

max Super Insurance Application Form & Personal Health Statement



Use this form if:

Dated July, 2007

- You want **Death Only** OR **Death & TPD** cover greater than \$350,000 (complete Steps 1 – 3)
- You want **Income Protection** cover (complete Steps 1 – 3)
- You're an existing **max Super** member and want to add insurance cover (see note before completing Step 3)

Instructions

- **Black or blue pen** please. We're not into pencil.
- Please use **BLOCK** letters.
- Please place a **tick** in boxes where required.
- Fill out as many answers as you can. Don't worry if you can't answer all questions. One of the **max Team** will contact you and help you with the rest.
- Any questions? Please contact the **max Team** on **1300 883 629**.
- When you've completed the application, please sign where indicated and mail to:

max Super

Reply Paid 4678

Melbourne VIC 8060 (No postage stamp required if posted within Australia)



- **Important Notice:** This application form relates to the current Product Disclosure Statement (PDS) for the max Super Fund (SPIN ETL0055AU), available from www.maxsuper.com.au, issued by Equity Trustees Limited (ABN 46 004 031 298, AFSL 240975, RSE L0003094) and should only be completed after you have read and understood the PDS as it relates to the insurance cover you are applying for. You should also read the Duty of Disclosure and Declarations in the PDS and at the end of this form. **max Super's** insurer is American International Assurance Company (Australia) Limited (ABN 79 004 837 861, AFSL 230043) trading as AIG Life.

Step 1 - Your Details

Let's get started.

max Super Membership Number (If known)

Mr/Mrs/Ms/Miss First Name

Middle Name(s)

Last Name

Gender

 M F

Date of Birth

 D, D / M, M / Y, Y, Y, Y

Occupation

Industry

Daily Duties

Step 2 - Insurance Application

So max can help you cover up.

max Super offers either **Death Only** OR **Death and Total & Permanent Disablement (TPD)** insurance, as well as **Income Protection** insurance to its Members. Your application for insurance cover will be assessed by max's insurer, AIG Life, and you will need to satisfy its underwriting criteria to obtain cover. Please refer to the **max Super** PDS for more information regarding your Insurance options. You don't have to take out insurance if you don't want insurance.

Death and Total & Permanent Disablement (TPD)

I would like **Death Only** cover Amount \$ (In multiples of \$50,000)

OR

I would like **Death and TPD** cover Amount \$ (In multiples of \$50,000)

Income Protection

I would like **Income Protection** cover Amount \$ (Up to 75% of your monthly income)

Step 2 (Continued)

So **max** can help you cover up.

Basic Personal Statements at the date of this application:

- | | Agree | Disagree |
|--|--------------------------|--------------------------|
| 1. I'm actively working and able to perform my usual duties. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I've never had back/neck pain for 7 or more consecutive days, and never had mental/nervous/stress disorders, cancer, blindness or deafness. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I've never had any company refuse or apply special or modified conditions or cancel any proposal to insure me for a life or disablement policy. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I'm not, as far as I'm aware, suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the HIV virus and I am not carrying antibodies to the HIV virus. | <input type="checkbox"/> | <input type="checkbox"/> |

Have you smoked any tobacco or any other substance in the last 12 months? Yes No

If YES, please state forms and quantities

General Insurance Declaration

...and nothing but the truth.

- **Truth and Accuracy** – I hereby declare that to the best of my knowledge and belief all of the answers to questions and personal statements on this Insurance Application 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 this 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 American International Assurance Company (Australia) Limited or **max Super** about acceptance of my application.
- **Duty of Disclosure** – I acknowledge that I have read and understand the Duty of Disclosure notice in accordance with the Insurance Contracts Act 1984 as detailed in the PDS. **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 understand the Privacy Statement as detailed in the PDS. I consent to my personal information being collected and used in accordance with the Privacy Statement.

Signature of person to be insured

Date

/ /

Only Complete Step 3 if:

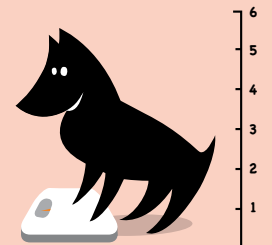
- You want **Death Only, OR Death & TPD** cover **greater than \$350,000**.
- You want **Income Protection** cover.
- You ticked **Disagree** to any of the four **Basic Personal Statements** above.

Step 3 - Personal Health Statement

How you doin'?

- i) Please state your height cm
- ii) Please state your weight kg
- iii) Do you permanently reside in Australia or New Zealand? Yes No
- iv) Do you intend to work, live or travel overseas? Yes No

If YES, please state the destination, duration, frequency and purpose



SECTION A - Medical Details

1. Have you ever had or received treatment for, or had symptoms of:
- | | Yes | No |
|---|--------------------------|--------------------------|
| (a) High blood pressure or blood disorder e.g. leukaemia, anaemia or haemophilia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Heart, vein or circulatory disorder, including chest pain, heart attack, heart murmur, raised cholesterol or rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
(c) Mental or nervous disorder (e.g. stress, depression, insomnia), fainting, epilepsy, paralysis, multiple sclerosis, migraines, brain disorder or any neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Back or neck pain, whiplash, sciatica or any muscle or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Asthma, bronchitis or other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Stomach, intestinal or rectal disorder, ulcer, bleeding from bowel, gall bladder or liver disorder, including hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Diabetes, thyroid or prostate disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?	<input type="checkbox"/>	<input type="checkbox"/>
(j) Impairment/disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?	<input type="checkbox"/>	<input type="checkbox"/>
(k) Dermatitis, psoriasis or any skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(l) Kidney, bladder, blood in urine or reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(m) Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>
(n) Drug or alcohol dependence?	<input type="checkbox"/>	<input type="checkbox"/>
(o) Any other medical condition not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
(p) Females only	<input type="checkbox"/>	<input type="checkbox"/>
i) Female organ disorder? (including abnormal pap smear, breast ultrasound or mammogram)	<input type="checkbox"/>	<input type="checkbox"/>
ii) Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of expected delivery	<input type="text"/>	<input type="text"/>

D D / M M / Y Y Y Y

SECTION B - Medical Background

	Yes	No
1. Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?	<input type="checkbox"/>	<input type="checkbox"/>
2. During the last five (5) years have you:		
(a) Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Been in hospital, clinic or nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Been advised to have an operation?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Had any tests, including blood tests, ECG, x-rays, or genetic tests?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquilisers?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to ANY of the questions in Sections A or B, please complete all Sections below. Otherwise, complete Sections D, E, F (Income Protection only) and G.

SECTION C - Answers in Detail

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

Question Reference (Section A or B)	Test, or nature of condition or complaint	Commencement Date	Duration	Time off work	Degree of Recovery (%)	Full details of treatment and results (include type of operations)	Full name and address of doctor or hospital (if any)

SECTION D - Other Details

1. Do you drink alcohol? Yes No
 If YES, what type of alcohol How much (daily intake)?

2. Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)? Yes No
 If YES, please provide the policy details in the schedule below.

Commencement Date	Insurer	Type of Cover	Amount of Cover	*To be Replaced 'Y' or 'N'

* For policies to be replaced, please attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

SECTION E - Family History

1. Have any of your parents, brothers or sisters (living or deceased) had Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder? Yes No
 If YES, please provide details in the schedule below.

Relation	Condition/Illness	Age at Onset (Approximately)	Age at Death (If Applicable)

2. Have any of your parents, brothers or sisters (living or deceased) been diagnosed prior to age 65 with any of the following conditions: Diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? Yes No
 If YES, please provide details in the schedule below.

Relation	Condition/Illness For Cancer - Specify Type	Age at Onset (Approximately)	Age at Death (If Applicable)

SECTION F - Further Income Details (if applying for Income Protection)

1. (a) Please state your monthly income from your current occupation (net of business expenses but before tax). DO NOT INCLUDE INVESTMENTS AND SUPERANNUATION - Please refer to the Income Protection section of the **max Super** PDS for further information.

Principal Occupation: Current Year \$ per month Previous Year \$ per month

(b) How long have you been at your current occupation? Years Months

(c) How much of the above income will continue if you are disabled? \$

i) For how long? ii) State source of income (e.g. sick leave)

2. If you become disabled, would you receive income from other sources? Yes No

If YES: (a) How much? \$ per month (b) For how long?

(c) State source of income

3. Do you also perform another occupation? Yes No

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



4. Are you self-employed or employed by your own company? Yes No

If YES, date your business started DD / MM / YYYY

If YES:

(a) How long have you been self-employed? (b) What was your previous occupation?

(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? Yes No

(e) How many people do you employ?

5. Do you work at home? Yes No If YES, state percentage of the time %

SECTION G - Doctor's Details (please provide current details)

Name Date of last consultation DD / MM / YYYY How long have you been a patient?

Address State Postcode

Contact Phone Number Email Address or Fax Number

Declaration and Consent

Here comes max, the autograph hound.

- **Duty of Disclosure** – I acknowledge that I have read and understand the Duty of Disclosure notice in accordance with the Insurance Contracts Act 1984 as detailed in the PDS. 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 understand the Privacy Statement in the PDS. I consent to my personal information being collected and used in accordance with the Privacy Statement.
- **Consent to Disclose** – I consent to American International Assurance Company (Australia) Limited (AIA) and to **max Super** on behalf of AIA, 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. I agree to be bound by the provisions of the policy document between American International Assurance Company (Australia) Limited and the Trustee, which govern the terms of life insurance and conditions set out in this document.

Signature of person to be insured Date DD / MM / YYYY

Medical Authority

An apple a day keeps the Doc away.

Full name of person to be insured

I,

1. Doctor(s)/ Hospital/Clinic 2. Doctor(s)/ Hospital/Clinic

authorise and

to disclose to American International Assurance Company (Australia) Limited full details of my health and medical history. A photocopy of this authorisation is as valid as the original.

Signature of person to be insured Date DD / MM / YYYY



Would you like an underwriter to contact you to clarify any information? Yes No

When you've completed the application, sign where indicated and send to: **max Super**
Reply Paid 4678
Melbourne VIC 8060