Group Insurance
Request for insurance/personal statement

This form can be used to obtain or change your insurance cover

Information about genetic tests

If you've had a genetic test, you only need to disclose this to us if your total insurance cover will be more than the amounts listed below. When considering your total insurance cover amounts you need to include the cover you're applying for, your cover held in superannuation and your cover held with other life insurers. The total insurance cover you can have and not disclose if you've had a genetic test are:

- **$500,000 life cover, or**
- **$500,000 total and permanent disability cover (TPD), or**
- **$200,000 critical illness (trauma) cover, or**
- **$4,000 a month income protection cover, salary continuance cover or business expenses cover.**

You also need to consider all cover that may have been arranged through a financial adviser, or directly with a life insurance company, or cover held under a group insurance arrangement.
If you've had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

Your duty to take reasonable care not to make a misrepresentation

About this application and your duty

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The duty to take reasonable care

When applying for insurance, there is 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.

The 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. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- think carefully about each question before you answer. If you are unsure about any question, we are here to help and you can contact us.
- 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, and
- you must not assume that we will contact your doctor for any medical information. If you are unsure about whether you should include information or not, please include it.

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts. The duty applies when you answer questions in your application and whenever we obtain more information from you.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you need help understanding the process of buying insurance or answering our questions.

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 for anyone who might need it. If you want, you can have a support person you trust with you.

Insurance is issued by Nippon Life Insurance Australia and New Zealand Limited ABN 90 000 000 402 AFSL 230694, trading as Acenda (the Insurer). The Insurer is a member of the Nippon Life Group. Any reference to 'Acenda', 'we', 'us' and 'our' means the Insurer.

What can we do if the duty is not met?

If the person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we 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 we can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances;
- what we would have done if the duty had been met - for example, whether we 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 we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, including what you can do if you disagree.

For completion by the Life to be Insured

Section 1 Insurance details

Fund/Policy name

Policy/Member number

Please specify the type of insurance cover being applied for:

☐ Death only cover ☐ Death and TPD ☐ Salary Continuance

Please enter the TOTAL amount of insurance cover being applied for under this policy (including any existing cover).

Type of Insurance	Amount		
Death	$	or	Units
Total and Permanent Disability Cover (TPD)	$	or	Units

Salary Continuance $ per month

Benefit Period

☐ 2 years ☐ 5 years ☐ to age 60 ☐ to age 65 ☐ to age 70

Waiting Period

☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Section 2 Adviser details (only if applicable)

Adviser name

Adviser phone number ( )

Adviser email

I am lawfully authorised to advise on, and deal in, Acenda Group Insurance policies under an Australian Financial Services Licence. I do not provide these services on behalf of Nippon Life Insurance Australia and New Zealand Limited ABN 90 000 000 402 AFSL 230694.

Signature of the financial adviser listed above

X Date (DD/MM/YYYY)

Section 3 Life to be Insured's details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr Other:

First name

Middle name

Family name

Previous name(s) (if applicable)

Gender

☐ Male ☐ Female

Date of birth (DD/MM/YYYY)

Contact details

Phone number

Email (Please provide your email address so notices about your application can be sent to you)

Address (Your residential address cannot be a PO Box)

Unit number | Street number | Street name

Suburb | State | Postcode | Country

Section 4 Options in underwriting your case

Fast tracking medical requirements

Unified Healthcare Group (UHG) is our preferred provider for insurance related tests. UHG provides a customer health evaluation service for us (and other insurers) that helps with fast and efficient processing of your application. This means that if you consent, UHG may contact you to arrange blood tests or other medical checks required for your insurance application. UHG is subject to our privacy requirements to protect your confidentiality. Do you permit us to arrange this service?

Yes ☐ No ☐

Section 5 Disclosure

We have explained to you earlier in this application the duty to take reasonable care not to make a misrepresentation that you are under when applying for cover with us, and want to take a moment to explain why it is so important.

You and your family's future and your ability to earn an income or maintain your business are worth protecting. To help ensure you and your loved ones are covered, we need to ask the following questions on your health and individual circumstances.

Please ensure that all your answers are accurate and correct. Failure to provide the correct information on any question may result in the company altering or voiding your policy, which may mean a claim will not be payable when you and your family need it most.

Declaration

Do you declare that:

- you will provide honest answers throughout this application, and
- you are aware that the Insurer can check your answers at any time after the policy is issued, and
- providing false or incorrect information may result in the Insurer altering or voiding your policy.

I, _____ have understood and agree to the above declaration

Section 6 Other insurance(s)

1 **Are you covered by, or are you applying for, any other life, disability, critical illness, income protection or salary continuance insurance with any company, including us (other than this application), including benefits under superannuation or insurance benefits provided by your employer?**

Yes ☐ Please provide details below

Company	Benefit type	Date started	Benefit amount	Waiting/ Benefit periods	Policy number	To be replaced*
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐

*If you answered 'Yes' that cover is to be replaced, please ensure you cancel your insurance with the Insurer or other provider once this application has been accepted.

No ☐

Section 7 Occupation and financial

These questions help us to understand what you do in your job and your financial circumstances.

2 Please provide details of your main job and any professional or trade qualifications you have.

a) Main job

b) Industry

c) Name of employer or trading name

d) Professional or trade qualifications

e) If less than 12 months with the employer above, please provide details of last employer, job and time with that employer

3 Please provide the percentage of time you spend doing the following types of work in your job. Your answer must add up to 100%.

Type of work	Percentage of time
Sedentary/Administration: includes all general clerical, office, administrative and desk duties. The emphasis is on mental rather than physical work although there may be a small element of standing/walking, and driving to and from appointments.	
Supervision of manual workers, field work, or site visits.	
Light manual work: includes light lifting of up to 10kg, using hand tools, operation of light machinery.	
Heavy manual work: includes carrying, lifting, pushing, pulling more than 10kg; the operation of heavy machinery; driving a commercial vehicle.	
Other.	
Total	**100%**

Section 7 Occupation and financial continued

4 Does your job include any hazardous types of work? Hazardous types of work may result in serious injury or death. Some common hazardous types of work are listed in the table below.

Yes ☐ Please provide details in the table below

Type of work	Percentage of time	Specific duties you perform
Heights over 10 metres		
Flying		
Underground work		
Offshore work – within Australian waters		
Offshore work – outside Australian waters		
Diving		
Using or handling explosives		
Using or handling chemicals, dangerous substances, or asbestos		
Other (please specify)		

No ☐

5 Date you started with your employer

6 On what basis are you employed?

a) Full-time ☐
Part-time ☐

b) Casual ☐
Contract ☐
Fixed-term employment ☐
Self-employed ☐
Not working ☐

7 In your main job, on average:

How many hours per week do you work?	
How many weeks per year do you work?	

If you are not currently working and have provided this information in question 7 above, please add zero here.

8 What are your current annual earnings from your main job?
(earnings are your base salary before tax and not including super contributions)

$

Section 8 Claims history

9 Have you ever made a claim or received benefits (including Income Protection, Total and Permanent Disablement (TPD), Salary Continuance, workers' compensation or third party insurance benefit) in regard to any illness, injury or condition, or have you applied for unemployment, sickness or accident benefits or other Centrelink or Veteran's Affairs benefits?

Yes ☐ Please provide details in the table below

Benefit type	Benefit amount	Reason for claim	Time off work	Date benefit ceased

No ☐

Section 9 Travel and pastimes

10 Are you an Australian citizen or permanent resident, or a New Zealand citizen living in Australia?

Yes ☐ Go to question 12

No ☐ Please provide details including how long you have lived in Australia, the visa you hold and the expiry date of that Visa.

11 Have you applied for permanent residency?

Yes ☐ Please provide details

No ☐ Reason for not applying

12 In the next 12 months, do you have definite plans to live or travel outside Australia?

Yes ☐ Please complete the table below

Date(s) of departure	Duration of stay	Destination(s)	Purpose of stay (e.g. holiday, business, residing)

No ☐

Section 9 Travel and pastimes continued

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at **acenda.com.au/memberforms**

13 Do you currently take part in, or have definite plans to take part in any of the following sports or activities?

Yes ☐ Please tick all that apply

- ☐ Scuba Diving
- ☐ Motor car or motor cycle sport?
- ☐ Private flying, gliding, parachuting or ballooning
- ☐ Football (any code)
- ☐ Professional or semi-professional sport
- ☐ Mountaineering or rock climbing
- ☐ Other hazardous pursuits or activities including horse riding, martial arts, combat sports or sailing?

If you ticked any of these boxes, please complete the **Pastimes questionnaire**

No ☐

Section 10 Doctor's details

14 Do you have a usual doctor?

Yes ☐ Please provide full name and address of your usual doctor or medical centre.

No ☐ Please provide the name and address of the last doctor you visited.

Name of doctor or medical centre

Address

Suburb | State | Postcode | Country

Telephone | Email

15 How long have you been attending this doctor / medical centre?

years months

When did you last attend?

16 If you have been attending this doctor or medical centre for less than 12 months, please also provide name and address of your previous doctor.

When did you last attend?

Section 11 Height and weight details

17 **What is your height?**

cm **or** feet/inches

What is your weight? Please do not guess.
Weigh yourself if you have not done so in the last week.

kg **or** stone/pounds

18 **In the last 12 months, have you lost more than 10kg (22lbs)?**

Yes ☐ Please provide details

No ☐

Section 12 Habits and lifestyle

Individual lifestyle choices play an important part in our lives. To get to know you better, these questions will help us better understand you and your lifestyle.

They are important for us to ask to be able to give you the best possible cover for your life insurance.

19 **In the last 12 months, have you been a:**

Please select all that apply.

☐ Regular smoker (smoke each day)	Go to **19a**
☐ Occasional smoker (smoke each week/ month / year)	Go to **19a & 19b**
☐ Social smoker (smoke with friends / family / colleagues)	Go to **19a & 19b**
☐ User of e-cigarettes or vaping	Go to **19c**
☐ User of nicotine-replacement products like patches, gum, etc.	Go to **19c**
☐ Non-smoker (you have not smoked at all)	Go to **20**

19a **How many cigarettes, including roll-ups, cigars or pipes do you smoke on average?**

Please do not guess.

☐ 41 or more a day ☐ 31-40 a day ☐ 21-30 a day ☐ 11-20 a day ☐ 1-10 a day
☐ Less than 7 a week ☐ Less than one a month

19b **When was the last time you smoked tobacco, cigarettes, cigars, or any other nicotine containing substances?**

☐ In the past month ☐ In the past 6 months ☐ In the past 12 months ☐ 1-5 years ago ☐ 6-10 years ago
☐ More than 10 years ago ☐ Never

19c **How often do you use nicotine replacement products (e.g. patches, gum, mints, other nicotine containing products like e-cigarettes or vaping)?**

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Twice a year
☐ Yearly Other ☐ I don't use these products

Section 12 Habits and Lifestyle continued

20 Do you drink alcohol?

Yes ☐ How many standard drinks do you consume on average?

Quantity: ☐ ☐ per day ☐ per week ☐ per month ☐ per year

A standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer
2 standard drinks = a pint (568 ml), a large glass of wine (200ml)

No ☐

21 How often do you have six or more standard drinks on one occasion?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

22 In the last 10 years, how often have you used recreational drugs not prescribed to you by a doctor?

This includes any drug swallowed inhaled or injected. Do not include vitamins, supplements, over-the-counter medications or the oral contraceptive pill.

☐ Frequently (more than 6 times per year) ☐ Occasionally (more than 3 times per year) ☐ Some weekends or holidays
☐ A few times ☐ Once ☐ Never

If you have used drugs in the last 10 years, please provide details including the type of drug and when you last took them:

23 Have you ever attended a health professional, support group or received medical advice, counselling or treatment about any type of dependency, addiction or substance abuse?

Yes ☐ Please provide details

No ☐

The following questions will help us understand your mental and physical wellbeing. These are important questions to answer accurately to avoid your insurance policy being altered or voided, which could result in a claim not being payable.

Please do your best to answer all questions to the best of your ability and do not guess.

Depending on the answers you provide we may need to check with your doctor.

Section 13 Physical wellbeing

Physical wellbeing - in the last 5 years

24 In the last five years, have you been diagnosed with, had symptoms of, or had treatment or medication for (select all that apply):

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at **acenda.com.au/memberforms**

a Asthma	Yes ☐ / No ☐	Please complete the **Asthma** questionnaire
b High blood pressure	Yes ☐ / No ☐	Please complete the **High Blood Pressure** questionnaire
c High Cholesterol	Yes ☐ / No ☐	Please complete the **High Cholesterol** questionnaire
d Skin lesions such as moles, naevus, keratosis or sun spots	Yes ☐ / No ☐	Please complete the **Cyst/Mole/ Skin Lesion** questionnaire

If you answer **yes** to any of the following questions, you must also complete the **Further information table** on page 15 of this application form.

e **Skin conditions** such as
- ☐ Persistent rash, eczema, psoriasis
- ☐ Dermatitis or skin allergies
- ☐ None of these

f **Blood or blood vessel conditions** such as
- ☐ Haemochromatosis,
- ☐ Varicose veins or Deep vein thrombosis (DVT)
- ☐ Pulmonary embolism
- ☐ Anaemia
- ☐ None of these

g **Respiratory conditions** such as
- ☐ Sleep apnoea
- ☐ COVID-19, Long/Post COVID syndrome
- ☐ Pneumonia
- ☐ Recurrent bronchitis
- ☐ None of these

Section 13 Physical wellbeing continued

h **Muscle, bone, ligament, cartilage or tendon injuries** such as

- ☐ Sprains or tears
- ☐ Repetitive strain injury (RSI)
- ☐ Carpal tunnel syndrome
- ☐ Fractured or broken bones or joints
- ☐ None of these

i **Brain, nerve or neurological conditions** such as

- ☐ Persistent headaches or migraines
- ☐ Vertigo, fainting or dizziness
- ☐ Head injuries such as concussion, fractured skull or brain damage
- ☐ None of these

j **Stomach, Bowel, gall bladder or digestive system conditions** such as

- ☐ Diverticulitis
- ☐ Irritable bowel syndrome (IBS)
- ☐ Haemorrhoids
- ☐ Reflux or stomach ulcer
- ☐ Any type of Hernia
- ☐ Gall stones
- ☐ None of these

k **Thyroid conditions** such as

- ☐ Hypothyroidism
- ☐ Hyperthyroidism including Grave's disease
- ☐ Goitre
- ☐ Thyroiditis
- ☐ None of these

l **Any of the following conditions**

- ☐ Low Blood pressure
- ☐ Impaired fasting glucose
- ☐ Any sexually transmitted infections
- ☐ None of these

m **Males only**

Kidney, bladder or reproductive conditions such as

- ☐ Prostate conditions such as prostatitis or enlarged prostate
- ☐ Kidney or bladder conditions such as kidney infections or kidney stones
- ☐ Urinary tract infections (UTI), cystitis or blood in urine
- ☐ None of these

n **Females only**

Kidney, bladder, breast or reproductive conditions such as

- ☐ Kidney or bladder conditions such as kidney infections or kidney stones,
- ☐ Urinary tract infections (UTI), cystitis or blood in urine
- ☐ Polycystic ovarian syndrome, endometriosis, abnormal cervical or pap smear, uterine polyps and fibroids or pelvic inflammatory disease
- ☐ Breast lumps, fibroadenomas or breast cysts (exclude any normal tests that do not require follow up in the next 12 months)
- ☐ Any pregnancy related conditions that you have not already told us about,
- ☐ None of these

Are you currently pregnant?

- ☐ Yes - please provide dute date (DD/MM/YYYY) | | | | | | | | |
- ☐ No

Physical wellbeing - in your lifetime

25 Other than what you have already told us, have you ever been diagnosed with, had symptoms of, or had treatment or medication for (please select all that apply):

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at **acenda.com.au/memberforms**

a Skin cancers such as Melanoma, Basal cell carcinoma (BCC)or squamous cell carcinoma (SCC)	Yes ☐ / No ☐	Please complete the **Cyst/Mole/ Skin Lesion** questionnaire
b Bone or joint conditions such as Gout or arthritis, Osteoporosis. Any joint or bone surgery	Yes ☐ / No ☐	Please complete the **joint/ musculoskeletal** questionnaire
c Back or neck conditions such as Back or neck pain, Sciatica or whiplash, Fractured spine, scoliosis or any back surgery	Yes ☐ / No ☐	Please complete the **Back/Neck** questionnaire
d Mental Health conditions such as Stress, anxiety, or depression, Post traumatic stress disorder (PTSD) or panic attacks. Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), Schizophrenia, eating disorder, attempted suicide or any other mental health disorder	Yes ☐ / No ☐	Please complete the **Mental Health** questionnaire

If you answer **yes** to any of the following questions, you must also complete the **Further information table** on page 15 of this application form.

e Cancers or tumours such as

- ☐ Any form of cancer or tumour, benign or malignant
- ☐ Leukaemia or lymphoma
- ☐ None of these

f Brain or neurological conditions such as

- ☐ Epilepsy
- ☐ Stroke, transient ischaemic attack (TIA), brain haemorrhage
- ☐ Paralysis, multiple sclerosis (MS), motor neurone disease (MND)
- ☐ Alzheimer's disease or dementia
- ☐ None of these

g Cardiovascular or Heart conditions such as

- ☐ Angina, heart attack
- ☐ Heart murmur, heart palpitations or irregular heartbeat
- ☐ Heart valve disease or heart related chest pain
- ☐ None of these

h **Lung or breathing conditions such as**

- ☐ Emphysema
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Silicosis
- ☐ None of these

i **Liver or pancreas conditions such as**

- ☐ Fatty liver, cirrhosis of the liver, hepatitis (excluding hepatitis A if fully recovered)
- ☐ Pancreatitis
- ☐ Any type of diabetes
- ☐ Polycystic kidney disease (PCKD)
- ☐ None of these

j **Autoimmune conditions such as**

- ☐ Rheumatoid arthritis or psoriatic arthritis
- ☐ Ankylosing spondylitis
- ☐ Lupus
- ☐ None of these

k **Bowel conditions such as**

- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Bowel polyps
- ☐ None of these

l **Chronic fatigue or chronic pain related conditions**

- ☐ Chronic Fatigue
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ None of these

m **Eye or Ear conditions such as**

- ☐ Blindness or partial blindness
- ☐ Cataracts, keratoconus
- ☐ Retinal detachment or glaucoma
- ☐ Tinnitus or Meniere's disease
- ☐ Deafness or cholesteatoma
- ☐ None of these

n **Blood or blood vessel conditions** such as

- ☐ Human immunodeficiency virus (HIV) or AIDS
- ☐ None of these

Section 13 Physical wellbeing continued

If you have selected any of the conditions in questions 24 or 25 where a questionnaire is required please refer to the Acenda website, **acenda.com.au/memberforms** for the relevant questionnaire. For all other conditions please complete the table below.

Further information

If you answered 'Yes' to any question in Section 13 (questions 24 and 25, except where a questionnaire is required), please provide details below

Page No.	Question No.	Details including condition, date condition/symptoms started, date of last symptoms, treatment, time off work, name and address of medical professional consulted

Thank you for your time and answers so far. We want to now check if there is anything else we should know to help us better understand your overall wellbeing.

Section 14 General medical

Other than what you have already told us, in the last **5 years have** you been:

***** Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.

We do not need to know about:

- **Colds, flu or minor viral illnesses that were short, isolated occurrences or medications for these conditions, unless you have not made a complete recovery.**
- **Childhood illnesses such as chicken pox, measles, mumps, tonsillitis or tonsillectomy, appendicitis or appendectomy, unless you have not made a complete recovery.**

26 **Referred to, or seen a specialist**

Yes ☐ Please provide details in the table below

No ☐

27 **Referred for, or had medical tests or investigations such as blood tests, X-ray, MRI, ECG or biopsy**

Yes ☐ Please provide details in the table below

No ☐

28 **Referred for, had treatment or taken medication**

Yes ☐ Please provide details including the results in the table below

No ☐

29 **Referred for, or had surgery**

Yes ☐ Please provide details in the table below

No ☐

If you answered 'Yes' to any question in Section 14 (questions 26-29), please provide details below

Page No.	Question No.	Details including condition, date condition/symptoms started, date of last symptoms, treatment, time off work, name and address of medical professional consulted

Section 14 General medical continued

30 Other than what you have already told us, in the next 12 months do you plan to:

☐ Seek medical advice	Yes ☐	No ☐
☐ Have tests and or investigations	Yes ☐	No ☐
☐ Have treatment	Yes ☐	No ☐
☐ Have surgery or an operation	Yes ☐	No ☐

*Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.
If you answered 'No' to all parts of question 30, please go to question 33

31 When do you plan on seeking medical advice? (DD/MM/YYYY)

32 What is the reason(s) for these tests, treatment(s) or surgery/operation?

Section 15 Family history

33 Have any of your immediate blood relatives (parents, brothers or sisters) suffered from any of the following conditions?

No ☐

Yes ☐ Please tick all that apply and provide details in the following table

- ☐ Heart disease or stroke
- ☐ Cancer and/or Melanoma
- ☐ Familial Polyposis of the colon
- ☐ Alzheimer's Disease
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Polycystic Kidney Disease (PCKD)
- ☐ Huntington's disease
- ☐ Motor Neurone disease
- ☐ Any other hereditary disorder

Family member (e.g. mother, brother)	Condition	If cancer, type and site	Age condition began

Section 16 Further information

If you use this page to provide further information, please note the page and question number the additional information refers to.

Page no.	Question no.	Further information

Section 17 Declaration

Read this section carefully before signing.

My decision to apply for insurance under Acenda Group Insurance is based on the Product Disclosure Statement and/or Policy Document for the relevant product that I have received and my understanding of the information it contains.

I understand and agree that:

(a) I have read and understand the duty to take reasonable care not to make a misrepresentation;

(b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;

(c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;

(d) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.

(e) Where this application is for insurance cover under a superannuation fund, I will provide the Insurer or the trustee or any appointed adviser, intermediary or administrator with any information which relates to my membership of that fund which they may request;

(f) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;

(g) I was actively at work performing the normal duties of my occupation when I applied for this insurance;

(h) All statements and declarations given by me on this form are true and correct; and

(i) The information contained in this application may be released to the trustee which has arranged this group insurance, or to an adviser, intermediary or administrator appointed by the trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise the Insurer to:

(a) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance; and

(b) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at Question 12 of Section 10, Doctor's details; and

(c) Provide a copy of the HIV Antibodies Blood test to my usual doctor or medical centre as nominated at Question 12 of Section 10, Doctor's details unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b) and (c) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my personal information in a manner set out in the Group's privacy policy available on **acenda.com.au**

I acknowledge that where my Employer (or former Employer) or the trustee of my superannuation fund has appointed an adviser, intermediary or administrator to arrange and/or administer the group insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance.

I understand that I can withdraw this consent at any time by contacting the Insurer on **1800 652 447** or email **enquiries.group@acenda.com.au**

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

Signature of Life to be Insured

X

Date (DD/MM/YY)

Section 17 Declaration continued

Have you completed or were you requested to complete any questionnaires in this application form?

No ☐ Please return this application form.

Yes ☐ Please return this application form together with the completed questionnaires. The questionnaires can be found on the Acenda website **acenda.com.au/memberforms**.

Send us your form

Mail:
Acenda Group Insurance
PO Box 23455
Docklands Vic 3008

Phone:
1800 652 447

Email:
enquiries.group@acenda.com.au

Website:
acenda.com.au

(DO NOT DETACH)

Authority to release medical information

(to be completed in All cases)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **Acenda**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Section 18 Authority to release medical information (to be completed in ALL cases)

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **Acenda**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **Acenda** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **Acenda** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **Acenda** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **Acenda**, or to third parties they engage, only if **Acenda** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **Acenda** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **Acenda** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

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