CommonwealthBank GroupSuper

This is an interactive form
SAVE PRINT CLEAR

Insurance application

Please phone us on **1800 023 928** with any questions about this form or visit **oursuperfund.com.au**.

Use of this form

You can use this form to apply for new, increased or varied Death and Total and Permanent Disablement (TPD) or Death-only cover, and/or Salary Continuance insurance cover in your Accumulate Plus account. Insurance cover is provided under policies issued to the trustee by AIA Australia Limited (the insurer) (ABN 79 004 837 861, AFSL 230043), referred to in this form as 'AIA' or 'the insurer'.

*Before applying, you should read the relevant **Reference Guide: Insurance Cover** for Accumulate Plus, available from oursuperfund.com.au/pds, for more details on insurance cover, including eligibility for cover, premium rates, when a benefit may or may not be paid, and any exclusions that may apply. We'll notify you in writing of the outcome of this application and if accepted, the date your cover begins. Interim accident cover may apply while an application is being assessed – read the Reference Guide for more information.*

***Do not complete this form to transfer any existing insurance cover** into Accumulate Plus from another eligible super fund, eligible AIA policy or CBA Employee Income Protection – complete the relevant **Request to transfer cover** form from oursuperfund.com.au/forms.*

Duty to take reasonable care not to make a misrepresentation

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the *Insurance Contracts Act 1984 (Cth)*.

When you apply for life insurance, the insurer conducts a process called underwriting. It's how they decide whether they can cover you, and if so, on what terms and at what cost. The insurer will ask questions they 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 the insurer in response to their questions is vital to their 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.

This duty applies to a new contract of insurance and 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. There are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984 (Cth)*. These are intended to put the insurer in the position they would have been in if the duty had been met.

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

Please note that there may be circumstances where the insurer later investigates whether the information given to them was true. For example, they may do this when a claim is made.

Before the insurer exercises any of these remedies, they will explain their reasons and what you can do if you disagree.

Guidance for answering our questions

You are responsible for the information provided to the insurer. When answering their 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.

Changes before your cover starts

Before your cover starts, the insurer may ask about any changes that mean you would now answer their questions differently. As any changes might require further assessment or investigation, it could save time if you let them know about any changes when they happen.

If you need help

It's important that you understand this information and the questions the insurer asks. Ask us or a person you trust, such as your adviser, for help if you have difficulty understanding the process of buying insurance or answering the insurer's questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If you want, you can have a support person you trust with you.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please contact us immediately and we'll let you know whether it has any impact on the cover.

Privacy information

'We', 'us' and 'our' refers to the fund's trustee, member administration service provider and/or the insurer (AIA).

Collection of and use of personal information

In order to assess your application for insurance cover, we may collect personal information about you, such as medical, lifestyle and financial information. This information may be collected directly from you, from your medical practitioner, your employer, a relevant insurer or another third party. Any medical information we collect may be disclosed to third parties only in limited circumstance. For example, it may be disclosed to the fund's consultants, administrators, employer, insurer and advisers. In some cases the law may also require us to disclose information to other people or organisations. It is possible that information may be disclosed to overseas recipients. If required, you can find out more about the countries in which overseas recipients may be located in our privacy policy at oursuperfund.com.au/privacy or call us for a copy.

Access

As a member, you generally have the right to request access to any information that we hold about you. There is no fee to make a request but an access charge may apply to cover the cost of providing the information. If applicable, we will let you know of any charge before acting on a request.

Further information

If you would like to know more about how we use and protect your personal information, a copy of our privacy policy is available on our website oursuperfund.com.au or by contacting us. Our privacy policy contains information about how you can ask us to correct any information we hold about you or make a complaint if you are concerned about your privacy.

All fields marked with an asterisk (*) in the following sections must be completed.

Part A: Personal information

A1. Member details

*Account number

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other *Sex: ☐ Male ☐ Female

*Full given name(s) *Surname

*Postal address

Unit number *Street number* *PO Box* *Street name*

Suburb *State* *Post code* *Country*

*Date of birth *Mobile number Email

▶ By providing your **mobile**, you consent to its use for security validations, e.g. to transact online. By providing your **email**, you consent to receiving communications such as newsletters, significant event notices and other important information to this email, although from time to time we may still need to send you information by post. **Note**: If no mobile, you **must** give a daytime contact number.

A2. Personal details

Job title/occupation

▶ *If the insurer does not consider your title/occupation as 'white' or 'professional' collar, the insurer will **decline** any application for new or increased cover.*

Employer

Average hours worked in main occupation per week

Gross annual income $

▶ *For CBA employees, this 'income' should be your super salary for insurance purposes.*

Your height centimetres **or** feet, inches

Your weight kilograms **or** stone, pounds

Have you smoked tobacco, e-cigarettes or any other substance in the last 12 months?

☐ No ☐ Yes ▶ What you have smoked?

▶ Average smoked? per day, per week **or** per year

Do you drink alcohol?

☐ No ☐ Yes ▶ Average standard drinks: per day, per week **or** per year

Do you plan to travel, live or work in another country within the next two years?

☐ No ☐ Yes ▶ Date(s) and countries/cities you intend to travel to

▶ Duration of your trip(s)

▶ Reason(s) for travel ☐ Holidays ☐ Business ☐ Residing/Migrating

1. 'Permanent' in this case means you're employed by the Commonwealth Bank Group on a permanent basis, as defined in **Reference Guide: Insurance cover (Death & TPD)**, including a fixed term arrangement, and your employer's super contributions are being paid to Accumulate Plus.

Part B: Insurance cover

Requested insurance cover

*Indicate the **total amount** of cover you want to have, i.e. including any existing cover, and any cover applied for under other request or transfer applications. Refer to the relevant **Reference Guide: Insurance Cover** (oursuperfund.com.au/pds) for more details on insurance cover, including eligibility for cover, product maximums, premium rates, when a benefit may or may not be paid, and exclusions. **Note**: The amount of TPD cover can't exceed Death cover, and you can't have TPD cover on its own. If requesting Death-only cover, write zero in the 'TPD' row.*

DEATH & TPD COVER or DEATH-ONLY COVER

Permanent[1] employees of Commonwealth Bank Group: If you currently have multiple-based cover, or you would be eligible for default cover (as outlined in *Reference Guide: Insurance Cover (Death & TPD)*, your cover can be based on a multiple of your notional salary, as a whole or half multiple between 0.5 and 10 inclusive, **or** a fixed dollar amount **or** a combination of both.

- **Total amount** of Death cover: ☐☐.☐ times super salary **and/or** $ ☐☐☐☐☐ fixed cover
- **Total amount** of TPD cover: ☐☐.☐ times super salary **and/or** $ ☐☐☐☐☐ fixed cover

Non-permanent[1] Group employees, including former Group employees and spouse members: All cover is a fixed dollar amount only.

- **Total amount** of Death cover: $ ☐☐☐☐☐ fixed cover
- **Total amount** of TPD cover: $ ☐☐☐☐☐ fixed cover

SALARY CONTINUANCE COVER

Important notes:

1. ***Before applying for Salary Continuance,*** *you should confirm if you are covered under other arrangements, e.g. salary continuance or income protection benefits through your employer, such as CBA Employee Income Protection (CBA EIP), through another super fund, or through a policy held directly with an insurer. While you may hold more than one policy for this type of cover, you may not receive the full benefit from one or more policies in the event of a claim – read the **Reference Guide: Insurance Cover (Salary Continuance)** for more details.*
2. *You will pay monthly premiums based on the level of cover you request below. In the event of a claim, your income immediately before your disablement is taken into account in determining the monthly benefit payable. If your pre-disability income is **less** than your level of accepted cover, a benefit based on the **lower** amount is paid. In this case, the excess premiums are **not** refunded. Therefore it's important that you notify us if your income changes to the extent that it's less than your accepted amount of cover. Read the **Reference Guide: Insurance Cover (Salary Continuance)** for more on how pre-disability income is calculated and how benefits are paid.*

All cover must be a fixed dollar amount only:

- **Total amount** of cover: $ ☐☐☐☐☐ per month – *ensure you've read '**Important note 2**' above*
- **Waiting period** – *choose **one** only*: ☐ 90 days ☐ 30 days
- **Benefit payment period**– *choose **one** only*: ☐ 2 years ☐ To age 65

Part C: Personal statement

Question	Response	Part D ref.
1. Do you engage in any hazardous pastimes or pursuits such as (but not limited to) football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than as a fare paying passenger), scuba diving or any sport(s) in a professional capacity?	☐ No ☐ Yes	**A** *(pg6)*
2. Have you:		
a) recently applied for or do you have a policy for death, total and permanent disability, trauma or salary continuance (excluding this application) either within a super fund or directly with an insurer?	☐ No ☐ Yes	**B** *(pg6)*
b) ever had an application for death, disability, trauma, accident or sickness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms?	☐ No ☐ Yes	**B** *(pg6)*
c) ever claimed a lump sum or accident or sickness benefit from any insurance policy, including but not limited to superannuation, workers' compensation, disability pension or Veterans' Affairs?	☐ No ☐ Yes	**B** *(pg6)*
3. Have you ever experienced symptoms, received medical advice, been treated for or been diagnosed with any back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, or an injury, complaint or disorder of any joint, bones or muscle, including arthritis, gout or repetitive strain injury (RSI)?	☐ No ☐ Yes	**C** *(pg7)*
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental illness, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, attention deficit disorder or Asperger's syndrome, myalgia or fibromyalgia or chronic fatigue syndrome?	☐ No ☐ Yes	**D** *(pg7)*

5. Have you received medical advice, undergone any treatment, investigation or operation for, or had:			
a) high blood pressure or raised cholesterol?	☐ No	☐ Yes	**E** *(pg8)*
b) cyst, moles, sunspots, skin lesions, skin cancer or melanoma?	☐ No	☐ Yes	**F** *(pg8)*
c) asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint?	☐ No	☐ Yes	**G** *(pg9)* **& I** *(pg10)*
d) chest pain, heart complaint, cardiomyopathy, stroke, neurological disorder, multiple sclerosis, muscular dystrophy or blood disorder?	☐ No	☐ Yes	**G** *(pg9)* **& I** *(pg10)*
e) cancer, leukaemia, diabetes or chronic kidney complaint?	☐ No	☐ Yes	**G** *(pg9)* **& I** *(pg10)*
6. Have you:			
a) taken any illegal or non-prescribed drugs (other than over the counter medications) in the last 10 years?	☐ No	☐ Yes	*
b) ever been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?	☐ No	☐ Yes	*
c) ever been infected with or tested positive for HIV, Hepatitis B and/or C or are you awaiting the results of such a test?	☐ No	☐ Yes	*
***Note**: If you answered 'yes' to any part of question 6, an additional confidential questionnaire will be sent to you, which you will need to complete and return to us before we can assess your application.			
7. a) In the last 5 years, have you had sexual intercourse without a condom with the following persons?			
i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection? *(this may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you)*	☐ No	☐ Yes	*n/a*
ii) Someone who injects non-prescribed drugs?	☐ No	☐ Yes	*n/a*
iii) Someone who is a sex worker?	☐ No	☐ Yes	*n/a*
iv) Someone who is infected with the HIV infection	☐ No	☐ Yes	*n/a*
v) Someone who is infected with Hepatitis B? *(you may answer 'No' if you're vaccinated and have immunity for Hepatitis B)*	☐ No	☐ Yes	*n/a*
vi) Someone who is infected with Hepatitis C?	☐ No	☐ Yes	*n/a*
b) In the last 5 years, have you been diagnosed with, or experienced symptoms of Sexually Transmitted Infection(s) (STIs), e.g. chlamydia, gonorrhoea, syphillis?	☐ No	☐ Yes	*n/a*
8. Apart from anything already stated:			
a) are you considering seeking medical advice, treatment, tests or surgery in the future?	☐ No	☐ Yes	**G** *(pg9)* **& I** *(pg10)*
b) have you, in the last 5 years, received any medical advice, medical treatment, investigation or operation not mentioned above (apart from colds, flu, contraceptive advice)?	☐ No	☐ Yes	**G** *(pg9)* **& I** *(pg10)*
9. This question is about your family's medical history. As far as you know, has your mother, father, sisters or brothers had any of the following? • Heart problems, cardiomyopathy, stroke or sudden death • Diabetes • Any dementia, Alzheimer's or Parkinson's disease • Cancer of any type • Motor neurone disease, Huntington's disease, multiple sclerosis, muscular dystrophy or polycystic kidney disease • Any other condition that runs in your family	☐ No	☐ Yes	**H** *(pg10)* **& I** *(pg10)*

▶ **If you answered 'No' to all questions in this Part C**, go straight to Part F of this form on page 12.

If you answered 'Yes' to any of the questions in this Part C, excluding question 6, you should complete the relevant Part D questionnaire in this form (Questionnaires A to I), as noted in the column next to any 'yes' responses above.

Part D: Questionnaires

Questionnaire A: Pastimes

▶ **Only complete Questionnaire A if you answered 'yes' to question 1 in Part C: Personal Statement.**

1. Do you engage in any of the following hazardous pastimes or pursuits?
   a) Flying (other than as a fare paying passenger on a commercial airline)? ☐ No ☐ Yes
   b) Underwater diving (scuba)? ☐ No ☐ Yes
      ▶ If yes to (b) above: (i) Do you dive more than 40 metres in depth? ☐ No ☐ Yes
      (ii) Do you dive alone? ☐ No ☐ Yes
   c) Football of any code (including touch football or Oztag)? ☐ No ☐ Yes
   d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing? ☐ No ☐ Yes
   e) Trail bike or quad bike riding (including off-road and dirt bikes)? ☐ No ☐ Yes
   f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports, horse riding or recreations involving heights? ☐ No ☐ Yes

*If you answered 'Yes' to any questions 1(a)–(f) above, please **also** provide the following:*

What activity(ies) you engage in?

At what level do you participate? ☐ Recreational (non-competition) ☐ Recreational (competition) ☐ Professional (inc. semi-prof)

Number of times you participate in the activity(ies) each year (e.g. hours flown, number of dives, events, etc.)

Do you receive any income from participating in the activity(ies)? ☐ No ☐ Yes

Questionnaire B: Insurance history

▶ **Only complete Questionnaire B if you answered 'yes' to any part of question 2 in Part C: Personal Statement.**

1. Other than this application, do you have or have you recently applied for death, total and permanent disability, trauma or salary continuance insurance on your life with AIA or any other insurance company, or with any super fund?
   ☐ No ☐ Yes – *provide details below:*

Insurance company	Type of cover	Insurance benefit	To be replaced?	Start date
		$	☐ No ☐ Yes	/ /
		$	☐ No ☐ Yes	/ /
		$	☐ No ☐ Yes	/ /

2. Has an application for death, total and permanent disability, trauma, or salary continuance insurance on your life ever been declined or deferred, or accepted with a loading, exclusion or special terms?
   ☐ No ☐ Yes – *provide details below:*

Insurance company	Date of decision	Terms offered and reason
	/ /	
	/ /	
	/ /	

3. Are you claiming or have you ever claimed a benefit from any source, e.g. a TPD benefit from a super fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits?
   ☐ No ☐ Yes – *provide details below:*

Benefit type/source/claim reason	Date commenced	Claim amount	Date finalised
	/ /	$	/ /
	/ /	$	/ /
	/ /	$	/ /

Questionnaire C: Joint / Musculoskeletal

Only complete Questionnaire C if you answered 'yes' to question 3 in Part C: Personal Statement.

1. Nature of complaint/doctor's diagnosis, e.g. sciatica, back pain, broken bone

2. Location of complaint, e.g. lower back, right knee, sciatic nerve

3. When did symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown

5. Was an x-ray or scan taken? ☐ No ☐ Yes – *provide date of most recent test:* / /

   ▶ Details of results of tests taken

6. Is the nature of the condition degenerative or a disc problem? ☐ No ☐ Yes

7. Are you still undergoing treatment or experiencing symptoms? ☐ No – *provide date details below* ☐ Yes

   ▶ Date symptoms ceased / / Date treatment ceased / /

8. Have you been off work as a result of this complaint or been unable to perform your normal day-to-day activities?

   ☐ No ☐ Yes – *provide details of period(s) off work below:*

   ▶

9. Do you have any residual or ongoing effects or restrictions as a result of this condition?

   ☐ No ☐ Yes – *provide dates and details below:*

   ▶

10. Is your treating doctor different from your usual doctor? ☐ No ☐ Yes – *provide details of treating doctor below:*

    ▶ Name Address

    Phone Fax

Questionnaire D: Mental health

Only complete Questionnaire D if you answered 'yes' to question 4 in Part C: Personal Statement.

1. Details of the condition (i.e. doctor's diagnosis)

2. Reason or cause: ☐ Marital problems ☐ Bereavement/family illness ☐ Post-natal ☐ Work-related

   ☐ Other – *please specify*:

3. Date symptoms first commenced / /

4. Have the symptoms ceased? ☐ No ☐ Yes – *date symptoms ceased*: / /

5. Have you taken or are you taking medication? ☐ No ☐ Yes – *provide details below*:

Type of medication	Dosage	Date ceased
		/ /
		/ /
		/ /

6. Have you attempted suicide or had suicidal thoughts? ☐ No ☐ Yes

7. Have you ever been hospitalised? ☐ No ☐ Yes – *indicate period(s) of hospitalisation below*:

8. Did the condition ever cause you to lose time off work? ☐ No ☐ Yes – *indicate period(s) off work below*:

Questionnaire D: Mental health (continued...)

9. Has your ability to work or perform daily activities been restricted in any way? ☐ No ☐ Yes – *provide details below*:

10. Is your treating doctor different from your usual doctor? ☐ No ☐ Yes – *provide details of treating doctor below:*

▶ Name Address

Phone Fax

Questionnaire E: High blood pressure / Raised cholesterol

▶ **Only complete Questionnaire E if you answered 'yes' to question 5(a) in Part C: Personal Statement.**

1. What condition to you have? *(indicate one or both as applicable)*: ☐ High blood pressure ☐ Raised cholesterol
2. When were you first diagnosed with this condition? / /
3. Do you have any problems or complications resulting from this condition, e.g. heart disease, chest pain?
   ☐ No ☐ Yes – *provide details below:*
   ▶
4. Are you taking regular medication for this condition? ☐ No ☐ Yes – *provide details below, including dosage:*
   ▶
5. Complete (i) for high blood pressure **and/or** (ii) for raised cholesterol, as applicable to you:
   i) Date of last blood pressure reading / /
   Was your blood pressure considered to be well-controlled, e.g. less than 140/90? ☐ No ☐ Yes ☐ Don't know
   ii) Date of last cholesterol reading / /
   Result of last cholesterol reading: ☐ 2.0 to 6.5 mmol ☐ 6.6 to 7.5 mmol ☐ 7.6 or above mmol ☐ Don't know
6. Is your treating doctor different from your usual doctor? ☐ No ☐ Yes – *provide details of treating doctor below:*

▶ Name Address

Phone Fax

Questionnaire F: Cysts, moles, sunspots or skin lesions

▶ **Only complete Questionnaire F if you answered 'yes' to question 5(b) in Part C: Personal Statement.**

1. Type: ☐ Cyst ☐ Mole ☐ Sunspot ☐ Skin lesion ☐ Melanoma ☐ Basal cell carcinoma
   ☐ Other – *please specify*:
2. Location of growth(s): ☐ Face/head ☐ Arm/leg ☐ Chest/front ☐ Back/shoulder
3. When was this? / /
4. Was the growth(s) removed? ☐ No ☐ Yes – *provide details below*:

▶ When was it removed / / Number of growth(s) removed

▶ Method of removal: ☐ Frozen/Burnt off ☐ Surgical/Cut out

5. Was the growth(s) reported as cancerous/malignant? ☐ No ☐ Yes – *provide details below*:

▶ Were any further tests, investigations, treatments, follow-up or re-excision required? ☐ No ☐ Yes – *provide details below*:

▶ Date and details of further tests, investigations, treatments, follow-up or re-excision:

6. Is your treating doctor different from your usual doctor? ☐ No ☐ Yes – *provide details of treating doctor below:*

▶ Name Address

Phone Fax

Questionnaire G: Personal and medical details

▶ **Only complete Questionnaire G if you answered 'yes' to any of questions 5(c), 5(d), 5(e) and/or question 8 in Part C: Personal Statement.**

1. When did you last consult a doctor? ☐ Within the last month ☐ 1 to 3 months ago ☐ 3 to 6 months ago ☐ 6 to 12 months ago ☐ 12 months to 2 years ago ☐ Over 2 years ago

   a) Reason for consultation:

   b) Result(s)/outcome(s) from your last consultation? *(tick any/all that apply)*

   ☐ All clear/normal/full recovery – no tests/prescribed treatment required (other than contraceptive or cold/flu medication) ☐ Routine tests conducted – results all clear/normal ☐ Tests conducted – results pending
   ☐ Ongoing treatment e.g. Ventolin inhaler ☐ Not fully recovered yet ☐ Referral to specialist/ health professional

   c) Was the doctor/medical centre your usual doctor/medical centre? ☐ No ☐ Yes

   If you have been a patient of this doctor for less than 12 months, provide details of your previous doctor/medical centres:

   Name Address

   Phone Fax

2. The following **questions 2(a)–(f) are for females only**, otherwise continue to question 3 below.

   a) Are you currently pregnant? ☐ No ☐ Yes – *what is the baby's due date:* / /

   b) Will you be returning to work in the same capacity as your current occupation, e.g. back to the same or greater hours within or at the end of your 12-month maternity leave? ☐ No ☐ Yes

   c) Have you ever had any complications with pregnancy or childbirth, e.g. diabetes, ectopic pregnancy or pre-eclampsia, excluding miscarriage in the first 15 weeks or elective caesarean? ☐ No ☐ Yes – *provide details/dates:*

   ▶

   d) Have you ever had an abnormal result for any of the following tests?

   (i) Pap smear: ☐ No ☐ Yes ii) Breast ultrasound: ☐ No ☐ Yes iii) Mammogram: ☐ No ☐ Yes

   If 'yes' to (i), (ii) or (iii) above, provide details and dates below:

   ▶

   e) Have you ever had a breast lump or breast cyst or any other type of breast abnormality, even if you have not consulted a doctor? ☐ No ☐ Yes

   If 'yes' above, provide details including dates and results of treatments below:

   ▶

   f) Have you ever sought treatment for any condition of the ovary, uterus, endometrium or perineum? ☐ No ☐ Yes

   If 'yes', provide details including dates and results of treatments below:

   ▶

3. Have you ever had, sought advice or treatment, experienced symptoms or suffered from any of the following:

   a) Asthma (other than childhood) chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint? ☐ No ☐ Yes

   b) Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever? ☐ No ☐ Yes

   c) Stroke, paralysis, neurological disorder, multiple sclerosis, muscular dystrophy or blood vessel disorder? ☐ No ☐ Yes

   d) Alzheimer's, Parkinson's dementia or any other disorder of the brain? ☐ No ☐ Yes

   e) Cancer, tumour or melanoma? ☐ No ☐ Yes

   f) Thyroid, glandular, pituitary or pancreatic disorder? ☐ No ☐ Yes

   g) Gastric or duodenal ulcer, persistent indigestion, gastro-oesophageal reflux disease, Barrett's oesophagitis, irritable bowel or other bowel disorder (e.g. polyps, ulcerative colitis or Crohn's disease)? ☐ No ☐ Yes

   h) Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar? ☐ No ☐ Yes

   i) Any disorder of the gall bladder or liver, including hepatitis B or C or fatty liver/raised liver function? ☐ No ☐ Yes

   j) Varicose veins, haemorrhoids or hernia? ☐ No ☐ Yes

   k) Disorder of the kidney, bladder or prostate (including raised PSA), blood in urine or kidney stones? ☐ No ☐ Yes

l) Epilepsy, fits of any kind, fainting episodes, dizziness or vertigo, or recurring headaches or migraines? ☐ No ☐ Yes

m) Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder (including insomnia)? ☐ No ☐ Yes

n) Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome? ☐ No ☐ Yes

o) Eczema, dermatitis, psoriasis or any other skin disorder? ☐ No ☐ Yes

p) Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder, embolism, thrombosis (DVT) or Factor V Leiden? ☐ No ☐ Yes

q) Any impairment of sight (other than corrected by glasses or lenses) or blurred vision? ☐ No ☐ Yes

r) Any impairment of hearing (including tinnitus, deafness, high frequency hearing loss) or speech? ☐ No ☐ Yes

s) Any other illness, injury, disease or disorder not mentioned above? ☐ No ☐ Yes

t) Other than for those conditions mentioned above, are you taking any regular prescribed medication? ☐ No ☐ Yes

u) Have you undergone screening for diseases or conditions such as, but not limited to, bowel cancer? ☐ No ☐ Yes

v) Within the last 3 years have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results, or an ultrasound (other than for pregnancy)? ☐ No ☐ Yes

w) Are you considering seeking medical advice, treatment, tests or surgery in the future? ☐ No ☐ Yes

▶ **If you answered 'Yes' to any part of Question 3 (a) to (x) above**, you will also need to provide additional details relating to each 'yes' answer in Part E: General Health Questionnaire on page 11.

Questionnaire H: Family history

▶ **Only complete Questionnaire H if you answered 'yes' to question 9 in Part C: Personal Statement.**

Family member	Condition (if cancer, please state type – breast, colon etc.)	Age diagnosed

If you have a favourable genetic test result, e.g. to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you **may** choose to disclose the result below.

Questionnaire I: Additional medical details

▶ **Only complete Questionnaire I if you answered 'yes' to any of questions 5(c)–(e), 8 or 9 in Part C: Personal Statement.**

1. Do you have total insurance cover, applied for including any cover with another insurer or super fund, of more than:
   - $500,000 of lump sum death cover, or
   - $500,000 of total and permanent disablement (TPD) cover, or
   - $200,000 of trauma and/or critical illness cover, or
   - $4,000 per month in total of any combination of income protection (including CBA Employee Income Protection), salary continuance cover and business overheads cover?

   ☐ No – *go to Part F (page 12)* ☐ Yes – *continue below*

***Note**: If you have a favourable genetic test result, e.g. to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you may choose to disclose the result.*

2. Have you had or do you in the next 12 months intend to have a genetic test?

   ***Note**: If you've had a genetic test as part of a medical research study conducted by an accredited university or medical research institution where your individual test result hasn't been and won't be provided to you, or you've specifically asked not to receive the test results, you may answer 'No'.*

   ☐ No – *go to Part F (page 12)* ☐ Yes – *continue below*

   a) What is/was the reason for your genetic test?

   b) What was the result of your genetic test?
   or ☐ test hasn't been done yet.

Part E: General health questionnaire

▶ **Only complete Part E if you answered 'yes' to any part of question 3 (a) to (x) in Questionnaire G.**

For any question from 3(a) to 3(x) in Questionnaire G where you answered 'yes', indicate the relevant question number at the top of the following columns and provide additional details relating to your answer for each of the questions below.

	Question ( )	**Question ( )**	**Question ( )**
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started	/ /	/ /	/ /
3. Date symptoms ceased (if applicable)	/ /	/ /	/ /
4. Are symptoms singular, recurrent or ongoing?			
5. How often do/did you have symptoms? *Choose **one** of: daily / weekly / monthly / quarterly / half-yearly / yearly / one-off / other (please specify)*			
6. How severe are the symptoms? *Choose **one** of the following: mild / moderate / severe / never had symptoms / symptoms ceased*			
7. Did you take medication or have any other treatment for this condition? *If 'Yes', provide details of medication/treatment*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
8. Are you still on treatment, including medication?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
9. Have you ever been off work as a result of this condition? *If 'Yes', indicate the total time off work*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
10. Do you have (or have you had) any residual, ongoing effects or restrictions as a result of this condition?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
11. Have you ever had an x-ray, scan or blood test for this condition?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
12. Is your treating doctor different from your usual doctor? *If 'Yes', provide the doctor's name and contact details*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

▶ **The following Parts F to J must be completed in all circumstances.**

Part F: Doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name | Address

Phone | Fax

Part G: Telephone underwriting

Telephone underwriting may reduce the need for follow-up information and medical reports, resulting in faster completion of an application.

I permit the fund and/or the insurer (AIA) to call me to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call forms part of my *Duty to take reasonable care not to make a misrepresentation,* as described on page 1 of this form.

☐ Yes ▶ Contact me on phone ____ between the hours ____ *(must be between 9am– 5pm AEST)* ☐ No

Part H: Election to keep insurance cover

*Super laws prevent us from providing insurance cover to you, or may require us to cancel your insurance cover, if your account is considered an **inactive account**, unless you've elected to keep your cover. For the purposes of insurance in super laws, 'inactive' means your account hasn't received any contributions or rollovers for 16 consecutive months. It's not compulsory to make an insurance election as part of this application for cover. You should be aware of the important implications in section H2 below if you choose not to make an election. Read more about these rules in the relevant **Reference Guide: Insurance cover**.*

*Complete either section H1 **or** H2 below:*

H1. If you want to make an election

☐ **I elect to keep any and all insurance cover** in this Accumulate Plus account, including any Death and TPD cover, Death-only cover and/or Salary Continuance cover, even if no contributions, rollovers or other amounts have been received in my account for a continuous period of 16 months or more.

By choosing this option, I understand that:

- This election applies to the insurance cover I'm applying for on this form, as well as any and all other cover that I currently hold in this Accumulate Plus super account.
- Insurance premiums will be deducted monthly from my account balance, which will reduce my super balance.
- This election continues until my account is closed, or until I notify the fund that I want to revoke an election.
- Even if I make this election, I can still cancel or reduce my insurance cover at any time.
- My amount of cover and the cost of my cover may change in accordance with the insurance policy terms, outlined in the relevant ***Reference Guide: Insurance cover*** (available from oursuperfund.com.au/pds).
- My cover may still end in circumstances set out in the relevant ***Reference Guide: Insurance cover***, e.g. where there are insufficient funds in my account to pay for my insurance premiums.

H2. If you don't want to make an election

☐ **I do not want to make an election** to keep my insurance cover where my account is considered to be an inactive*.

By choosing this option I understand the following implications:

- The cover I'm applying for under this application will **not** be provided to me if my account is considered inactive* as at the date the fund receives this application. In this case, if I want to continue with my application for cover without making an inactivity election, I'll have to make a contribution or rollover to my account first.
- All cover on my account, including cover received under this application, may be **automatically cancelled** as required by law on the date this account meets the criteria for an inactive account* on or after the date the fund receives this application.
- If I've previously made an inactivity insurance election to keep my cover for this Accumulate Plus account, **I revoke that previous inactivity election**, in which case all cover on my account, including cover received under this application, may be automatically cancelled as required by law on the date this account meets the criteria for an inactive account* on or after the date the fund receives this application.

** Refer to the definition in the box at the beginning of this section.*

Part I: Consent for accessing health information

In this Part I, 'we', 'us' or 'our' refer to AIA, as the fund's insurer. Note: SafeScript is software that maintains prescription records for some high-risk medicines. It's currently only available to practices in Victoria.

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 (AIA) 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.

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 AIA, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form AIA 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.
- AIA 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 AIA 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.

Name

Signature

Date

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 AIA, or to third parties they engage, only if AIA 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:

- AIA 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 AIA 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.

Name

Signature

Date

Part J: Declaration

- I have read the *Duty to take reasonable care not to make a misrepresentation* section on page 1 of this form and I am aware of the consequences of not meeting this duty.
- I have read and understood the ***Product Disclosure Statement (PDS)*** and ***Reference Guide: Insurance cover*** relevant to my insurance cover type in Accumulate Plus, available from oursuperfund.com.au/pds.
- If I do not fully complete, sign and date this application, or provide any additional information requested by the insurer, my application for insurance cover won't be considered until such time as I do so.
- If the insurer accepts this application for cover, the cover applied in Accumulate Plus will be:
  - equal to the amount of cover I requested in Part B, subject to my total cover not exceeding product maximums
  - effective from the start date advised to me in writing and premiums will be deducted from the first premium due date thereafter
  - subject to the rules and premiums of insurance cover in Accumulate Plus, including any special conditions, such as exclusions or loadings, that the insurer may apply to me.

I authorise:

- AIA to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example, re-insurers, medical consultants, legal advisers)
- AIA and any person appointed by AIA to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me.

I agree to provide further medical authorities if requested.

I declare that:

- The answers to the questions and declarations on this form are true and correct, including those not in my own handwriting.
- I have not withheld any information which may affect AIA's decision to provide insurance.
- I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.
- I have read and understood privacy information, as summarised on page 1 of this form and the ***Reference Guide: General information***, or available from oursuperfund.com.au/privacy or by contacting us. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that privacy information.
- I agree that a photocopy or electronically transmitted image of this form shall be considered as effective and valid as the original signed form.
- I understand and consent to my information being collected, disclosed and used in accordance with the fund's privacy policy, which is available by contacting the fund or visiting **oursuperfund.com.au** (under the 'Privacy' link on the homepage).

Signature of person to be insured ✘

Print name

Date dd / mm / yyyy

▶ To help us assess your application as quickly and efficiently as possible, **please check that you have read and completed all of Parts A, B, C, F, G, H, I and J of this form, as well as any additional questionnaires in Part D and/or E as required, based on your answers to Part C.** If you've corrected or over-written any answers or information on this form, please initial next to those amendments or changes.

Please return your completed form to Commonwealth Bank Group Super:
Mail: GPO Box 4303, Melbourne VIC 3001 **Email**: please log in to your account and use the online enquiry form.

Member interests in Commonwealth Bank Group Super (the fund) (ABN 24 248 426 878) are issued by Commonwealth Bank Officers Superannuation Corporation Pty Limited (the trustee) (ABN 76 074 519 798, AFSL 246418). Insurance cover is provided under policies issued to the trustee by AIA Australia Limited (the insurer) (ABN 79 004 837 861, AFSL 230043). The target market for this product can be found in the product's Target Market Determination at oursuperfund.com.au/tmd.