How many weeks do you work per year? | | |

What are the principle duties of your occupation and where do you perform these duties?

Duties (eg office, manual, site supervision, selling, etc)	Percentage of time (%)

Location (eg office, on site, at home, driving, etc)	Percentage of time (%)

Do you intend to change your occupation or duties, employment status or take extended leave within the next 12 months? ..... Yes ☐ No ☐

If 'yes', details of change

Date of change d d / m m / y y y y

PART A – Short personal health statement

Please provide the following details:

Height _____ cm or _____ feet/inches

Weight _____kg or _____ stone/pounds

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

Important information

If you answer "Yes" to any of the questions in the short personal health statement below, please DO NOT continue completing this section. Instead, please complete Part B.

1. Do you engage in any hazardous activities, pursuits or occupational duties, such as but not limited to motorised sports, scuba diving below 40 metres or aviation (other than as a fare paying passenger on a licensed public service (eg Qantas))? ..... ☐ Yes ☐ No
2. Do you have any definite plans to travel or reside overseas in the future? (Holidays less than 4 weeks don't need to be disclosed) ..... ☐ Yes ☐ No
3. Have you ever suffered symptoms of, or had, or been told you have, or received or are contemplating any advice or treatment for:
   - i) Muscular skeletal disorders (eg back, joint), arthritis, loss of limb or paralysis ..... ☐ Yes ☐ No
   - ii) Impairment of sight or hearing (not including long or short sightedness) ..... ☐ Yes ☐ No
   - iii) Mental or nervous disorder including stress, anxiety, depression or neurological condition ..... ☐ Yes ☐ No
   - iv) Cancer or tumour of any type ..... ☐ Yes ☐ No
   - v) Diabetes or liver disease including hepatitis ..... ☐ Yes ☐ No
   - vi) High blood pressure, high cholesterol, chest pain, heart complaint or stroke ..... ☐ Yes ☐ No
   - vii) Disorders and or disease of the kidney, bladder, bowel or stomach? ..... ☐ Yes ☐ No
4. Have you ever:
   - i) Suffered from AIDS or been infected with the HIV virus, or ..... ☐ Yes ☐ No
   - ii) Used intravenous drugs or had sexual activity with someone you know or suspect to be HIV positive, or ..... ☐ Yes ☐ No
   - iii) Engaged in male to male anal sexual activity? ..... ☐ Yes ☐ No
5. To the best of your knowledge, have two or more members of your immediate family, i.e. parents, brothers or sisters (living or deceased) suffered from any hereditary disease before age 60? ..... ☐ Yes ☐ No
6. Does your alcohol consumption exceed more than 20 standard drinks per week? ..... ☐ Yes ☐ No

If you answered "No" to all of the above questions, please go straight to Section 14 'Signature of insured person'.

PART B – Full personal health statement

4. Insurance history (must be completed)

Office use only 6

If you have existing insurance providing benefits similar to that being applied for, we'll take this existing insurance cover into account when considering whether or not to accept this application.

1. Do you have with us or any other company, or are you currently applying for, any type of life, superannuation, sickness, accident, trauma, lump sum disablement or disability insurance? ..... Yes ☐ No ☐
   If 'yes', please provide:

Name of company	Type of insurance	Insured benefit	Date commenced	Is policy to be discontinued/ replaced?
		$	/ /	Yes* ☐ No ☐
		$	/ /	Yes* ☐ No ☐

***If you've indicated that it's your intention to replace insurance you currently have with the cover you're now applying for, the replacement cover under any policy we issue will only start when the insurance which is to be replaced is cancelled.**

2. Has any application for insurance ever been refused, postponed, accepted with an increased premium or on modified terms? ..... Yes ☐ No ☐
   If 'yes', please provide details:

3. Are you claiming or have you ever claimed benefits from any source eg, an insurance policy, workers compensation, social security (including unemployment benefits), veterans affairs, sickness benefits, invalid pension, third party, etc? ..... Yes ☐ No ☐
   If 'yes', please provide:

Date	Source	Reason	Has the claim been settled/ benefits ceased?	Date ceased
/ /			Yes ☐ No ☐	/ /
/ /			Yes ☐ No ☐	/ /

5. Residence and travel (must be completed)

Office use only 7

1. Were you born in Australia? ..... Yes ☐ No ☐
   If 'yes', please go straight to question 3
2. Are you an Australian citizen or do you hold an Australian Permanent resident visa? ..... Yes ☐ No ☐

   How long have you lived in Australia? ☐ Country of birth ☐ Visa type ☐

3. Do you travel overseas in your job? ..... Yes ☐ No ☐

   Countries ☐ Purpose ☐

   Duration ☐ Frequency ☐

4. Do you have definite plans to live or travel overseas in the future? ..... Yes ☐ No ☐

   If 'yes', please advise Date leaving d d / m m / y y y y Date returning d d / m m / y y y y

   Countries to be visited ☐ Reason for trip ☐

6. Medical history (must be completed, except when a medical examination is required)

Office use only 8

1. What is your height and weight?

   Height _____ cm or _____ feet/inches

   Weight _____ kg or _____ stone/pounds

2. Are you left handed or right handed? Left ☐ Right ☐
3. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
   a. Heart attack, angina, chest pain, stroke, hypertension (high blood pressure) or high cholesterol readings? ..... Yes ☐ No ☐
   b. Asthma, bronchitis, emphysema? ..... Yes ☐ No ☐
   c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder? ..... Yes ☐ No ☐
   d. Epilepsy, fainting attacks or fits of any kind? ..... Yes ☐ No ☐
   e. Recurrent indigestion, ulcer, Hepatitis (A, B, C or D)? ..... Yes ☐ No ☐
   f. Cancer, tumour, sunspot, skin cancer, lump or growth of any kind or breast lumps (even if you have not seen a doctor)? ..... Yes ☐ No ☐
   g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses) ..... Yes ☐ No ☐
   h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs? ..... Yes ☐ No ☐
   i. Arthritis, gout, fibromyalgia, osteoporosis, tendonitis, tenosynovitis, overuse syndrome or any regional pain syndrome or chronic fatigue? ..... Yes ☐ No ☐
   j. Diabetes or abnormal blood sugar? ..... Yes ☐ No ☐
   k. Psoriasis, eczema or any other disorder of the skin, or any allergic or chemical sensitivity reaction? ..... Yes ☐ No ☐

If you answered 'yes' to any of the conditions above, please also complete a Special health questionnaire (on pages 9 to 12) for each condition.

4. Other than those conditions stated in question 3, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:

   a. Heart murmur or any other heart or blood vessel disorder? ..... Yes ☐ No ☐

   b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? ..... Yes ☐ No ☐

   c. Tuberculosis or any other lung or respiratory system disorder? ..... Yes ☐ No ☐

   d. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? ..... Yes ☐ No ☐

   e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancrea? .... Yes ☐ No ☐

   f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? ..... Yes ☐ No ☐

   g. Sleep apnoea or any sleeping disorder? ..... Yes ☐ No ☐

   h. Thyroid disorder or any other glandular disorder? ..... Yes ☐ No ☐

   i. Any sickness, injury or physical impairment not previously mentioned? ..... Yes ☐ No ☐

5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)? ..... Yes ☐ No ☐

6. Have you ever had or are you considering having a genetic test? ..... Yes ☐ No ☐

7. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation? ..... Yes ☐ No ☐

8. Other than already stated, during the last 3 years have you been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist or any other health care professional, been in hospital, had any operation or had any tests or investigations (eg, x-ray, ECG etc)? ..... Yes ☐ No ☐

9. Has your mother or father, or any brother or sister had breast, ovarian, colon or other cancer, diabetes, high blood pressure, heart problems, stroke, mental disorder, haemochromatosis, Huntington's disease, muscular dystrophy, familial adenomatous polyposis, polycystic kidney, osteoporosis, Creutzfeldt-Jakob disease or any other hereditary disease? ..... Yes ☐ No ☐

   If 'yes', please provide details in the following table.

Family member (relationship to you)	Condition/sickness (for cancer/heart disease, specify type)	Age at onset (approx)	Age at death (if applicable)

10. Females only

   a. (i) Have you ever had an abnormal pap smear or breast ultrasound or mammogram? ..... Yes ☐ No ☐

   If 'yes', please provide details of test(s), result(s) and date(s).

   (ii) Have you had any follow up tests beyond the initial test mentioned in a(i)? Yes ☐ No ☐

   If 'yes', please provide details of test(s), result(s) and date(s).

   b. Are you currently pregnant? ..... Yes ☐ No ☐

   (i) If 'yes', due date d d / m m / y y y y

   (i) Have there been or are there expected to be any complications? ..... Yes ☐ No ☐

   If 'yes', please provide details.

If you answered 'yes' to 4, 5, 6, 7 or 8 please provide details.

Question no. ☐ Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. ☐ Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced d d / m m / y y y y Time off work Degree of recovery (%)

Date of last symptoms d d / m m / y y y y Treatment received

Full name and address of doctor or hospital

State Postcode

7. Habits (must be completed, except when a medical examination is required

Office use only 10

1. Have you ever smoked tobacco or any other substance, or, in the last 12 months, used any nicotine replacement therapy product? ....Yes No

   If 'yes', type (eg, cigarettes, gum, patches)? .... Daily quantity?

   How many years? Date ceased? if applicable d d / m m / y y y y

   Other

2. Do you drink alcohol? ....Yes No

   If 'yes', please advise number of standard drinks per week? Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? ....Yes No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol? ....Yes No

   If you answered 'yes' to question 3 or 4, please provide details in the following table

Question no.	Date from	Date to	Type of usage (alcohol, heroin etc)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		

8. Doctor's details (must be completed)

Office use only 11

If you don't have a usual doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your usual doctor

Address Postcode

Work phone ( ) Fax ( )

2. How long have you been a patient of this doctor? Date of last consultation d d / m m / y y y y

Reason and outcome of last consultation

3. If you've been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address Postcode

Please provide date, reason and outcome of last consultation(s).

9. HIV (must be completed)

Office use only 12

	Yes	No
1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV?	☐	☐
2. In the last 3 years have you or do you intend to:	**Yes**	**No**
a. Work as or engage in sexual intercourse with a prostitute?	☐	☐
b. Engage in male to male anal sexual activity?	☐	☐
c. Have sexual intercourse with an intravenous drug user?	☐	☐
d. Have sexual intercourse with someone you suspect or know to be HIV positive?	☐	☐

If you have answered 'yes' to any of the above, our underwriters will contact you for further information.

10. Activities (must be completed)

Office use only 13

1. In the last 12 months have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity eg, football, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (eg, Qantas)? Yes ☐ No ☐

If 'yes', please answer the activities questionnaire on page 8.

2. Type of activity?

3. Do you want to be considered for cover whilst taking part in this activity? ☐ Yes, please complete Section 11 ☐ No

11. Activities questionnaire (must be completed if you indicated 'yes' in Section 10 question 3)

Office use only 14

Underwater diving

a. Type (scuba, hookah etc)

b. What are your qualifications for this activity?

c. How long have you been doing this?

d. How often do you do this?

e. Are you professional or amateur?

f. Maximum depth of dives Metres

g. Average depth of dives Metres

h. Geographical location

i. Do you dive in wrecks, potholes or caves? Yes ☐ No ☐

j. Have you ever had a diving accident or diving sickness? (eg, blackout, needed decompression etc) Yes ☐ No ☐

k. Do you intend to change the scope of your license/participation? Yes ☐ No ☐

If 'yes' to i – k, please provide details.

Motor sports

a. Type (car, bike etc)

b. Events (speedway, off road etc)

c. How long have you been doing this?

d. How often do you do this?

e. Are you professional or amateur?

f.

Category (eg, touring cars)	Class (eg, AA/D)	Vehicle & type of fuel	Engine capacity	No. of vehicles in event	Max speed km/hour

k. Do you intend to change the scope of your license/participation? Yes ☐ No ☐

If 'yes', please provide details.

Flying – power-driven aircraft or conventional glider

a. What type of flying do you do (private, agricultural, ultralight etc)?

b. Total number of hours flown as a pilot? Hrs Number of hours in the past 12 months? Fixed Wing Hrs Helicopter Hrs

c. Number of hours expected in the next year? Fixed Wing Hrs Helicopter Hrs

d. Geographical location

e. What class license do you hold?

f. Do you intend to change the scope of your license? Yes ☐ No ☐

If 'yes', please provide details.

Abseiling, caving, mountaineering, rock climbing

a. Activity

b. How long have you been doing this?

c. How often do you do this?

d. Geographical location

e. Maximum altitude/depth

f. Equipment used

g. Maximum grade of climb

h. Type (top roping etc)

Other activity

a. Describe activity

b. What are your qualifications for this?

c. How long have you been doing this?

d. How often do you do this?

e. Geographical location

f. Are you professional or amateur?

12. Special health questionnaires

Skin Lesion/Skin Cancer/Sun Spot

1. How many skin lesions, skin cancers or sun spots have you had treated? .....

2. Please provide details of each of the above in the table below. If more than 3, provide details on a separate page.

	Lesion 1	Lesion 2	Lesion 3
a) Where on the body was it located: eg, arm, nose, scalp.			
b) Was the lesion benign or malignant?			
c) What was the diagnosis? ie the name advised by your doctor eg, melanoma, BCC, keratosis etc.			
d) What was the date of diagnosis, biopsy, or treatment?			
e) How was it treated?* See examples of treatment types below.			

***Examples of treatment types:** Excised (surgically removed), curettage (removal with a scraping instrument), cryotherapy (freezing off), diathermy (burning off), topical cream eg, Efudix/Aldara or photodynamic therapy.

3. Have you been advised to have regular skin checks? ..... Yes ☐ No ☐
   If 'yes', please advise by whom and the frequency.

4. What was the date and result of your last skin check and the name and address of the doctor or clinic consulted?
   Name & address

   Date d d / m m / y y y y

5. Has any further follow-up or treatment been recommended? ..... Yes ☐ No ☐
   If 'yes', please provide details.

6. Do you have or can you obtain a copy of any pathology reports which relate to the skin lesion(s)/cancer(s) or sun spot(s) treated? ..... Yes ☐ No ☐
   If 'yes', please attach a copy to this application.

7. Does your regular doctor, skin specialist or skin clinic have details regarding the lesion(s)/cancer(s) or sun spot(s)? ..... Yes ☐ No ☐
   If 'yes', please indicate which one and provide the name and address if it's not your usual doctor.
   If 'no', please provide the name and address of the doctor who has full details.
   Name & address

8. Do you have any skin lesions for which you are considering consulting a doctor or seeking medical advice or treatment? ..... Yes ☐ No ☐
   If 'yes', please provide details.

Hypertension (High Blood Pressure)

1. When were you first diagnosed with hypertension? d d / m m / y y y y

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition? ..... Yes ☐ No ☐

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two readings/tests, including dates and any change to your treatment

Date	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
/ /		
/ /		

5. Have you had an electrocardiogram (ECG), Blood Pressure monitor or any other heart test? ..... Yes ☐ No ☐

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Do you have any complications as a result of hypertension? ..... Yes ☐ No ☐

If 'yes', please provide details

7. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐

If 'no', please provide the name and address of the doctor who has full details

High Cholesterol

1. When were you first diagnosed with high cholesterol/triglycerides? d d / m m / y y y y

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition? ..... Yes ☐ No ☐

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two cholesterol test results, including dates and any change to your treatment

Date	Result (If unsure, answer 'unsure')	If treatment was changed, give details
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	

5. Have you had an electrocardiogram (ECG), blood pressure monitor or any other heart test? ..... Yes ☐ No ☐

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐

If 'no', please provide the name and address of the doctor who has full details

Asthma

1. Date asthma first diagnosed d d / m m / y y y y

2. How often do you experience symptoms? eg, wheezing, breathlessness, chest tightness.

3. When did you last experience symptoms?
d d / m m / y y y y

4. Are you woken during the night with symptoms? ..... Yes ☐ No ☐
If 'yes', how often and date of last occurrence.

5. Have you ever been off work due to your asthma? ..... Yes ☐ No ☐
If 'yes', please advise when and for how long.

6. What is your current treatment? Include type of medication and dosage.

7. Have you ever required use of oral steroids? ..... Yes ☐ No ☐
If 'yes', please advise when and for how long.

8. Have you ever been in hospital or received emergency treatment for asthma? ..... Yes ☐ No ☐
If 'yes', please advise when, for how long and where.

9. Do you ever measure your peak flow? ..... Yes ☐ No ☐
If 'yes', please advise your highest and lowest readings in the past 6 months.

10. Have you ever consulted a specialist for this condition? ..... Yes ☐ No ☐
If 'yes', please advise name and address of doctor and date of last consultation.

11. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐
If 'no', please provide name and address of doctor who has full details.

12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Anxiety/Depression/Nervous disorder

1. Nature of condition and underlying cause.

2. Describe your symptoms.

3. Date symptoms commenced. d d / m m / y y y y
i) Are you still experiencing symptoms? ..... Yes ☐ No ☐
ii) If 'no', when did you last experience symptoms?
d d / m m / y y y y

4. Have you had any recurrence of this condition? ..... Yes ☐ No ☐
If 'yes', please advise when and how many times.

5. Have you taken regular or occasional medication for this condition? ..... Yes ☐ No ☐
If 'yes', please advise type, dosage and frequency.

6. Are you still taking this medication? ..... Yes ☐ No ☐
If 'no', please advise date ceased d d / m m / y y y y

7. Have you had any other treatment (eg, counselling, hospitalisation, ECT)? ..... Yes ☐ No ☐
If 'yes', please advise type, dates, hospital and name and address of treating doctor.

8. Have you ever been off work or had your normal daily activities restricted in any way due to this condition? ..... Yes ☐ No ☐
If 'yes', please advise when and for how long.

9. Have you any ongoing effects or restriction in your activities of any kind? ..... Yes ☐ No ☐
If 'yes', please provide details.

10. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? ..... Yes ☐ No ☐
If 'yes', please advise dates and name and address of all persons consulted.

11. Please provide details of your most recent visit for this condition. Include date, name and address of the doctor or health professional consulted.

12. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐
If 'no', please provide name and address of doctor who has full details.

Back/Neck

1. Area of spine affected? Neck, upper or lower back?

2. Date of first symptoms d d / m m / y y y y

3. What was the cause?

4. Have you had any diagnostic investigations eg, CT Scans, x-rays etc? ..... Yes ☐ No ☐
   If 'yes', please provide details of test(s), result(s) and date(s).

5. Are you still experiencing symptoms? ..... Yes ☐ No ☐
   If 'no', please provide date of last experienced symptoms? d d / m m / y y y y

6. How often do/did you have symptoms?

7. Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ..... Yes ☐ No ☐

8. Have you ever been off work due to your spinal symptoms or unable to perform your normal day to day activities? ..... Yes ☐ No ☐
   If 'yes', when and for how long?

9. What is the nature of the treatment (eg, spinal manipulation, deep tissue massage etc)?

   i) Are you still receiving treatment? ..... Yes ☐ No ☐

   ii) If 'no', when did you cease treatment?
   d d / m m / y y y y

10. Have you ever consulted a specialist for this condition? ..... Yes ☐ No ☐
    If 'yes', provide name and address of specialist and date of last consultation.

11. Please provide details of your most recent visit to any other doctor or therapist for this condition. Include date, name and address of doctor or therapist consulted.

12. Have you had any ongoing effects of any kind?
    Eg, pain, discomfort or limitations of movement etc? ..... Yes ☐ No ☐
    If 'yes', please provide details.

13. Is it necessary to avoid lifting or to restrict your daily activities in any way? ..... Yes ☐ No ☐
    If 'yes', please provide details.

14. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

Any other condition

1. Name of condition (exact diagnosis)

2. The cause

3 a. Describe symptoms

   b. Date symptoms commenced d d / m m / y y y y

   Date symptoms ceased d d / m m / y y y y

   c. How often do/did you have symptoms?

4. Have you ever been off work or had your normal daily activities restricted in any way because of this condition? ..... Yes ☐ No ☐

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		

5. Have you any residual, on-going effects or restriction in your daily activities? ..... Yes ☐ No ☐
   If 'yes', please provide details.

6. Have you taken regular or occasional medication for this condition? ..... Yes ☐ No ☐
   If 'yes', please advise names of medication(s), dosage(s) and frequency.

   Are you still taking this medication? ..... Yes ☐ No ☐

7. Have you had any other treatment for this condition (eg, physiotherapy, operation, alternative remedies)? ..... Yes ☐ No ☐

8. Have you had any diagnostic investigations (eg, scope, scan, x-rays, EEG, ECG etc)? ..... Yes ☐ No ☐

9. Have you ever been in hospital or received emergency treatment for anything related to this condition? ..... Yes ☐ No ☐

10. If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.

11. Details of your most recent visit to a doctor or other therapist for anything related to this condition.

Date	Reason for consultation, investigations, findings, advice
/ /	

Doctor/Therapist name and specialty

12. Has further treatment been recommended for this condition? . Yes ☐ No ☐
    If 'yes', please provide details.

13. Does your regular doctor have details of this condition? ..... Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

13. Consent and medical history authorisation (must be completed)

I acknowledge that:

- I've read this application form and confirm that the answers given are my true and complete answers, even if the answers either in this form or any attachment, are not in my handwriting, I declare that they have been correctly written down at my dictation.
- I've read my Duty of Disclosure and have not withheld any information material to the Insurer and understand that this duty continues to apply and that the insurance applied for will not become effective until Suncorp Portfolio Services Limited (SPSL) advises the risk has been accepted.
- I've read and understood the Medical History Authorisation which enables Suncorp Portfolio Services Limited (SPSL), at its discretion, to obtain full details of my medical records and I understand that SPSL may obtain a report from my usual doctor or any doctor whom I have consulted.
- Any statements I've made on or with an application to another insurer and which I have presented to SPSL are intended by me as declarations and representations to SPSL and I acknowledge that SPSL will use them in assessing this application for insurance.
- I've read and agree to be bound by the Suncorp privacy policy which is available on our website at suncorp.com.au
- I may request access to my personal information by contacting you, although I may in some circumstances not be granted access to it. Also, I acknowledge that if the personal information requested from me isn't provided to you, then you may not be able to provide services covered in the Privacy Statement.
- I acknowledge Income Protection has a specific exclusion for disability caused directly or indirectly by war.

I consent to:

- the use of personal information about me by SPSL (if applicable) for the purposes of providing insurance through my membership of WealthSmart, including to assess and decide whether to agree to an application and on what terms (if any) or any amendment or increase of any insurance provided; to provide and manage the insurance cover relating to an application that has been accepted; to investigate and, if covered, manage and pay any claims made in relation to any insurance I have with you or other members of the Suncorp Group and
- the disclosure of personal information about me by SPSL (if applicable) to, and obtaining personal information from, other parties for any of these purposes. These other parties include the policy owners' Adviser, other members of the Suncorp Group, loss assessors and claim investigators, other insurance companies and reinsurers, mailing houses, claims reference providers, research and telephone service providers, hospitals, medical and other health professionals, government departments, other trustees, legal and other professional advisers and other service providers.
- to be contacted by phone by a Suncorp representative if there is a need to get more information from me.

If I've disclosed personal information about any other person, I confirm that I'm authorised to disclose personal information about that person and to consent to its use and disclosure to other parties (and obtaining other personal information about that person from other parties) for the purposes above.

Medical History Authorisation

To Doctor

- I authorise any doctor, hospital, clinic and other medical or related facility, or any other person who has attended me, to provide SPSL with any information with respect to any sickness, injury, consultation, tests (including genetic test(s)), prescriptions or treatment and copies of all hospital records.
- I authorise the Health Insurance Commission to release to SPSL, at their request, a copy of my medical history records.
- I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

14. Signature of insured person

Signature of the Person to be Insured ✗

Date d d / m m / y y y y

Print full name

Please send the completed form and any required attachements to:

Suncorp WealthSmart®
GPO Box 2585
Brisbane QLD 4001