)

Diabetes questionnaire

Only complete this questionnaire if you answered **YES** to question 4 in Section 6 of Step 3.

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 describe.

--

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

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

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) / /

Step 3 – Complete Personal Statement (continued)

Mental health questionnaire

Only complete this questionnaire if you answered **YES** to question 5 in Section 6 of Step 3.

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.

Step 3 – Complete Personal Statement (continued)

8. Are you currently or have you ever been on treatment, including medication?

Yes No

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

Step 3 – Complete Personal Statement (continued)

Back/Neck questionnaire

Only complete this questionnaire if you answered **YES** to question 6 in Section 6 of Step 3.

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 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 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) / /

Step 3 – Complete Personal Statement (continued)

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **YES** to question 7 in Section 6 of Step 3.

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		Left	Right
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	If other , state which joint		
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>		

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. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

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) / /

Step 3 – Complete Personal Statement (continued)

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **YES** to question 8 in Section 6 of Step 3.

1. Please provide details in the table below.

Yes No

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

By what method (e.g. surgically, frozen or burnt off)?	Date of removal (dd/mm/yyyy)
	/ /
	/ /
	/ /
	/ /

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 of tests (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)

 / /

Step 3 – Additional information/comments

About the Insurer

Insurance cover is provided by Zurich Australia Limited ABN 92 000 010 195 (the “Insurer”) and subject to the terms and conditions of the insurance policy issued to ANZ Staff Superannuation (Australia) Pty Limited ABN 92 006 680 664 AFSL 238268 RSEL L0000543 (the Trustee of ANZ Staff Super) by the Insurer (the “Policy”). You should read the Product Disclosure Statement (PDS) for Employee Section members for a summary of the terms and conditions of the Policy. You can download the PDS from anzstaffsuper.com or contact ANZ Staff Super on **1800 000 086** if you would like a copy of the Policy. Your application will be assessed by the Insurer and ANZ Staff Super will advise you of the outcome in writing.

The Insurer requires the information from this form to determine your application for cover or additional cover. The Insurer’s Privacy Policy details how the Insurer manages personal information. It is available free of charge by calling Zurich on 131551 or may be downloaded from zurich.com.au/important-information/privacy.html.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer. To meet this duty, you must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

About this application

When you apply for life insurance, we conduct a process called underwriting. It’s how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the fund trustee may pass on to us personal information you provide to them. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question

- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don’t assume we will ask others such as your doctor.
- review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you would now answer our questions differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we’ll let you know whether it has any impact on the cover.

Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

If you need help

It’s important that you understand this information and the questions we ask. Ask us for help if you have difficulty answering our questions or understanding the application process.

If you’re having difficulty due to a disability, understanding English or for any other reason, we’re here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including all of the following:

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

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 the Insurer or Trustee 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 three 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 three 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.

Protecting members' privacy

The Trustee, ANZ Staff Superannuation (Australia) Pty Limited, seeks to take all reasonable steps to protect members' privacy and the confidentiality of members' personal information.

The administrator, Australian Administration Services Pty Limited (ABN 62 003 429 114) which forms part of the Link Group of companies, collects (on behalf of the Trustee) personal information directly from members and their employers. Sometimes information about you may be collected from other third parties such as a previous superannuation fund, your financial adviser or publicly available sources. We collect, use and disclose personal information about you to provide and manage your account and give you information about your super, or as required by super and tax laws.

If you do not provide the personal information requested or it is incomplete or inaccurate, we may not be able to manage your account properly and processing of transactions to, from or in relation to your account may be delayed.

Members' personal information is kept confidential but may be disclosed by the Trustee or administrator to third parties, such as ANZ Staff Super's actuary, insurer, medical consultants, underwriter, legal adviser and auditor and other external service providers who are contracted to assist with administering members' benefits. It may also be disclosed where expressly authorised or required by law, for example to government agencies such as the Australian Taxation Office and Australian Financial Complaints Authority. Members' personal information may also be disclosed to the Group Superannuation Department of ANZ for the purposes of administering members' benefits or resolving members' enquiries or complaints.

Members' personal information may be disclosed to related entities of the administrator located overseas (in particular, its related entity Link Administration Private Limited (India)) as part of the day-to-day provision of administration or ancillary services.

The Trustee's Privacy Policy Statement contains more detail about how we deal with your personal information and information about how you can access and seek correction of information we hold about you. It also includes information about how you can lodge a complaint about how we've dealt with your personal information and how that complaint will be handled.

If you have any queries in relation to privacy issues, please contact:

ANZ Staff Super
Mail: GPO Box 2139
Melbourne VIC 3001
Phone: 1800 000 086
Fax: (02) 9287 0320
Email: enquiry@anzstaffsuper.com

The Trustee's Privacy Policy Statement is available on ANZ Staff Super's website anzstaffsuper.com or by calling us on **1800 000 086**. You can also access the administrator's privacy policy on our website.

The Insurer's Privacy Policy details how the Insurer manages personal information. It is available free of charge by calling Zurich on 131551 or may be downloaded from zurich.com.au/important-information/privacy.html.

Step 4 – Declaration and consent

Increase insurance cover

I have obtained, read and understand the insurance information in the PDS and In Detail booklet for Employee Section members.

I have read and understand the questions in this Personal Statement.

I confirm the truth and accuracy of the responses given by me in this Personal Statement.

I understand and acknowledge that:

- this Personal Statement and any other evidence required by the Insurer will form the basis of my application for insurance cover or for an increased level of insurance cover; and
- the Insurer may require me to provide further additional medical or other evidence for the assessment of my application for insurance cover or for an increased level of insurance cover.

I have read the “Protecting members’ privacy” statement on this form (see below). I also acknowledge that the Insurer’s Privacy Policy details how the Insurer manages personal information and is available free of charge by calling 131551 or may be downloaded from zurich.com.au/important-information/privacy.html.

I consent to the collection, use, storage and disclosure of my personal information (including health information) as described in the “Protecting members’ privacy” statement on this form.

I have read the “duty to take reasonable care” and understand the remedies available to the Insurer if I fail to take reasonable care not to make a misrepresentation to the Insurer. I understand that the duty to take reasonable care continues after I have completed this application until I am notified in writing that my application for insurance cover or additional insurance cover has been accepted.

I understand that if my application is accepted by the Insurer:

- the cover or additional cover I have applied for will not commence under the Policy until my application is accepted by the Insurer in writing and the increased premium for that cover will apply from that day;
- any existing cover will not be affected should my application be declined by the Insurer; and
- any insurance cover will be provided to me on the terms contained in the Policy as changed from time to time.

I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by the Insurer.

Signature

X

Date

□ □ / □ □ / □ □ □ □

Step 5 – Decrease or cancel insurance cover

I wish to decrease or cancel the death and TPD insurance cover I have in ANZ Staff Super: *(Select an option)*

- decrease my death and TPD insurance cover to blocks of insurance cover (in half block increments); or
- cancel my death and TPD insurance cover.

Step 6 – Sign the form

Decrease or cancel insurance cover

I acknowledge that:

- I have read and understand the information provided in the PDS and In Detail booklet for the Employee Section on insurance cover.
- I have read the “Protecting members’ privacy” statement on this form (see below).
- I consent to the collection, use, storage and disclosure of my personal information as described in the “Protecting members’ privacy” statement on this form.
- I understand that decreases in or cancellation of my cover will take effect when ANZ Staff Super receives this form (signed and dated) and premiums for my current level of cover will be deducted until that day. The reduced premium for any remaining cover will apply from that day.
- I understand that if I cancel or reduce my cover and wish to increase it in the future, I’ll need to provide detailed health and other personal information which will be assessed by the Insurer and the cover or additional cover I have applied for will not commence under the Policy until my application is accepted by the Insurer.

Signature

X

Date

□ □ / □ □ / □ □ □ □

Please return your completed form to: ANZ Staff Super, GPO Box 2139, Melbourne VIC 3001