

2. Type of insurance

Is this a new application for insurance or an application to increase insurance cover?

new increase (complete the boxes below with total amount of cover, not the amount of the increase)

Type of insurance

Type	Cover
<input type="checkbox"/> death only or <input type="checkbox"/> TPD only or <input type="checkbox"/> death and TPD	amount \$ <input type="text"/> (min. \$50,000) TPD amount \$ <input type="text"/> (min. \$50,000) death amount \$ <input type="text"/> (min. \$50,000) TPD amount \$ <input type="text"/> (min. \$50,000)
and/or <input type="checkbox"/> salary continuance	buyback option yes <input type="checkbox"/> no (default) <input type="checkbox"/> amount \$ <input type="text"/> per month (min. \$500 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.	<input type="text"/> % (This is optional and is a maximum of 10% of your monthly income.)

Please apply indexing to my sum insured:

yes (default) no

Salary continuance only

benefit period	<input type="checkbox"/> 2 years (to age 65 if earlier)	<input type="checkbox"/> 5 years (to age 65 if earlier)	<input type="checkbox"/> age 65
waiting period	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days
type of cover	<input type="checkbox"/> agreed value*	<input type="checkbox"/> 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.

Please pay my insurance premium:

proportionally according to my account balance from my investment option
 from my investment option with the highest balance**

**If no selection is made or if the balance in your nominated investment option is insufficient, we will deduct premiums from the investment option with the highest balance.

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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	no <input type="checkbox"/>	yes <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	no <input type="checkbox"/>	yes <input type="checkbox"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	<input type="checkbox"/>	yes	<input type="checkbox"/>
o. An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
p. Abnormal vaginal bleeding within the last 12 months or endometriosis?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
q. Are you currently pregnant?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
If yes, please state expected delivery date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				

2. Have you ever suffered symptoms of or had any other illness, disease or disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
3. In the last 5 years have you:				
a. Had any medical examinations, consultations, X-rays, pathology tests or procedures?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
b. Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
4. Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
5. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? (Only if you are applying for TPD or salary continuance cover)	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
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	<input type="checkbox"/>	yes	<input type="checkbox"/>
b. Have you consulted a chiropractor, osteopath, physiotherapist or acupuncturist?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>

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	<input type="checkbox"/>	yes	<input type="checkbox"/>
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	<input type="checkbox"/>	yes	<input type="checkbox"/>
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	<input type="checkbox"/>	yes	<input type="checkbox"/>
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)

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

If yes, how much? \$ per month

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 Insurance 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 AIA Australia or the Trustee about acceptance of my application.
 - **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 on page 2 in this Insurance Book.
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 Features Book. 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 financial adviser** – I consent to allow Perpetual to provide my financial 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 to be used as outlined in the Features Book. 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	<input type="text"/>	date	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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	<input type="text"/>	date	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Would you like an underwriter to contact you to clarify any information? no yes

7. Financial adviser use only

Financial adviser details

financial adviser name	<input type="text"/>										
phone (after hours)	<input type="text"/>				phone (business hours)	<input type="text"/>					
mobile	<input type="text"/>				fax	<input type="text"/>					
AFSL licensee name	<input type="text"/>				AFSL number	<input type="text"/>					
Perpetual adviser number	<input type="text"/>										
dealer group	<input type="text"/>					dealer branch	<input type="text"/>				
email address	<input type="text"/>										
financial adviser signature	<input type="text"/>				date	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>



IL GN / / (Group)

IL AN / / (Adviser)

IL CN / / (Client)