

Insurance Application Form & Personal Health Statement

Use this form if you want Death only or Death and TPD cover greater than \$350,000 (Steps 1-3); if you want Income Protection Cover (Steps 1-3) or if you want an existing **max Super** member and want to add Insurance Cover (see note before completing Step 3).

Please use a **dark pen** and CAPITAL letters (except for your email address), print it and send it to us. Use (X) to mark boxes. Forms are located on our website at maxsuper.com.au/member/forms-docs. If you have any questions, call us on 1300 629 787.

Step 1: Your details

Member number	Date of birth	M	F
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	Last name		
<input type="text"/>	<input type="text"/>		
Given name(s)			
<input type="text"/>			
Occupation	Industry		
<input type="text"/>	<input type="text"/>		
Daily duties			
<input type="text"/>			

Step 2: Insurance application

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)

<input type="checkbox"/> I would like Death Only cover	Amount \$ <input type="text"/>
	(in multiples of \$50,000)
OR	
<input type="checkbox"/> I would like Death and TPD cover	Amount \$ <input type="text"/>
	(in multiples of \$50,000)

Income Protection

<input type="checkbox"/> I would like Income Protection cover	Amount \$ <input type="text"/>
	(Up to 75% of your monthly income)

Only Complete Step 3 if:

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

Step 3: Personal health statement

- 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

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

SECTION A - Medical Details

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever had or received treatment for, or had symptoms of: | | |
| (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"/> |
| (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"/> |

SECTION A - Medical Details cont'd

	Yes	No
(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		
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:

□	□	□	□	□	□	□	□	□	□
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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:	<input type="checkbox"/>	<input type="checkbox"/>
(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'
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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? \$ per month

(b) 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 - -

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)

Date of last consultation

How long have you been a patient?

Title

Last name

Given name(s)

Residential address

Suburb

State

Postcode

Contact phone number

Email address or fax number

Declaration and consent

- **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 AIA 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

Full name of person to be insured

I,

1. Doctor(s)/ Hospital/Clinic

authorise

and

2. Doctor(s)/ Hospital/Clinic

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)

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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
P.O. Box 3528
Tingalpa DC QLD 4173