Perpetual

Perpetual MySuper
Perpetual Superannuation Limited ABN 84 008 416 831 AFSL 225246 RSE L0003315
MySuper product authorisation number 51068260563643

INSURANCE APPLICATION – STANDARD

Please complete all pages of this form in black ink using BLOCK letters.

This form should be used if you:

- are aged 55 or older, or
- require more than $1 million of death only cover, or
- require more than $1 million of TPD only cover, or
- require more than $1 million death and total and permanent disablement insurance cover, or
- earn over $128,000 per annum and therefore require more than $8,000 monthly benefit of salary continuance cover, or
- require agreed value salary continuance cover, or
- have answered 'yes' to any of the questions in the 'Insurance cover' section of the MySuper member application form.

Are you an existing Perpetual MySuper member?

yes ☐ account number

1. Member details

title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ other

first name(s)

last name

date of birth / / current age gender ☐ male ☐ female

unit number street number

street name

suburb (if relevant) OR city

state postcode

country

email address

occupation

industry

daily duties (including % time spent performing each duty)

2. Type of insurance

Type of insurance (for an increase in cover, the amount nominated will be added to any existing cover)

Type(s) of insurance cover		New	Increase
☐ death only	amount	$	$
or			
☐ TPD only	amount	$	$
or			
☐ death and TPD	death amount	$	$
	TPD amount	$	$
and/or			
☐ salary continuance	amount	$ per month (min. $500 per month)	$ per month
	(This cannot be greater than 85% of your monthly income, which includes a maximum 10% allowance for super contributions. That is your cover amount cannot be greater than 75% of your monthly income plus an additional 10% of your monthly income representing a super contribution component. For example if you have a monthly salary of $4,000 the maximum monthly cover amount you have is 75% x $4,000 plus 10% x $4,000.)		
What percentage of your cover amount indicated above represents a Super contribution component? If this is left blank nil will be assumed.		% (This is optional and is a maximum of 10% of your monthly income.)	

Salary continuance only

benefit period	☐ 2 years (to age 65 if earlier)	☐ 5 years (to age 65 if earlier)	☐ to age 65
waiting period	☐ 30 days	☐ 60 days	☐ 90 days
type of cover	☐ agreed value*	☐ indemnity	

* If you are applying for agreed value salary continuance cover, the following additional financial information is also required:

If you are self employed

- Profit & Loss statements for your business or practice (including any trusts if applicable) for the last 2 years,
- your income tax returns and notice of assessments including any business entities for the last 2 years, and
- if you are applying for cover of $15,000 per month or more, Statement of Assets and Liabilities (held personally or in trust) from your accountant.

If you are not self employed and you are applying for cover

- up to $12,500 per month, income tax return and notice of assessment for the last year, or
- above $12,500 per month, income tax returns and notice of assessments for the last 2 years, or
- above $15,000 per month, income tax returns and notice of assessments for the last 2 years **plus** Statement of Assets and Liabilities (held personally or in trust), from your accountant.

3a. Personal statement – Part 1

annual salary ($) | number of hours worked per week | height (cm) | weight (kg)

1. Are you:
   a. an Australian citizen or holder of an Australian permanent resident visa? no yes
   b. a New Zealand citizen holding a current special category visa who is residing in Australia indefinitely? no yes
2. Have you smoked tobacco or any other substance in the last 12 months? no yes

   If yes, please state forms and quantities:
3. Do you drink alcohol? no yes

   If yes, state how many standard drinks you consume per week:
   (One standard drink = 30 ml spirits (one nip), 100 ml wine, 10 oz/285 ml beer)
4. Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer?) no yes

   If yes, please provide the policy details in the schedule below.

Commencement date	Insurer	Type of cover	Amount of cover	To be replaced
				no yes
				no yes

At the date of application:

5. Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full time basis due to injury or illness (even if you are not currently working on a full time basis or are unemployed)? no yes
6. In the last three (3) years, have you had any advice or treatment, taken prescribed drugs or been hospitalised for any injury or illness (excluding for colds or flus)? no yes
7. Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? no yes
8. Are you under any treatment by diet, medication, prescribed drugs or other therapy? no yes
9. Has any company ever refused or applied special or modified conditions or cancelled any application to insure you for a life or disability policy? no yes
10. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? no yes

    If you answered yes to any of the questions above, please provide full details:

11. Do you have definite plans to travel or reside overseas? no yes

    If 'yes', please state:

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure

3a. Personal statement – Part 1 (continued)

Family history

12. a. Have any of your immediate family (father, mother, brother, sister), prior to the age of 60 (living or dead), ever suffered from:

- Heart disease or stroke? no ☐ yes ☐
- Breast cancer, ovarian cancer, prostate cancer or colon (bowel) cancer? no ☐ yes ☐
- Polycystic kidney disease or diabetes? no ☐ yes ☐
- Mental disorder? no ☐ yes ☐
- Huntington's chorea, Alzheimer's disease, Dementia, Motor neurone disease, Multiple sclerosis, Muscular dystrophy or Parkinson's disease? no ☐ yes ☐
- Any other hereditary disease? no ☐ yes ☐

If 'yes', please provide details in the table below:

	Condition/illness (for heart disease or cancer please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

- b. Are you required to undergo any regular screening as a result of your family history? If 'yes', please provide details. no ☐ yes ☐

3b. Personal statement – Part 2

Section A: Medical details

1. Have you ever had or received treatment for or had symptoms of:
   a. High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke? no ☐ yes ☐
   b. Asthma, chronic lung disease, sleep apnoea or other respiratory disorder? no ☐ yes ☐
   c. Indigestion, gastric or duodenal ulcer, hernia/s or any bowel disorder? no ☐ yes ☐
   d. Diabetes, abnormal blood sugar, gout or thyroid disorder? no ☐ yes ☐
   e. Depression, anxiety/stress state, fatigue, panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder? no ☐ yes ☐
   f. Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness, tremor or recurrent headaches or any neurological disorder including multiple sclerosis? no ☐ yes ☐
   g. Arthritis, repetitive strain injury (RSI), chronic fatigue syndrome, fibromyalgia? no ☐ yes ☐
   h. Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles? no ☐ yes ☐
   i. Psoriasis or eczema, skin disorder or abnormality with hearing, eyesight or speech? no ☐ yes ☐
   j. Cancer, cyst, lump, tumour or growth of any kind? no ☐ yes ☐
   k. Liver, pancreas, prostate, kidney or bladder disorder, renal colic or stone? no ☐ yes ☐
   l. Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia? no ☐ yes ☐
   m. Hepatitis B or C or are a Hepatitis B or C carrier. Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus? no ☐ yes ☐

3b. Personal statement – Part 2 (continued)

Females only

Have you ever had or been advised to have treatment for:

n. Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? no yes

o. An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries? no yes

p. Abnormal vaginal bleeding within the last 12 months or endometriosis? no yes

q. Are you currently pregnant?
If yes, please state expected delivery date / / no yes

2. Have you ever suffered symptoms of or had any other illness, disease or disorder? no yes

3. In the last 5 years have you:

a. Had any medical examinations, consultations, X-rays, pathology tests or procedures? no yes

b. Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? no yes

4. Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? no yes

5. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? no yes

(Only if you are applying for TPD or salary continuance cover)

a. Have you ever been involved in an accident that has caused you to be off work or reduce your working capacity for greater than 10 consecutive days? no yes

b. Have you consulted a chiropractor, osteopath, physiotherapist or acupuncturist? no yes

Lifestyle statement

6. a. Have you ever used any illicit drugs not prescribed by a medical practitioner?
If 'yes', a 'Drugs Questionnaire' is required. no yes

b. In the past 5 years have you:
i. Engaged in male to male sexual activity **without** a condom (except in a relationship between you and only one other person where neither of you has had sex **without** a condom with anyone else in the past 5 years) or no yes

ii. had sex **without** a condom:
– with someone you know or suspect to be HIV positive or
– with someone who injects non prescribed drugs or
– with a sex worker or as a sex worker? no yes

If 'yes', a 'Confidential Supplementary Personal Statement' is required.

If you answered YES to ANY of the questions in Section A, please complete remainder of form. Otherwise, go to Sections C and D.

Section B: Answers in detail

If you answered YES to ANY question in Section A, please provide details in the schedule below. If there is insufficient space, please provide a signed and dated supplementary statement.

question reference		time off work		date of illness/injury		degree of % recovery	

illness, injury or tests

results of tests

reason and type of treatment including date of last symptoms

full name and address of doctor or hospital (if any)

3b. Personal statement – Part 2 (continued)

Section C: Doctor's details

name of doctor

address

suburb (if relevant) OR city

state postcode

telephone

date of last consultation

/ /

how long have you been a patient?

name of doctor

address

suburb (if relevant) OR city

state postcode

telephone

date of last consultation

/ /

how long have you been a patient?

Section D: Further salary details (for salary continuance only)

1.a. Please state your monthly salary from your current occupation (if self-employed, net of business expenses but before tax). Include income from personal exertion only. (Do not include non-personal exertion income such as dividends, interest, rental income or royalties).

Principal occupation:

Current year $ per month

Previous year $ per month

1.b. How long have you been at your current occupation? years months

How much of the above income will continue if you are disabled? $

i. For how long? years/months

ii. State source of income (eg. sick leave)

2. If you became disabled, would you receive income from other sources? no yes

If yes

a. How much: $ per month

b. For how long years/months

c. State source of income

3. Do you also perform another occupation? no yes

If yes, describe the daily duties of this occupation (including manual work)

4. Do you receive any unearned income? (eg. from investments such as rental property or dividends) no yes

If yes, how much? $ per month

3b. Personal statement – Part 2 (continued)

5. What was your previous occupation?

6. Are you self-employed? (sole trader, business partner, employee of own company/trust) no ☐ yes ☐

If yes

a. Date your business started ☐☐ / ☐☐ / ☐☐☐☐

b. How long have you been self-employed? years/months

c. What percentage of your work is: i. Freelance? % ii. Contract? %

d. If self-employed, did your business make a loss in the last financial year? no ☐ yes ☐

If yes, please provide copies of Profit and Loss Statements for the last two (2) years.

e. How many people do you employ?

7. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? no ☐ yes ☐

If yes, when ☐☐ / ☐☐ / ☐☐☐☐

Date of discharge ☐☐ / ☐☐ / ☐☐☐☐

8. Do you work at home? no ☐ yes ☐

If yes, state percentage of the time %

9. Do you earn commission or bonuses? no ☐ yes ☐

If yes, state percentage of total income %

4. General declaration

- **Truth and Accuracy** – I hereby declare that to the best of my knowledge and belief all of the answers to questions on this application form are true and accurate and I have not deliberately withheld any information material to the proposed insurance.
- **Changes to Contract** – I understand that I must advise the insurer of any material change in my health during the period between the application date shown below and the cover commencement date. I understand that my failure to advise of such a change may make the contract of insurance voidable by the insurer.
- **Acceptance of the application** – I note that this application is subject to acceptance by the insurer and that the insurance cover does not commence until I have been advised by the Trustee and insurer about acceptance of my application and (where applicable) I have provided written acceptance of any special acceptance terms.
- **Duty of Disclosure** – I acknowledge that I have read and understood the 'Your duty of disclosure' in accordance with the Insurance Contracts Act 1984, as detailed in this 'Insurance in your super' document.
  Warning: You have a duty to disclose all information relevant to the insurer's decision to accept your application.
- **Privacy Statement** – I have read and understood the Privacy disclosure as detailed in the Perpetual MySuper 'Your MySuper account' document. I consent to my personal information being collected and used and disclosed in accordance with the Privacy disclosure.
- **Consent to provide personal health information to my adviser** – I consent to allow Perpetual to provide my adviser with any personal health information to assist the Trustee and insurer in assessing my application for insurance.

☐ I do not authorise my financial adviser to be provided with any personal health information submitted in relation to my application for insurance.

Election to maintain cover (optional)

☐ I wish to opt-in to maintain my insurance cover in the event that my account becomes inactive for a continuous period of 16 months (where my insurance cover would otherwise be required to be cancelled). I understand and acknowledge that the ongoing insurance premiums being charged to my account will likely reduce my account balance.

signature date ☐☐ / ☐☐ / ☐☐☐☐

5. Consent

Consent to Disclose – I consent to AIA Australia and to the Trustee on behalf of AIA Australia, seeking medical information from any doctor who at any time I have consulted prior to the date below. While I am insured, I authorise the provision of such information to AIA Australia. I consent to the use of my personal information. I agree to be bound by the provisions of the Policy Document between AIA Australia and the Trustee, which govern the terms of life insurance and conditions set out in this document.

signature date / /

6. Medical authority

I,

authorise any Medical Practitioner, hospital, clinic or other person (including any life insurance company, underwriter or third party acting on behalf of AIA Australia), to disclose to AIA Australia full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

signature date / /

Would you like an underwriter to contact you to clarify any information? no yes

7. Financial adviser use only

Adviser details

financial adviser name

phone (business hours) mobile

email

[1] Perpetual adviser ID

OR [2] dealer group AND

b.dealer branch*

*City or suburb of the dealer group office you operate through

If Senior Adviser details are completed above, please also provide name of your accountant.

Please send your completed form to:

Reply Paid 4171
Perpetual MySuper
GPO Box 4171
Sydney NSW 2001

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