Suncorp Employee Superannuation Plan
Insurance application form

Issue date: 1 April 2022

Use this form to apply for insurance cover or increase your existing cover if you're a member of the Suncorp Employee Superannuation Plan

Please note:

— If you're a member with existing insurance cover and have ceased employment with the Suncorp Group, you can apply for an increase to your current Life cover only or Life & Total and Permanent Disability (TPD) cover only – please choose 'Additional Cover' and specify the amount you would like to increase your existing insurance cover by.

— If you are a former Promina Corporate Superannuation Fund member, or your employer has arranged insurance cover with an external insurer, you have to apply for insurance cover or increase your existing cover using a different insurance application form. The insurance tab in your online account will include a link to the relevant insurance application form that applies to you.

Tips to help you complete this form

— Complete online or use a blue or black pen and write in CAPITAL letters

— Use an '✕' to mark answer boxes

— Complete all sections of the form and sign and date on the last page

Have any questions?

If you'd like help completing this form, or if you have any questions, please call us on 1800 652 489 between 9am and 5pm (AEST) Monday to Friday.

The duty to take reasonable care

When you apply for insurance, you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

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. Under the *Insurance Contracts Act 1984 (Cth)* there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it would have been in if the duty had been met. For example, the Insurer may:

— avoid the cover (treat it as if it never existed);

— vary the amount of the cover; or

— vary the terms of the cover.

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 the questions in this form

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.

Please note that 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 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 that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know if you're having difficulty due to a disability, understanding English or for any other reason - we're here to help and can provide additional support.

1. Personal Details

Suncorp Employee Superannuation Plan account number

Title*

☐ Single ☐ Married ☐ De-facto

Gender* ☐ Male ☐ Female

Last name*

Given name(s)*

Date of birth* D D / M M / Y Y Y Y

Daytime phone number

Mobile phone number*

Email address*

* mandatory field

2. Insurance cover

Life and TPD

You may select a different level of Life and TPD cover to suit your needs, as per below. You can select Income Protection cover further below.

Please tick the appropriate box:

Insurance type	Description
☐ Default Cover	7.5% of your salary multiplied by future years and complete months of service to age 70.
☐ Additional Cover	$ _____ Nominate the additional amount of insurance cover you require.

The maximum benefit limit (MBL) that applies for additional cover is $1 million for Life cover and $1 million for TPD cover, including the amount under your Default Cover (if applicable). Please confirm which type of additional cover you are applying for:

☐ Life cover ☐ TPD cover ☐ Life & TPD cover

- When applying for Life and TPD, the TPD cover amount can't exceed the Life cover amount.
- If you are employed by the Suncorp Group and you are applying for Default Cover only within 130 days of joining the Suncorp Group, please proceed to section 13.
- If you are employed by the Suncorp Group and you are applying for Default Cover 130 days after joining the Suncorp Group, you will need to complete sections 3 to 12 before proceeding to section 13.
- If you are applying for Additional Cover, you will need to complete sections 3 to 13.
- If you have an existing level of insurance cover above the new MBL, you will continue to enjoy that level of insurance cover in your new SESP account. However, you will not be able to increase your cover level further. If you have an existing level of insurance cover below the MBL, you will continue to enjoy that level of insurance cover in your new SESP account. However, any future increases to your existing cover will be capped at the new MBL.

Income Protection

☐ Income Protection cover (IP)
Waiting period: 60 days
Benefit period: 2 years

Amount of cover $ _____ pa
(This cannot be greater than 75% of your base salary)

3. Occupation details

Date joined company D D / M M / Y Y Y Y

Occupation _____

Hours worked per week _____ Basis of employment ☐ Permanent ☐ Casual ☐ Contract

Employees

What is your current annual base salary (excluding superannuation)? $ _____

Your salary is pre-tax income which includes any packaged elements not received directly by you as taxable earnings, but excludes any directors fees, bonuses (except for Financial Planners), overtime, commission, investment income, compulsory superannuation contributions and profit distribution.

4. Insurance history

If you have existing insurance providing benefits similar to that being applied for, we will 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 insurance fee 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	/ /

How to complete the rest of this application

You can complete 'Part A – Short personal health statement' if the following applies to you.	**You must complete 'Part B – Full personal health statement' if the followingapplies to you.**
You're under age 55 and applying for sums insured up to the Automatic Acceptance Limit (AAL), including any existing cover, for Life cover only or Life & TPD cover. You can't complete 'Part A – Short personal health statement' if you're applying for IP. Please complete 'Part B – Full personal health statement'. **Please note if you answer "Yes" to any of the questions in 'Part A – Short personal health statement', you'll also need to complete 'Part B – Full personal health statement'.**	You're age 55 and over or — would like sums insured over the AAL (including any existing cover), for Life cover only or Life & TPD cover and/or; — you're applying for Income Protection (IP) cover.

PART A – Short personal health statement

Only complete Part A where you are under age 55 and applying for sums insured up to the AAL (including any existing cover) for Life cover only or Life & TPD cover. If this does not apply to you or you are also applying for Income Protection cover you must complete Part B.

1. What is your height and weight? Height ☐ cm Weight ☐ kgs

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.

2. Have you smoked tobacco or any other substance in the last 12 months?. ☐ Yes ☐ No
3. 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
4. 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
5. Have you ever suffered symptoms of, or had, or been told you have, or received or are contemplating any advice or treatment for:
   a. Muscular skeletal disorders (eg. back, joint), arthritis, loss of limb or paralysis? ☐ Yes ☐ No
   b. Impairment of sight or hearing (not including long or short sightedness)? ☐ Yes ☐ No
   c. Mental or nervous disorder including stress, anxiety, depression or neurological condition?. ☐ Yes ☐ No
   d. Cancer or tumour of any type? ☐ Yes ☐ No
   e. Diabetes or liver disease including hepatitis? ☐ Yes ☐ No
   f. High blood pressure, high cholesterol, chest pain, heart complaint or stroke?. ☐ Yes ☐ No
   g. Disorders and or disease of the kidney, bladder, bowel or stomach?. ☐ Yes ☐ No
6. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV? ☐ Yes ☐ No
7. In the last 5 years have you or do you intend to:
   a. Work as or engage in sexual intercourse with a prostitute? ☐ Yes ☐ No
   b. Had unprotected anal sexual intercourse with more than one partner? ☐ Yes ☐ No
   c. Have sexual intercourse with an intravenous drug user? ☐ Yes ☐ No
   d. Have sexual intercourse with someone you suspect or know to be HIV positive? ☐ Yes ☐ No

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

8. To the best of your knowledge, have two or more members of your immediate family, ie. parents, brothers or sisters (living or deceased) suffered from any hereditary disease before age 60? ☐ Yes ☐ No
9. 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 13 'Declaration and signature'.

PART B – Full personal health statement

5. Residence and travel (must be completed)

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)

1. What is your height and weight? Height ____ cm Weight ____ kgs
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 or stroke? ☐ 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, 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, tendonitis, tenosynovitis, RSI 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 page 5) 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 pancreas? ☐ 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 illness, 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 where you received (or are currently awaiting) an individual result? ☐ 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? ☐ 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
    (ii) Have there been or are there expected to be any complications?. ☐ Yes ☐ No

    If 'yes', please provide details ____

c. Are you currently pregnant? ☐ Yes ☐ No

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

(ii) 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.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

Question no.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

Question no.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

Question no.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

Question no.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

Question no.

Illness, 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 | Treatment received

Full name and address of doctor or hospital

State | Postcode

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

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 = 30 ml (1 nip) spirits, 100 ml (1 glass) wine, 60 ml (1 serve) sherry or port, 285ml (middy/half pint) full strength 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)

If you do not have a usual doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your usual doctor _____

   Address _____

   _____ State 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 have been attending your current doctor for less than 2 years, please provide the following details:

   Name of previous doctor/medical centre _____

   Address _____

   _____ State Postcode

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

9. HIV (must be completed)

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? ☐ Yes ☐ No
2. In the last 5 years have you or do you intend to:
   a. Work as or engage in sexual intercourse with a prostitute? ☐ Yes ☐ No
   b. Had unprotected anal sexual intercourse with more than one partner? ☐ Yes ☐ No
   c. Have sexual intercourse with an intravenous drug user? ☐ Yes ☐ No
   d. Have sexual intercourse with someone you suspect or know to be HIV positive? ☐ Yes ☐ No

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

10. Activities (must be completed)

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 9.
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)

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 Meters

g. Average depth of dives Meters

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

g. 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 provide details of test(s), result(s) and date(s).

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

   Name and address

   State Postcode

   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 and address

   State Postcode

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')
D D / M M / Y Y	

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

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')
D D / M M / Y Y	

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	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
D D / M M / Y Y	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
D D / M M / Y Y	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. Do you have any complications as a result of hypertension? ☐ Yes ☐ No

   If 'yes', please provide 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 usual 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
    IIf '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 from	Duration	Reason/Restriction
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		

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
D D / M M / Y Y	

Doctor/Therapist name and specialty	
D D / M M / Y Y	

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. Declaration and signature (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 'The duty to take reasonable care' 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 the Trustee advises the risk has been accepted.

— Any statements I've made on or with an application to another insurer and which I have presented to the Trustee are intended by me as declarations and representations to the Trustee and I acknowledge that the Trustee will use them in assessing this application for insurance.

— Before or at the time I provided any personal information, I read and understood the Your Privacy information contained in this form.

— 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 as covered in the Your Privacy information contained in this form.

— A benefit may not be payable if the event is caused directly or indirectly by war.

I consent to:

— the Trustee collecting, using and disclosing my personal information, including sensitive information, in accordance with the Your Privacy information contained in this form. This includes:

— the use of personal information about me by the Trustee (if applicable) for the purposes of providing insurance through my membership of the Suncorp Employee Superannuation Plan, 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.

— the disclosure of personal information about me by the Trustee (if applicable) to, and obtaining personal information from, other parties for any of these purposes. These other parties include my adviser, 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 representative of the Trustee 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.

Signature of Person to be insured	
Date	D D / M M / Y Y Y Y
Print full name	

Where to send the form

Please send the completed form and any required attachments to:

Mail: **Suncorp Employee Superannuation Plan**
GPO Box 2585
Brisbane QLD 4001

Email: **super@spsl.com.au**

Your Privacy

Your privacy is important to us. We may collect, use, disclose and handle your personal information in the manner set out in this section.

What is 'personal information'?

Personal information is information or an opinion, whether true or not, about a person whose identity is apparent from the information or opinion. Personal information includes any information we collect from you directly or from another party such as your employer, another superannuation fund, your financial adviser or another personal representative, as well as publicly available sources. It includes your name, address, date of birth, tax file number, contact details and any other information you provide to us either directly or through a website, a third party or via a service provider.

Personal information also includes 'sensitive information'.

What is 'sensitive information'?

Sensitive information is information or an opinion about a person's racial or ethnic origin, political opinions, religious beliefs, membership of a professional association or trade union, sexual preferences, criminal record, health information or genetic information.

Why do we collect personal information?

We only collect personal information about you where it is necessary to establish and administer our products and services on your behalf and to keep you up to date with important changes that could affect your super or your insurance. We also collect personal information from non-members to provide information about our products and services. We handle personal information with the highest level of care and in line with the *Privacy Act 1988* (Act) and the *Australian Privacy Principles* (APPs). Where it is reasonable and practical, we will collect the information directly from you.

We will notify you when we collect your personal information from a third party and why it has been collected. We will take reasonable steps to make sure you and the third party are aware of this policy in relation to the information we collect.

We may be required to collect personal information in accordance with superannuation and taxation laws and any other relevant legislation.

In the event we receive unsolicited personal information about you from other sources, we will destroy or de-identify the information as soon as practicable if it is lawful and reasonable to do so.

We will not collect sensitive information about you without your consent and only where the information is reasonably necessary to administer our products and services. Exceptions will apply where the information is required under Australian law or in other circumstances under the Act.

We will collect health information about an individual in order to provide death and disability insurance.

What happens if you don't give us your personal information?

If you decide not to provide your personal information to us, we may not be able to provide you with our products or services. Many of our products and services require us by law to collect your personal information to identify who we are dealing with.

How we use and disclose your personal information

We collect, use, hold and disclose your personal information generally to establish and administer our products and services.

Personal information is primarily used by us to:

- start and maintain a correct superannuation account/record for you;
- identify you and your superannuation entitlements;
- accurately calculate the amount of benefit you should receive;
- assess, manage and pay any claims you may be entitled to, including claims that contain an insured component;
- communicate with you and provide advice about your superannuation and insurance cover;
- provide information to you about our products and services.

Personal information may also be:

- disclosed by us to our insurers so we can provide you insurance cover;
- used by us or a trusted supplier to undertake market research with you;
- used by us to search the Australian Taxation Office's lost member register;
- disclosed by us to our trusted suppliers such as mailing houses or market research organisations so they can complete a business activity for us;
- disclosed by us to government agencies to comply with legislation (such as the *Income Tax Assessment Act 1997*);
- disclosed by us to software administrators and assurance providers so that they can complete a business activity for us;
- used or disclosed for another purpose that is related to our functions or activities.

If you don't want us to use your personal information for marketing and research purposes, you can opt out at any time by contacting us and letting us know.

We will not sell or lease personal information to third parties. We will only distribute personal information when required by law.

We may disclose your personal information to your financial adviser or other third party but only after that person has provided us with their explicit authorisation for that disclosure to occur. Such authorisation is required in writing and a person will be required to provide proof of identity before the authorisation is accepted.

We may be required to collect and use certain government related identifiers such as tax file numbers or Centrelink references to provide certain services to you. We do not adopt government identifiers as a customer identifier. We will not use government identifiers in any way which is inconsistent with the purpose for which they were originally issued unless it is authorised by Australian law, or by a court or tribunal order.

Can your personal information be disclosed overseas?

We engage third parties to provide services to us that support our primary functions of providing products and services to customers. These business partners or service providers may be located overseas and may not be subject to Australian privacy laws or standards.

Further, our insurers may disclose your personal information to third party recipients (including business partners, service providers and related companies) which are located outside Australia and/or are not established in, or do not carry on business in, Australia. Insurers are required to comply with the Act and the APPs.

Recipients of your personal information supplied by us to provide you with products and services, including insurance benefits, may be located in Brazil, Canada, China, Fiji, India, Indonesia, Israel, Japan, Malaysia, New Zealand, Philippines, Singapore, South Africa, the United Kingdom, USA and members of the European Union.

Can you access your personal information?

If you're registered, you can access your personal account information through your online account at any time. In this secure service, you can check your details such as your date of birth, address and account information and can also make changes to some of these details if needed.

If you don't have access to your online account, you can change your details by contacting us. We will have to conduct an identity check to establish your identity prior to considering any changes.

If you believe personal information that we hold about you is inaccurate, incomplete, or not up to date, please let us know and we will take steps to correct it at no charge. Sometimes changes to your information cannot be made. If we don't correct or change the information that we hold about you at your request, we will give you a written notice including reasons for refusal, generally within 30 days of the request. If you are not satisfied with the reasons provided, you may submit a complaint. You may request us to attach a statement with your personal information record stating that you believe your personal information held with us is inaccurate, out of date, incomplete, irrelevant or misleading.

There may be some situations where we will not be able to provide you with access to your personal information. These situations may include where the access would have an unreasonable impact on the privacy of others, the information relates to existing or anticipated legal proceedings, providing access would be unlawful, or we have reason to suspect that unlawful activity or misconduct of a serious nature is being or may be engaged in. Our Complaints Officer can advise if any of these situations apply to your circumstances.

Can your personal information be used for direct marketing?

We may use your personal information to send you marketing materials and information about our products and services. The materials may be sent in various forms including email, mail, SMS and social media. If you have a preference for the type of communication used, we will endeavour to use that type whenever practical to do so. Personal information collected from you may be used to provide updates and promotional information about us and our products and services, such as upcoming sponsorship events.

If you want to opt out of receiving marketing materials, you should contact us.

We will not share or provide your personal information to other organisations other than as outlined in our privacy policy.

Our privacy policy

Our privacy policy contains information about how to make a complaint about an alleged breach of your privacy and how we'll deal with your complaint, as well as other important information about how your personal information is collected, used and disclosed. You can view our privacy policy at suncorp.com.au/super/privacy. A paper copy of our privacy policy can be provided free of charge on request.