



Section A – Your details

Member number	Surname	Given name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of superannuation fund		Employer
<input type="text"/>		<input type="text"/>
Salary or yearly remuneration	Occupation	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
1. What is your: Height <input type="text"/> cm or <input type="text"/> ft/in Weight <input type="text"/> kg or <input type="text"/> st/lb		
2. Have you smoked in the last 12 months? No <input type="checkbox"/> Yes <input type="checkbox"/> ▶ If 'yes', please indicate what you smoke <input type="text"/>		
What is your average? <input type="text"/> per day <input type="text"/> per week or <input type="text"/> per year		
3. Do you drink alcohol? No <input type="checkbox"/> Yes <input type="checkbox"/> ▶ If 'yes', please provide the average number of standard drinks consumed:		
<input type="text"/> per day <input type="text"/> per week or <input type="text"/> per year		

Section B – Personal statement

1. Do you engage in any hazardous pastimes or pursuits such as, but not limited to, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than a fare paying passenger), scuba diving or any sport(s) in a professional capacity?	No <input type="checkbox"/> Yes <input type="checkbox"/>	A
2. Have you: a) Recently applied for or do you have a policy for life, total and permanent disability, trauma or salary continuance (excluding this application)? b) Ever had an application for life, disability, trauma, accident or sickness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms? c) Ever claimed a lump sum or accident or sickness benefit from any insurance policy, including but not limited to superannuation, workers' compensation, disability pension or Veterans Affairs?	No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	B B B
3. Have you ever received medical advice, been treated for or diagnosed with back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, injury of any joint, bones or muscle, arthritis, gout or repetitive strain injury (RSI)?	No <input type="checkbox"/> Yes <input type="checkbox"/>	C
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental disorder, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, myalgia or fibromyalgia or chronic fatigue syndrome?	No <input type="checkbox"/> Yes <input type="checkbox"/>	D
5. Have you received medical advice, undergone any treatment, investigation or operation for, or had: a) High blood pressure or raised cholesterol? b) Cyst, mole, sunspots or melanoma? c) Asthma (other than childhood), bronchitis or any other lung complaint requiring hospitalisation? d) Heart complaint, stroke or neurological disorder, including multiple sclerosis? e) Cancer, leukaemia, diabetes or chronic kidney complaint?	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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	E F G G G
6. Have you: a) Taken any illegal drugs in the last five years? b) Been advised or received counselling or treatment for alcohol or substance abuse? c) Been infected with or tested positive for HIV/AIDS, Hepatitis B and/or C? d) In the last five years, ever engaged in unprotected male to male sexual intercourse or worked as or engaged the services of a prostitute?	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 <input type="checkbox"/> Yes* <input type="checkbox"/>	
7. Apart from anything already stated: a) Are you considering seeking medical advice, treatment, tests or surgery in the future? b) Have you, in the last five years, received any medical advice, any medical treatment, investigation or had any operation not mentioned above (apart from colds, flu, contraceptive advice)?	No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	G G
8. To the best of your knowledge, have any of your natural parents, brothers or sisters suffered from or been diagnosed with: a) Heart or circulatory problems, stroke, high blood pressure, diabetes? b) Depression or any other mental illness? c) Cancer of any type? d) Huntington's disease, muscular dystrophy, polycystic kidney disease or any other hereditary disease?	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 <input type="checkbox"/> Yes <input type="checkbox"/>	H H H H

Have you answered 'yes' to any questions (1 to 5) or (7 and 8) in Section B?

No **▶ Go straight to Section E on page 8. Do not complete Section C or D.**

Yes **▶ 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.**

*If you have answered 'yes' to question 6, a confidential questionnaire will be sent to you.

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Section C – Questionnaire A – Pastimes questionnaire

Only complete if you answered 'yes' to question 1 of Section B – Personal statement

1. Do you engage in any of the following hazardous pastimes or pursuits?

a) Flying? (other than as a fare paying passenger on a commercial airline)	No <input type="checkbox"/> Yes <input type="checkbox"/>
b) Underwater diving (scuba)	No <input type="checkbox"/> Yes <input type="checkbox"/>
If 'yes' (i) do you dive more than 40 metres in depth?	No <input type="checkbox"/> Yes <input type="checkbox"/>
(ii) do you dive alone?	No <input type="checkbox"/> Yes <input type="checkbox"/>
c) Football of any code (other than touch or Oztag)	No <input type="checkbox"/> Yes <input type="checkbox"/>
d) Motor sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing	No <input type="checkbox"/> Yes <input type="checkbox"/>
e) Trail bike riding	No <input type="checkbox"/> Yes <input type="checkbox"/>
f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports or recreations involving heights?	No <input type="checkbox"/> Yes <input type="checkbox"/>

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? (tick (✓) the appropriate box)

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)?

No Yes

Questionnaire B – Insurance history questionnaire

Only complete if you answered 'yes' to any part of question 2 of Section B – Personal statement

1. Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance on your life with CommInsure, or any other insurance company? No Yes

If 'yes', please provide details below:

Insurance company	Type of cover	Insurance benefit	To be replaced?	Date commenced
		\$	No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /
		\$	No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /
		\$	No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /

2. Has an application for life, total and permanent disability, trauma, or salary continuance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No Yes

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 benefit from any source, e.g. TPD benefit, from any superannuation fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits? No Yes

If 'yes', please provide details below:

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



Only complete if you answered 'yes' to question 3 of Section B – Personal statement

Only complete if you answered 'yes' to question 4 of Section B – Personal statement

- Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.
- Location of complaint, e.g. lower back, right knee, sciatic nerve.
- When did symptoms first begin?
- Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.
- Was an x-ray or scan taken?
No Yes ▶ If 'yes', please complete the details below:
Date of most recent test / /
Details of results of tests taken:
- Is the nature of the condition degenerative or a disc problem?
No Yes
- Are you still undergoing treatment or experiencing symptoms?
No ▶ If 'no', please complete the details below:
Yes
Date symptoms ceased / /
Date treatment ceased / /
- Have you been off work as a result of this complaint or been unable to perform your normal day to day activities?
No Yes ▶ If 'yes', please indicate period(s) off work:
- Do you have any residual, ongoing effects or restrictions as a result of this condition?
No Yes ▶ If 'yes', please provide dates and details:
- Is your treating doctor different from your usual doctor?
No Yes ▶ If 'yes', please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number Fax number
 () ()

- Please provide details of the condition (doctor's diagnosis):
- Please indicate the reason or cause by ticking the appropriate box(es):
Bereavement/family illness
Marital problems
Post natal
Work related
Other (please specify)
- Date symptoms first commenced:
 / /
- Have the symptoms ceased?
No Yes ▶ If 'yes', please provide the date symptoms ceased:
 / /
- Have you taken or are you taking medication?
No Yes ▶ If 'yes', please provide details

Type of medication	Dosage	Date ceased (if not ongoing)
		/ /
		/ /
		/ /
- Have you attempted suicide or had suicidal thoughts?
No Yes
- Have you ever been hospitalised?
No Yes ▶ If 'yes', please indicate period(s) hospitalised:
- Did the condition ever cause you to take time off work?
No Yes ▶ If 'yes', please indicate period(s) off work
- Has your ability to perform daily activities been restricted in any way?
No Yes ▶ If 'yes', please provide dates and details:
- Is your treating doctor different from your usual doctor?
No Yes ▶ If 'yes', please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number Fax number
 () ()



**Questionnaire E – High blood pressure/
Raised cholesterol questionnaire**

Only complete if you answered 'yes' to question 5a of
Section B – Personal statement

- Name of condition
High blood pressure Raised cholesterol
- When were you first diagnosed with this condition?
- Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain?
No Yes ▶ If 'yes', please provide details:
- Are you taking regular medication for this condition?
No
Yes ▶ If 'yes', please provide details, including dosage:
- Blood pressure** **Cholesterol**
When was your last blood pressure reading? When was your last cholesterol reading?
 / / / /
Was it considered to be well controlled, e.g. less than 140/90? What was the result of your last cholesterol reading?
No Yes 2.0 to 6.5 mmol
Don't know 6.6 to 7.5 mmol
7.6 or above
Don't know
- Is your treating doctor different from your usual doctor?
No Yes ▶ If 'yes', please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number Fax number
 () ()

**Questionnaire F – Cysts, moles, sunspots or
skin lesion questionnaire**

Only complete if you answered 'yes' to question 5b of
Section B – Personal statement

- Please provide type:
Cyst Mole Sunspot Skin lesion
Melanoma Basal cell carcinoma
Other ▶ please specify:
- Location of growth(s)
Face/head Back/shoulder Chest/front
Arm/leg
- When was this?
- Was/were the growth(s) removed?
No Yes ▶ If 'yes', please complete below:
When was it removed?

How many growths were removed?

Method of removal:
Frozen/burnt off Surgical/cut out
- Was/were the growth(s) reported as cancerous (malignant)?
No Yes ▶ If 'yes', were any further tests, investigations, treatments, follow up or re-excision required?

No Yes ▶ If 'yes', please provide dates and details of further tests, investigations, treatments, follow up or re-excision:
- Is your treating doctor different from your usual doctor?
No Yes ▶ If 'yes', please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number Fax number
 () ()



Only complete if you answered 'yes' to any part of question 5 C, D & E and/or 7 of Section B – Personal statement

1. When did you last consult a doctor?

- Within the last month 1 to 3 months ago 3 to 6 months ago
 6 to 12 months ago 12 months to 2 years ago Over 2 years ago

a) What was the reason for this consultation?

b) What was the result/outcome from your last consultation? (tick (✓) the appropriate box)

- Referral to specialist/health professional Tests conducted – results pending
 Ongoing treatment e.g. Ventolin inhaler Routine tests conducted – results all clear/normal
 All clear/normal/full recovery – no tests or prescribed treatment Not fully recovered yet
 required (other than contraceptive and cold/flu medication)

c) Was the doctor/medical centre consulted, your usual doctor/medical centre?

No Yes

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

--

State

Postcode

Phone number

Fax number

()

()

2. This question is for females only, otherwise please continue to question 3.

a) Are you currently pregnant?

No Yes ▶ If 'yes', what is the due date for your baby?

/ /

b) Have you ever had any complications with pregnancy or childbirth? (e.g. diabetes, ectopic pregnancy)

No Yes ▶ If 'yes', please provide details and dates below

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c) Have you ever had an abnormal result for any of the following tests?

- i) Pap smear No Yes
 ii) Breast ultrasound No Yes
 iii) Mammogram No Yes

If 'yes', please provide details and dates below

--

d) Have you ever had a breast lump or breast cyst (even if you have not consulted a doctor)?

No Yes ▶ If 'yes', please provide details including dates and results of treatments.

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▶ Please continue to question 3 overpage...



Questionnaire G – Personal and medical details questionnaire (continued)

3. Have you ever had, or sought advice or treatment, experienced symptoms or suffered from any of the following:

a)	Chest pains, heart complaint, heart murmur, palpitations or rheumatic fever	No <input type="checkbox"/> Yes <input type="checkbox"/>
b)	Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
c)	Cancer, tumour or melanoma	No <input type="checkbox"/> Yes <input type="checkbox"/>
d)	Thyroid, glandular or pancreatic disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
e)	Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
f)	Diabetes or abnormal blood sugar	No <input type="checkbox"/> Yes <input type="checkbox"/>
g)	Any disorder of the gall bladder or liver, including hepatitis B, C or raised liver function	No <input type="checkbox"/> Yes <input type="checkbox"/>
h)	Varicose veins, haemorrhoids or hernia	No <input type="checkbox"/> Yes <input type="checkbox"/>
i)	Disorder of the kidney, bladder or prostate, blood in urine or kidney stones	No <input type="checkbox"/> Yes <input type="checkbox"/>
j)	Epilepsy, fits of any kind, fainting episodes or recurring headaches or migraines	No <input type="checkbox"/> Yes <input type="checkbox"/>
k)	Asthma (other than childhood), bronchitis or any other lung complaint requiring hospitalisation in the last 5 years?	No <input type="checkbox"/> Yes <input type="checkbox"/>
l)	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
m)	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome	No <input type="checkbox"/> Yes <input type="checkbox"/>
n)	Eczema, dermatitis, psoriasis or any other skin disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
o)	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
p)	Any impairment of sight (other than corrected by glasses or lenses) or blurred vision	No <input type="checkbox"/> Yes <input type="checkbox"/>
q)	Any impairment of hearing or speech including tinnitus	No <input type="checkbox"/> Yes <input type="checkbox"/>
r)	Any sexually transmitted diseases	No <input type="checkbox"/> Yes <input type="checkbox"/>
s)	Any other illness, injury, disease or disorder not mentioned above	No <input type="checkbox"/> Yes <input type="checkbox"/>
t)	Other than those conditions mentioned above, are you taking any regular prescribed medication	No <input type="checkbox"/> Yes <input type="checkbox"/>
u)	Within the last three years, have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results, a genetic test or an ultrasound (other than for pregnancy)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
v)	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No <input type="checkbox"/> Yes <input type="checkbox"/>

If you have answered 'yes' to any of the above questions, please provide full details of each 'yes' answer in **Section D – General health questionnaire on page 7.**

Questionnaire H – Family history questionnaire

Only complete if you answered 'yes' to any part **question 8** of **Section B – Personal statement**

1. Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

2. Have you had or do you intend on having a genetic test?

No Yes

3. What was the result of the genetic test? (please mark the appropriate box)?

Have not been tested yet Positive (I have the gene) Negative (I do not have the gene) Unsure



If you have answered 'yes' to any part of **question 3 a to v** in **questionnaire G**, please complete the table below:

Details for question number:	Question ()	Question ()	Question ()
1. Name of condition?			
2. Date symptoms first started?	/ /	/ /	/ /
3. Date symptoms ceased (if applicable)?	/ /	/ /	/ /
4. Are these symptoms 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.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
8. Are you still on treatment, including medication?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
9. Have you ever been off work as a result of this condition? If 'yes', please indicate the total time off work.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
10. Have you had any residual, ongoing effects or restrictions as a result of this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
11. Have you ever had an x-ray, scan or blood test for this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
12. Is your treating doctor different from your usual doctor? If 'yes', please provide the doctor's name and contact details.	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>



Section E – Duty of disclosure

Your duty of disclosure

Before you enter into, or become insured, under a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your insurance. Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have covered you on any terms if the failure had not occurred, the insurer may avoid the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may avoid your cover at any time.

An insurer who is entitled to avoid your cover may, within three years of issuing it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Section F – Privacy of your personal information

How we handle your personal information

Personal information is information or opinion that allows others to identify you. It includes your name, age, gender, contact details as well as your health and financial information. CommInsure are part of the Commonwealth Bank Group.

We will act to protect your personal information in accordance with the National Privacy Principles or an industry privacy code.

The Group is a collection of related organisations that provide banking, finance, insurance, funds management, financial planning and advice, superannuation, stockbroking and other services.

The protection of your personal information is a vital part of our service. It is supported by our long experience of keeping personal information confidential.

We collect personal information to provide you with the products and services you request and the law may also require us to collect personal information. We will tell you who collects the personal information, advise you of their contact details, your right of access to that information and what will happen if you choose not to provide the information.

Personal information may be used and disclosed within the Group to administer our products and services, as well as for prudential and risk management purposes. We also use the information we hold to help detect and prevent illegal activity. We co-operate with police and other enforcement bodies as required or allowed by law.

We disclose relevant personal information to external organisations that help us provide services. These organisations are bound by confidentiality arrangements. They may include overseas organisations.

You can seek access to the personal information we hold about you. If the information we hold about you is inaccurate, incomplete or outdated, please inform us so that we can correct it. If we deny access to your personal information, we will let you know why.

For example, we may give an explanation of a commercially sensitive decision, rather than direct access to evaluative information connected with it.

Further information and feedback

If you have any questions or would like further information on our privacy and information handling practices, please contact us by:

E-mail at CustomerRelations@cba.com.au

Telephone **1800 805 605***, or writing to the address below:

Privacy Officer

Customer Relations

Commonwealth Bank Group

Reply Paid 41

Sydney NSW 2001

* A free call unless made from a mobile phone, which will be charged at the applicable mobile rate.



These sections must be completed in all circumstances

Section G – Telephone underwriting

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion. I permit the insurer (Commlnsure) 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 of disclosure as described in Section E.

No Yes If 'yes', I am contactable on the following number ()

between the hours of () am pm and () am pm (note they must be usual business hours eastern standard time)

Section H – 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

() State Postcode

Phone number

()

Fax number

()

Section I – Declaration

I have read the duty of disclosure in this Personal statement and I am aware of the consequences of non-disclosure.

I understand that the duty of disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer 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 Association and any other body holding information on me.
• any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

I declare that:

- the answers to all the questions and the declarations on this Personal Statement are true and correct (including those not in my own handwriting);
• I have not withheld any information which may affect CMLA's decision to provide insurance.
• I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.
• I have read and understood privacy of your personal information in Section F on page 8. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.
• I have read and understand the obligations outlined in the duty of disclosure in Section E on page 8.

A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Full name

()

Signature of life to be insured

X ()

Date

() / () / ()

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

Send this form, along with the Insurance Variation form to:

NGS Super
GPO Box 4303 Melbourne VIC 3001

