

Use this form to apply for, or increase your cover.
You can also change your Income Protection
waiting period or occupation category.

Please read this information before you complete the form

Apply for or increase your insurance

- you must complete Sections 1, 2, 3, 6 and 8.

Apply to change your Income Protection waiting period

- If you would like to decrease your waiting period you must complete Sections 1, 2, 4, 6 and 8.
- If you would like to increase your waiting period you must complete Sections 1, 2, 4 and 8.

Change your occupation category

- complete Sections 1, 2, 5 and 8.

Please provide as much information as possible to assist us in processing your request. Before completing this form, ensure you read the relevant Product Disclosure Statement, Member Guide and your Member Statement to identify your current insurance cover with the fund.

Please use pen and BLOCK letters to complete this form. Any boxes should be marked with 'X'. Please make sure you have completed all relevant sections.

1 Your personal details

Surname

Given names

Title

Member number

Email¹

Date of birth (DD/MM/YYYY)

Mobile number

Phone number

Other/Previous names (if applicable)

Residential address

Town/Suburb/City

State

Postcode

Occupation

Employer

¹ Please ensure the email address provided is your personal address as we may send information of a sensitive and personal nature to it.

2 Duty to take reasonable care

If you apply for life insurance, you will be treated as if you are applying for cover under an individual consumer insurance contract. The Insurer will conduct a process called underwriting. It's how it decides whether it can cover you, and if so on what terms and at what cost.

As part of underwriting, the Insurer will ask questions it needs to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance.

The information you provide in response to those questions will be vital to the Insurer's decision. As such, when applying for life insurance you have a legal duty to take reasonable care not to make a misrepresentation to the Insurer. 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

If you do not meet your legal duty, this can have serious impacts on your insurance. Your cover could be avoided

2 Duty to take reasonable care (continued)

(treated as if it never existed), the amount of cover varied or its terms may be changed. This may also result in a claim being declined or a benefit being reduced. Whether the Insurer can exercise one of these remedies depends on a number of factors, including:

- whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances
- what the Insurer would have done if the duty had been met – for example, whether it would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

Guidance for answering questions

You are responsible for the information provided to the Insurer.

When answering questions, please:

- Think carefully about each question before you answer. 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.
- > Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

There may be circumstances where the Insurer later investigates whether the information given to it was true. For example, it may do this when a claim is made.

Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances which the Insurer reasonably considers to be relevant in assessing your application. As any changes might require further assessment or investigation, it could save time if you let us or the Insurer know about any changes when they happen.

If you need help

It's important that you understand your obligations and the questions asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

I have read and understood my duty to take reasonable care

3 Apply for or increase your cover

1. Type of cover

Please indicate the type of cover/additional cover you are applying for:

Death only (including terminal illness)

Death & TPD

Income protection

Do you want the cover received in this application to replace your existing cover?

Yes

No

(If you choose no, any cover received in this application will be in addition to your existing cover and any existing cover will be matched to your election. This means if you're applying for fixed cover any existing unitised cover will also be converted to fixed cover.)

2. Death only (including terminal illness) or Death & TPD

Please indicate whether you would like unitised or fixed cover (you cannot have a combination of both). Please refer to Section 8 of the PDS and the Member Guide for information on unit based cover vs fixed cover.

Unitised cover **OR**

Fixed cover

Note: You can apply for a maximum of \$5 million Death only (including terminal illness) and \$2.5 million for TPD insurance. TPD only cover can not exceed Death only (including terminal illness) cover.

Unitised cover: Please insert the number of units of cover you require. (Refer to the PDS and Member Guide for details of the cover available).

Death only (including terminal illness)

units **AND**

Death & TPD cover

units

OR

Fixed cover: Please insert the dollar amount of cover you require.

Death only (including terminal illness)

AND

Death & TPD cover

3 Apply for or increase your cover (continued)

3. Income protection cover

What is your current gross monthly income? (Please refer to the Member Guide for the definition of income)

How much cover do you require per month? (You can only insure up to 87% of your monthly income. Maximum \$30,000 per month.)

What waiting period would you like to apply for? (for new member IP applications only) 30 days 60 days 90 days

4 Change your Income Protection waiting period

I want to reduce my waiting period to 30 days 60 days

I want to increase my waiting period to 60 days 90 days

5 Change your occupation category

If you are in a low risk occupation, you may be entitled to be in White collar or Professional occupation category. These occupation categories offer a higher level of cover or lower premium than the General, Health or Education occupation categories. If you do not complete this section, or do not qualify for a White Collar or Professional category, your occupational category will be General, Health or Education based on your Division.

What is your current occupation?

Your employment status Full-time Part-time Casual

What is the average number of hours you work in a week in your main occupation? hours

Please provide a brief description of your duties.

Please indicate below whether the following statements are correct.

White Collar

- 1. My usual work duties do not require me to perform duties of a manual nature. Yes No
- 2. My work duties are of a clerical, administrative or management nature. Yes No
- 3. My work duties are undertaken within an office environment for 80% of the time (excluding travel time between offices). Yes No

If you answered Yes to all questions, you are eligible to be in White collar occupation category. Please note: Teachers are not eligible to receive a White Collar occupation category.

Professional

In addition to the requirements set out under White Collar:

- 1. I hold a tertiary qualification relevant to my current occupation, or am a member of a professional institute, or am a senior member of my organisation's executive team. Yes No
- 2. I earn in excess of \$100,000 per annum from my profession. Yes No

If you qualify for a White collar occupation category and answered Yes to statements 1 and 2 above, you are eligible for a Professional occupation category.

6 Personal questions (continued)

- i) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? Yes No
- 4. a) In the last five years have you taken any illegal drugs or drugs that weren't prescribed for you? Yes No
- b) Has a doctor or healthcare provider told you to reduce or stop drinking alcohol, or have you received counselling or treatment for alcohol, substance or drug use? Yes No
- c) Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
- 5. a) Apart from any condition you have already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis? Yes No
- b) Apart from any condition you have already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years? Yes No
- 6. This question is about your family's medical history. As far as you know, has your mother, father, sisters or brothers had any of the following (please select all that apply): Yes No
- a) Heart or circulatory problems, stroke, cardiomyopathy, diabetes? Yes No
- b) Depression or any other mental illness? Yes No
- c) Cancer of any type? Yes No
- d) Huntington's disease, muscular dystrophy, MS (multiple sclerosis), polycystic kidney disease, Parkinson's disease or any other inherited blood or neurological disorder? Yes No

⚠ Only complete if you answered **Yes** to any part of **question 6** of **Section B – Personal Statement**

Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

- 7. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months? Yes No

Before answering these questions you may wish to check the Smart Traveller website: smartraveller.gov.au

If Yes please provide details below:

Country/destination	Date of departure from Australia (if applicable)	Date of return/arrival in Australia	Reason for travel

For each **Yes** answer you must complete a corresponding questionnaire as noted in the column beside your **Yes** answer above. Proceed to relevant questionnaire in **Section C**.

6 Personal questions (continued)

C. Questionnaire A – Pastimes

ⓘ Only complete if you answered **Yes** to any part **question 1** of **Section B – Personal Statement**

1. Do you engage in any high risk sports or activities:

- | | | |
|--|-----|----|
| a) Aviation (other than as a fare paying passenger on a commercial airline)? | Yes | No |
| b) Underwater diving (scuba)? | Yes | No |
| If Yes | | |
| i) do you dive at more than 40 metres, or engage in cave, nitrox or wreck diving? | Yes | No |
| ii) do you dive alone? | Yes | No |
| c) Football of any code (other than touch or Oztag)? | Yes | No |
| d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing? | Yes | No |
| e) Trail bike or quad bike riding (including off road and dirt bike)? | Yes | No |
| f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports, horse riding, abseiling, mountaineering or recreations involving heights? | Yes | No |

If you have answered Yes to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

At what level do you participate?

Recreational only (non competition)

Recreational with competition

Semi-professional/professional

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)? Yes No

If Yes, please provide full details

6 Personal questions (continued)

C. Questionnaire B – Insurance history

⚠ Only complete if you answered **Yes** to any part **question 2** of **Section B – Personal Statement**

1. Apart from this application, do you have or have you recently applied for life, total and permanent disability, trauma, income protection or salary continuance on your life with TAL or any other insurance company? Yes No

Please complete the table below:

Insurance company	Type of cover	Insurance benefit	To be replaced?		Date commenced
		\$	Yes	No	/ /
		\$	Yes	No	/ /
		\$	Yes	No	/ /

2. Have you ever had an application for life, total and permanent disability, trauma, or salary continuance on your life turned down, been asked to pay higher premiums or had exclusions or special terms applied? Yes No

If Yes please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

3. Are you claiming or have you ever claimed a disability or similar benefit from any source, e.g. TPD benefit, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits? Yes No

If Yes please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
	/ /	\$	/ /
	/ /	\$	/ /
	/ /	\$	/ /

6 Personal questions (continued)

C. Questionnaire C – Joint/musculoskeletal

ⓘ Only complete if you answered **Yes** to any part **question 3e** of **Section B – Personal Statement**

1. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did your symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

5. Was an x-ray or scan taken? Yes No

If Yes, please complete the details below:

Date of your most recent test

 / /

Details of results of tests taken:

6. Is the nature of your condition degenerative or a disc problem? Yes No

7. Are you still undergoing treatment or experiencing symptoms? Yes No

If No, please complete the details below:

Date your symptoms ceased

 / /

Date your treatment ceased

 / /

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities? Yes No

If Yes, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition? Yes No

If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

 ()

Fax Number

 ()

6 Personal questions (continued)

C. Questionnaire D – Mental health

⚠ Only complete if you answered **Yes** to any part **question 3f** of **Section B – Personal Statement**

1. Please provide details of your condition (doctor's diagnosis):

2. Please indicate the reason or cause by marking the appropriate box(es):

Bereavement/family illness

Marital problems

Post natal

Work related

Other (please specify)

3. Date symptoms first commenced:

 / /

4. Have the symptoms ceased? Yes No

If Yes, please provide the date symptoms ceased:

 / /

5. Have you taken or are you taking medication? Yes No

If Yes, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)

6. Have you attempted suicide or had suicidal thoughts? Yes No

7. Have you ever been hospitalised? Yes No

If Yes, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work? Yes No

If Yes, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way? Yes No

If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

 ()

Fax Number

 ()

6 Personal questions (continued)

C. Questionnaire E – High blood pressure/ Raised cholesterol

⚠ Only complete if you answered **Yes** to any part **question 3a** of **Section B – Personal Statement**

1. Name of condition

High blood pressure

Raised cholesterol

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain? Yes No

If Yes, please provide details, including dosage:

4. Are you taking regular medication for this condition? Yes No

If Yes, please provide details, including dosage:

5. High blood pressure
When was your last blood pressure reading?

Was it considered to be well controlled, e.g. less than 140/90?

Yes No Don't know

Raised cholesterol
When was your last cholesterol reading?

What was the result of your last cholesterol reading?

2.0 to 6.5 mmol 6.6 to 7.5 mmol
7.6 or above Don't know

6. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

Fax Number

6 Personal questions (continued)

C. Questionnaire F – Cysts, moles, sunspots or skin lesion

⚠ Only complete if you answered **Yes** to any part **question 3g** of **Section B – Personal Statement**

1. Please provide type:

- Cyst
- Mole
- Sunspot
- Skin lesion
- Basal cell carcinoma
- Other (please specify)

2. Location of growth(s)

- Face/head
- Back/shoulder
- Chest/front
- Arm/leg

3. When was this?

4. Was/were the growth(s) removed? Yes No

If Yes, please complete below:

When was it removed?

How many growths were removed?

Method of removal:

- Frozen/burnt off
- Surgical/cut out

5. Was/were the growth(s) reported as cancerous (malignant)? Yes No

If Yes, were any further tests, investigations, treatments, follow up or re-excision required? Yes No

If Yes, please provide dates and details of further tests, investigations, treatments, follow up or re-excision: Yes No

6. Is your treating doctor different from your usual doctor? Yes No

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

Fax Number

6 Personal questions (continued)

D. General health

ⓘ If you have answered **Yes** to any part of **Section B – Personal Statement**, please complete the table below:

Details for question number:	Question ()	Question ()	Question ()
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started?			
3. Date symptoms ceased (if applicable)?			
4. Are these symptoms singular, recurrent or ongoing?			
5. How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).			
6. Severity of symptoms? Please choose one of the following: mild, moderate, severe, never had symptoms, symptoms ceased.			
7. Did you take medication or have any other treatment for this condition? If Yes please give details of the medication/treatment.	Yes	No	Yes No
8. Are you still on treatment, including medication?	Yes	No	Yes No
9. Have you ever been off work as a result of this condition? If Yes, please indicate the total time off work.	Yes	No	Yes No
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	Yes	No	Yes No
11. Have you ever had an x-ray, scan or blood test for this condition?	Yes	No	Yes No
12. Is your treating doctor different from your usual doctor? If Yes, please provide the doctor's name and contact details.	Yes	No	Yes No

6 Personal questions (continued)

E. Your personal information privacy

Your privacy as a member of Prime Super

The information you provide in this form is collected by and held for Prime Super by the fund Administrator, in accordance with the Australian Privacy Principles of the Privacy Act. Such information is usually disclosed to third parties, including the Insurer or medical consultant who may be involved with the assessment of this application, and is held by the fund Administrator and the Insurer. For further information about privacy or to obtain a free copy of our Privacy Policy, please visit our website primesuper.com.au or by contacting customer service on **1800 675 839**, write to us at Locked Bag 5103, Parramatta, NSW 2124 or email us at administration@primesuper.com.au.

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).

 The following sections must be completed in all circumstances.

F. Your personal information privacy

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion.

I permit the insurer (TAL) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my duty to take reasonable care as described in Section 2.

Yes

No

If Yes, I am contactable on the following number

6 Personal questions (continued)

G. Your doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Doctor's Address

Town/Suburb/City

State

Postcode

Phone number

Fax number

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's Address

Town/Suburb/City

State

Postcode

7 Your privacy and the Insurer

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 and sensitive information is set out in the TAL Privacy Policy available at tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1300 209 088.

8 Member declaration

I have read the duty to take reasonable care in this Personal Statement and I am aware of the consequences of non-disclosure.

I understand that the duty to take reasonable care continues after I have completed this statement until my application for cover has been accepted by TAL Life Limited ABN 70 050 109 450 (TAL) in writing.

I authorise:

- the insurer to provide any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers)
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Services and any other body holding information on me that is reasonably relevant to this application or my cover.

I agree to provide further medical authorities if requested and reasonably relevant to this application or my cover.

I declare that:

- the answers to all the questions and the declarations in this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may reasonably affect TAL's decision to provide insurance
- I acknowledge that if I am increasing my cover through a change in occupation category, then my cover is Limited Cover for the increased amount for 24 months and will remain until I have been in Active Employment for 30 consecutive days after the end of the initial 24 month period
- I have read and understood the "Your personal information privacy" in Section E. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section
- I have read and understand the obligations outlined in the "Your Duty to take reasonable care" in Section 2.
- I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

I acknowledge that:

- the answers I have provided, together with any special conditions, will form the basis of any insurance cover provided
- I acknowledge that insurance cover will only be provided on the terms and conditions set out in the Insurance Policy Document (between Prime Super and the Insurer). Those terms and conditions may change from time to time and Prime Super will notify me of those changes where required by law.

Full name

Member signature

Date

 Please ensure that you initial any amendments or changes made throughout this form

Return this form to us via by mail or email

mail: Prime Super
Reply Paid 85860
PARRAMATTA NSW 2124
No stamp required

email: administration@primesuper.com.au
visit: primesuper.com.au
call: 1800 675 839