BT Super Investment Insurance Advice

BT Super for Life
Application Form

INSURER
Westpac Life Insurance Services Limited
ABN 31 003 149 157

TRUSTEE
BT Funds Management Limited
ABN 63 002 916 458,
as trustee of Retirement Wrap
ABN 39 827 542 991

USE THIS FORM FOR

Please use this form if you wish to apply for Customised Insurance cover within BT Super for Life. The following products are available:

- Customised Death cover;
- Customised Death and Total & Permanent Disability cover;
- Customised Salary Continuance Insurance cover.

This attachment consists of two forms:

- Application Form
- Personal Statement

In order to assess your request for cover, we require the relevant Medical Questionnaires to be provided together with both these forms if you have answered 'yes' to the medical questions in Section K of the Personal Statement (page 5). Medical Questionnaires are listed in the 'Insurance' section of BT Super for Life Internet Banking.

Please submit the forms to the following address:

BT Super for Life
GPO Box 3958
SYDNEY NSW 2001

Questions? Please call BT Customer Relations on 1300 653 553.

PLEASE READ BEFORE SIGNING THIS FORM

This Application Form, forms part of the BT Super for Life Product Disclosure Statement (PDS). The BT Super for Life Product Disclosure Statement is referred to as the PDS. Before you complete this Application Form please read:

a. the 'Privacy Information' provided within the Additional Information Booklet.

b. the information about 'Your Duty of Disclosure'.

YOUR DUTY OF DISCLOSURE

You have a duty, under the Insurance Contracts Act 1984, to tell us every matter that you know, or could reasonably be expected to know, is relevant to the decision whether to insure you and, if so, on what terms.

The duty of disclosure applies before you enter into, extend, vary or reinstate cover, and applies until the time when you are issued with an Insurance Certificate or other written confirmation of the issue, extension, variation or reinstatement.

If any information provided to us changes (including any change to your health, occupation or pastimes) before you are issued with an Insurance Certificate or other written confirmation of cover, you must tell us.

The duty does not require disclosure of any matter:

- that diminishes the risk to be undertaken; or
- that is of common knowledge; or
- that the Insurer knows or, in the ordinary course of its business, ought to know; or
- as to which compliance with your duty is waived by us.

Non-disclosure

If you fail to comply with your duty and the cover would not have been entered into if the failure had not occurred:

- the cover may be varied to reduce the sum insured or to reflect the terms that would have applied if you had complied with your duty; or
- the cover may be treated as never having existed if it is within 3 years of entering into the cover or your non-disclosure was fraudulent.

ACCOUNT HOLDER DETAILS — SECTION A

Complete this section for all applications

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname

Maiden name (if you changed your name through marriage)

Given name(s)

Date of birth (dd/mm/yyyy) / /

Telephone number ( )

Gender

Male ☐ Female ☐

Smoker

Yes ☐ No ☐

Occupation

BT Super for Life Account number

Please note the address for notices will be the same as the address on your superannuation account.

Are you an employee of the Westpac Group? Yes ☐ No ☐

If **'Yes',** please provide your employee number.

CUSTOMISED DEATH & TPD COVER — SECTION B

Complete this section for all Customised Death & TPD applications

Please note the occupation you state in the Personal Statement may result in an occupational loading to be applied.

Cover for the Account holder	
Death cover	$
TPD cover	$

Please note the amount of TPD cover applied for cannot exceed the amount of Death cover applied for.

CUSTOMISED SALARY CONTINUANCE INSURANCE — SECTION C

Complete this section for all customised Salary Continuance Insurance cover applications

BENEFIT DETAILS

Monthly benefit applied for

$

Benefit Period

2 years ☐ 5 years ☐ Age 65 ☐

Waiting Period (days)

30 days ☐ 90 days ☐ 180 days ☐ 720 days ☐

The following combinations are available:

Waiting Period	Benefit Period
30 day, 90 day	2 years, 5 years, to age 65
180 day, 720 day	to age 65

The insurer has restrictions depending on your occupation category. You will be notified if you are not eligible for your selected Waiting and Benefit Period.

PREMIUM PAYMENT DETAILS — SECTION D

Premiums will be deducted from your BT Super for Life account on a monthly basis.

DECLARATION AND AGREEMENT — SECTION E

Complete this section for all applications

I, the Insured Person or legal representative of the Insured Person, declare and agree that:

- I have read and understood this completed form and declare that the statements made and the information completed on therein is true and correct as at the date I signed this form.
- I have read and understood the section titled 'Privacy Information' in the Additional Information Booklet and I agree to the various uses and disclosures of my personal information as set out in that section.
- This form will constitute part of my insurance(s) and the basis of my contract with the Insurer.
- I have read and understood my duty of disclosure, details of which are set out in the Additional Information Booklet provided to me.

Account holder signature

Date (dd/mm/yy)

/ /

Please complete the Personal Statement form over the page.

BT Super Investment Insurance Advice

BT Super for Life
Personal Statement

Name of Account holder to be insured

BT Super for Life Account Number

Is the Account Holder a member of the Westpac Group Plan?

Yes ☐ No ☐

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Westpac Life Insurance Services Limited
ABN 31 003 149 157

TRUSTEE

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ACCOUNT HOLDER DETAILS — SECTION A

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Surname

Maiden name (if you changed your name through marriage)

Given name(s)

Gender

Male ☐ Female ☐

Date of birth (dd/mm/yyyy)

Number of financial dependants

Continued on page 2

Home phone number
( )

Business phone number
( )

Mobile phone number

Most convenient phone number to call, to clarify any information?
- ☐ Home
- ☐ Business
- ☐ Mobile

TRAVEL AND RESIDENCY — SECTION B

1 Are you a permanent resident of Australia? Yes ☐ No ☐

If **'No',** provide details (eg date of entry, category of visa held and expiry date etc)

2 Do you intend to travel or reside outside Australia in the next 12 months? Yes ☐ No ☐

If **'Yes',** provide details

When will your travel commence? (dd/mm/yyyy)
/ /

Total duration of travel in next 12 months? *(insert number of days)*

Country/Countries

Region(s)

Reason?
- ☐ Business
- ☐ Temporary work assignment
- ☐ Holiday
- ☐ Other (specify below)
- ☐ Visit relatives

INSURANCE AND CLAIMS DETAILS — SECTION C

1 Have you ever had an application for life, total and permanent disability or salary continuance insurance/income protection either *declined, deferred, cancelled or accepted with a loading, exclusion or special terms?* Yes ☐ No ☐

If **'Yes',** provide details

2 Other than this application have you applied for Life, Total & Permanent Disability, Salary Continuance Insurance, or Income Protection with another company or ourselves? Yes ☐ No ☐

You should include benefits from your employer, business or credit insurance or your super. (Please note that a claim may be prejudiced in the event that this information is not given accurately.)

If **'Yes',** please provide details

COMPANY 1

Company name

Type of insurance

Reason for cover

Date commenced (dd/mm/yyyy) / /

Insured amount $

Waiting Period / Benefit Period /

Will the insurance be cancelled? Yes ☐ No ☐

COMPANY 2

Company name

Type of insurance

Reason for cover

Date commenced (dd/mm/yyyy) / /

Insured amount $

Waiting Period / Benefit Period /

Will the insurance be cancelled? Yes ☐ No ☐

COMPANY 3

Company name

Type of insurance

Reason for cover

Date commenced (dd/mm/yyyy) / /

Insured amount $

Waiting Period / Benefit Period /

Will the insurance be cancelled? Yes ☐ No ☐

COMPANY 4

Company name

Type of insurance

Reason for cover

Date commenced (dd/mm/yyyy) / /

Insured amount $

Waiting Period / Benefit Period /

Will the insurance be cancelled? Yes ☐ No ☐

If you have indicated above that you will cancel any insurance, you must do so within 14 days of receiving your Insurance Certificate from the insurer. If you do not do so, your cover will terminate at the end of the 14th day after you receive your Insurance Certificate and, upon confirmation that the other insurance was not cancelled, we will refund any further premium you have paid in respect of the cover specified in the Insurance Certificate.

3 Are you in receipt of benefits, or have you ever made a claim from any source eg an insurance or superannuation policy, Workers Compensation, Third Party, Centrelink (including unemployment benefits, invalid pension or sickness benefits), Veterans Affairs etc? Yes ☐ No ☐

If **'Yes',** provide details

Date (dd/mm/yyyy) / /

Source

Reason

Date finalised (dd/mm/yyyy) / /

Date (dd/mm/yyyy) / /

Source

Reason

Date finalised (dd/mm/yyyy) / /

PURSUITS AND PASTIMES — SECTION D

Do you currently engage in, or intend to engage in, any pursuits or pastimes that may be considered hazardous. For example any type of football, motor racing, rock climbing, boxing, scuba or skindiving, parachuting or flying (other than as a fare paying passenger on a regular airline) or any other competitive sport? Yes ☐ No ☐

If **'Yes',** complete the appropriate 'Pursuits and Pastimes Questionnaire' on page 10, then return to Section G.

FAMILY HISTORY — SECTION E

To the best of your knowledge, have any of your blood related parents, brothers or sisters, been diagnosed with any of the following conditions, or suffered from any hereditary condition?

- Heart Attack/Disease
- Stroke
- Cancer *(specify type)*
- Huntington's Disease
- Alzheimer's Disease
- Kidney Disease
- Diabetes
- Multiple Sclerosis
- Muscular Dystrophy

If **'Yes',** provide details

Relationship (do not state name)	Condition/s	Age diagnosed	Age at death (if applicable)

SMOKING AND ALCOHOL — SECTION F

1 Have you smoked tobacco, marijuana or any other substances in the last 12 months? Yes ☐ No ☐

If **'Yes',** provide details

Type	Quantity *(per day)*
☐ Cigarettes	
☐ Pipes / cigars	
☐ Other *(specify)*	

2 Have you used a nicotine replacement therapy in the last three months? Yes ☐ No ☐

3 Have you ever been advised by a medical practitioner to give up, or reduce the amount of smoking based on specific medical grounds and/ or have you ever been advised that you have suffered any medical condition as a result of your smoking? Yes ☐ No ☐

4 Do you consume alcohol? Yes ☐ No ☐

If **'Yes',** provide details (quantity is based on a 'standard' drink ie 250ml beer, 125ml wine, 30ml spirits)

Type

Quantity

daily OR weekly

Continued on page 4

5 Have you ever been advised to undergo or receive counselling or treatment regarding the use of alcohol? Yes ☐ No ☐

HEIGHT AND WEIGHT — SECTION G

What is your current height and weight?

Height

cm OR ft in

Weight

kg OR st lb

DOCTOR'S DETAILS — SECTION H

1 What is the name and address of your usual doctor / general practitioner?

Doctor's name

Address

State *Postcode*

Telephone number ( )

Fax number ( )

2 How many years have you been attending this doctor?

years

If **less** than two years, please provide name and address of your previous doctor

Doctor's name

Yes ☐ No ☐

Address

State *Postcode*

Telephone number ( )

Fax number ( )

HEALTH DETAILS — SECTION I

1 To the best of your knowledge, have you ever had, or been told you have had, any of the following conditions listed below?

A ASTHMA

Yes ☐ No ☐

If **'Yes',** have you had any symptoms or treatment of asthma since childhood (ie 16 years of age)?

Yes ☐ No ☐

If **'Yes',** please indicate if any of the following apply:

	Yes	No
Have you had an asthma attack within the last two years?	☐	☐
Have you had more than 5 days off work or been on limited duties within the last 2 years due to your asthma condition?	☐	☐
In the last ten years, have you been admitted to hospital, or required emergency treatment, including the use of systemic steroids, for asthma?	☐	☐
Are you currently using non-steroidal inhalers or bronchodilators more than once a week for asthma?	☐	☐

▶ If **'Yes'**, please complete the **Asthma Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking:

B SPINE, BACK OR NECK INJURY, PAIN, STRAIN OR DISORDER

Yes ☐ No ☐

If **'Yes',** please indicate if any of the following apply:

	Yes	No
Was your back/neck condition diagnosed as anything other than muscular aches, strains, pains or spasms?	☐	☐
Have you had more than five days off work, or been on limited duties, within the last four years due to a back/neck condition?	☐	☐
Has a doctor/general practitioner ever advised you to undergo any tests, investigations, or to take prescription medication for a back/neck condition?	☐	☐

▶ If **'Yes'**, please complete the **Back and Neck Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

C SKIN LESION (eg cyst, mole, melanoma, basal cell carcinoma, squamous cell carcinoma)

Yes ☐ No ☐

If **'Yes',** please indicate if any of the following apply:

	Yes	No
Have you noticed or become aware of any recent change in size or colour of any skin lesion for which you have not consulted a doctor?	☐	☐
Have you had more than one lesion/cyst?	☐	☐
Has any lesion/cyst been confirmed by a specialist/consultant to be malignant (cancerous)?	☐	☐
Has any lesion been removed by a procedure other than being burnt/frozen off?	☐	☐
Were you advised to have any further tests, treatments, checks or follow-ups for any lesion?	☐	☐

▶ If **'Yes'**, please complete the **Skin Lesion Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

D GOUT

Yes ☐ No ☐

If **'Yes'**, have you had any symptoms, treatment, or time off work in the last two years due to your gout?

Yes ☐ No ☐

Continued on page 5

▶ If **'Yes,** please complete the **Gout Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

Ⓔ ANY VISION IMPAIRMENT OR EYE DISORDER

Yes ☐ No ☐

If **'Yes'**, have you had any treatment for your vision impairment or eye disorder other than the use of glasses, contact lenses or successful corrective laser eye surgery to treat long or short sightedness?

Yes ☐ No ☐

▶ If **'Yes,** please complete the **Eye Disorder Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

Ⓕ JOINT PROBLEMS

Yes ☐ No ☐

If **'Yes'**, please indicate if any of the following apply:

	Yes	No
Have you had any problem with a joint other than the shoulder, wrist, elbow, knee or ankle?	☐	☐
Was your joint problem anything other than just a strain or sprain?	☐	☐
Have you had any symptoms or complications from a joint problem in the last two years?	☐	☐
Have you ever had more than five days off work or been on limited duties due to any joint problem?	☐	☐

▶ If **'Yes'**, please complete the **Joint Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

Ⓖ MENTAL OR NERVOUS DISORDER, ANXIETY, STRESS OR DEPRESSION

Yes ☐ No ☐

If **'Yes'**, please indicate if any of the following apply:

	Yes	No
Have you ever been diagnosed with, or suffered from any mental or nervous condition, other than a single episode of emotional or psychological reactions to a stressful situation (limited to bereavement and marriage breakdown)?	☐	☐
Have you had any symptoms or treatment for any mental or nervous condition in the last three years?	☐	☐
Have you ever been referred for specialist psychological or psychiatric counselling, been admitted as an in-patient to any hospital or clinic, or taken any medication for longer than one week for any mental or nervous condition?	☐	☐
Has a mental or nervous condition ever prevented or restricted you from performing any of your occupational duties?	☐	☐

▶ If **'Yes'**, please complete the **Mental Health Questionnaire** listed in the 'Insurance' section on BT Super for Life Internet Banking.

FOR QUESTIONS 2–10, IF YOU ANSWER 'YES' TO ANY QUESTION, PLEASE PROVIDE FULL DETAILS ON THE NEXT PAGE.

❷ If you answer 'Yes' to any of the questions in bold, please complete the appropriate medical questionnaire. To the best of your knowledge, have you ever had, or been told you have had, any of the following conditions listed below?

	Yes	No
Ⓐ Blood disorder (eg anaemia, haemophilia, blood transfusion, leukaemia, lymphoma)	☐	☐
Ⓑ High Blood Pressure or High Cholesterol	☐	☐
Ⓒ Heart or cardiovascular condition (eg **chest pain,** angina, rheumatic fever, heart complaint, blood vessel conditions)	☐	☐
Ⓓ Kidney, bladder or prostate disorder (eg kidney stones, urinary tract infections)	☐	☐
Ⓔ **Bowel,** colon, gastro-intestinal or **reflux** condition (eg hernia, **ulcers** (non mouth), irritable bowel syndrome, colitis, haemorrhoids)	☐	☐
Ⓕ Repetitive Strain Injury (RSI), Chronic Fatigue Syndrome (CFS), Occupational Overuse Syndrome (OSS), Tenosynovitis, Chronic Pain Syndrome or Fibromyalgia	☐	☐
Ⓖ Stroke, Paralysis or Nerve disorder	☐	☐
Ⓗ **Epilepsy** or Fainting Attacks	☐	☐
Ⓘ Any other neurological disorder (eg headaches, dizziness, Multiple Sclerosis, dementia, meningitis, **head injury,** motor neurone disease)	☐	☐
Ⓙ Liver or gall bladder disorder (eg hepatitis, jaundice, haemochromatosis)	☐	☐
Ⓚ **Diabetes**, thyroid or glandular disorder (eg low/ high blood sugar, pancreatic conditions)	☐	☐
Ⓛ **Respiratory or lung disorders** (eg asthma, bronchitis, pneumonia, emphysema, tuberculosis, lung disorder)	☐	☐
Ⓜ Sleep apnoea or any sleeping disorder	☐	☐
Ⓝ Eye, ear, or speech disorder or any other physical impairment	☐	☐

❸ Other than already disclosed, have you in the last 5 years?

	Yes	No
Ⓐ Taken any prescribed medication on a regular or ongoing basis (other than for colds and common flus)?	☐	☐
Ⓑ Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?	☐	☐
Ⓒ Had any other operation, investigation (including genetic tests) or consultation with any health services provider?	☐	☐

❹ Do you CURRENTLY have any other disability, illness, injury or symptoms not already disclosed? Yes ☐ No ☐

❺ Are you contemplating, or have you been told to seek any advice, tests (including genetic tests), investigations or treatments not already disclosed? Yes ☐ No ☐

❻ **Do you intend to claim any benefits from an insurer, or have you been off work for more than a total of 15 calendar days, due to an illness or injury, for which you have not already disclosed?** Yes ☐ No ☐

❼ **Have you been infected with, or exposed to, the Human Immunodeficiency Virus (HIV), suffer from AIDS, or engaged in any activities that are reasonably accepted as having an increased risk of exposure to the virus?** Yes ☐ No ☐

Females Only

❽ **Have you ever had any gynaecological disorder (eg endometriosis, cervical cancer etc) or abnormal results from a PAP smear test?** Yes ☐ No ☐

❾ **Have you ever had any complications with pregnancy?** Yes ☐ No ☐

❿ **Have you ever had breast lumps or an abnormal result from a breast examination?** Yes ☐ No ☐

⓫ **Are you currently pregnant?** Yes ☐ No ☐

If **'Yes',** when is your due date (dd/mm/yyyy)

__ __ / __ __ / __ __ __ __

Please provide full details to any 'Yes' answers in questions 2-10.

If the table in the next column is not relevant to your answer, or space is insufficient, provide more details in an attachment.

Question no. | Disorder / Test / Reason

Date commenced (dd/mm/yyyy) | Date of last symptoms (dd/mm/yyyy) | Degree of recovery %

Full details of investigations and treatment

Name and address of the doctor or hospital

Postcode

Question no. | Disorder / Test / Reason

Date commenced (dd/mm/yyyy) | Date of last symptoms (dd/mm/yyyy) | Degree of recovery %

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Full details of investigations and treatment

Name and address of the doctor or hospital

Postcode

Continued on page 7

Question no. | Disorder / Test / Reason

Date commenced (dd/mm/yyyy) | Date of last symptoms (dd/mm/yyyy) | Degree of recovery %

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Postcode

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Date commenced (dd/mm/yyyy) | Date of last symptoms (dd/mm/yyyy) | Degree of recovery %

Full details of investigations and treatment

Name and address of the doctor or hospital

Postcode

EMPLOYMENT DETAILS — SECTION J

1 What is your current occupation?

Industry

2 What is the current annual income, **after deducting business expenses but before tax?**

$

3 Are you an employee of the Westpac Group? Yes ☐ No ☐

If **'Yes',** please provide your employee number

If you are applying for Salary Continuance or Total & Permanent Disability (TPD), please answer questions 4 to 13.

4 Are any duties associated with your occupation hazardous? (eg working at heights, underground, offshore or underwater, or with explosives, chemicals or high voltage)

If 'Yes', please provide details.

5 Name and address of your current employer or business if self employed *(You are 'self employed' if you are a sole trader, a partner in a business or an employee of your own company or trust)*

Name

Address

Postcode

6 Please provide details of your employment history over the last five years.

Previous occupation

Industry

Date from (dd/mm/yyyy) | Date to (dd/mm/yyyy)

Employed ☐ Self employed ☐

Continued on page 8

Previous occupation

Industry

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Employed ☐ Self employed ☐

Previous occupation

Industry

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Employed ☐ Self employed ☐

Previous occupation

Industry

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Employed ☐ Self employed ☐

7 Please describe the duties of your current occupation and approximate percentage performed for each.

Duties (if manual duties, please describe)	Location (eg office, at home, at site, etc)	%
1		
2		
3		
4		
Total		100

8 Do you have any trade, professional or tertiary qualifications? Yes ☐ No ☐

If **'Yes',** provide details

Qualification

9 How long have you been with your current employer or business (if self employed)?

years months

10 How many hours do you work per week and how many weeks per year do you work in your current occupation?

hours per week weeks per year

11 Do you intend to change your occupation or employment status in the immediate future? Yes ☐ No ☐

If **'Yes',** provide details

When do you anticipate a change?

Type of new occupation?

12 Do you have a second occupation? Yes ☐ No ☐

If **'Yes',** hours worked

per week

Annual income from this occupation

$

Please provide further details below of second occupation, including title, employer and a brief description of duties

13 Have you ever been declared bankrupt, or have any entities owned or controlled by you been placed under administration or into liquidation? Yes ☐ No ☐

If **'Yes',** provide date, circumstances and date of discharge (if applicable)

Date declared (dd/mm/yyyy) / / Date discharged (dd/mm/yyyy) / /

Circumstances

INCOME DETAILS — SECTION K

Please only complete this section if you are applying for Salary Continuance Insurance

PART A – TO BE COMPLETED BY 'EMPLOYEES' ONLY

1 Please detail income earned over the last two years

Description	Year ending (dd/mm/yy) / /	Year ending (dd/mm/yy) / /
Paid salary	$	$
Employer superannuation contributions	$	$
Salary sacrifice (eg motor vehicles, personal superannuation contributions)	$	$
Commission	$	$
Bonuses	$	$
Other *(please specify)*	$	$
Total	$	$

Continued on page 9

PART B – TO BE COMPLETED BY 'SELF EMPLOYED' ONLY
(You are 'self employed' if you are a sole trader, a partner in a business or an employee of own company or trust)

1 What percentage of the business do you own?

%

2 How many people do you employ other than yourself?

Full time

Part time

3 Please detail income earned over the last two years for the business in which you work

Description	Year ending (dd/mm/yy) / /	Year ending (dd/mm/yy) / /
A Total gross income	$	$
B **Less** total expenses	$	$
C **Equals** net profit before tax	$	$
D % ownership	%	%
Multiply D × C	$	$
Add back any personal salary / wages, motor vehicle for personal use, director's fee, personal superannuation	$	$
Total net income earned	$	$

4 Are you currently generating a total monthly net income of at least the same rate as shown for the most recent year in the table above? Yes ☐ No ☐

If **'No',** provide details

Reason for change

Current monthly total net income earned

5 In the event of your total disability, will the business continue to operate? Yes ☐ No ☐

If **'Yes',** please give an estimate of how much new income you would be entitled to receive after:

6 months of total disability $ per month

12 months of total disability $ per month

PART C – TO BE COMPLETED BY ALL APPLICANTS

Do you receive more than $5,000 pa income (after deduction of expenses but before taxation) from: Yes ☐ No ☐

- investments, dividends, rental property or similar (but not including negative geared investments), or
- any business that you have ownership of but don't work in?

If **'Yes',** what is this amount per annum?

$ pa

Pursuit and Pastimes Questionnaires

If you answered *'Yes'* in Section F, only complete the applicable section below and then return to Section G.

SCUBA OR SKINDIVING

1 Are you a qualified diver? Yes ☐ No ☐

If **'Yes',** please provide details

How many dives per annum?

Number of dives over 40m per annum?

2 Do you participate in sink hole, wreck or other hazardous dives or use mixed gases? Yes ☐ No ☐

If **'Yes',** please provide details

AVIATION

1 Do you currently, or intend to hold, an aviation licence? Yes ☐ No ☐

If **'Yes',** please provide details

Type of licence?

Type of aircraft flown?

Charter ☐ OR Private ☐

Number of hours flown last year? hours

Number of intended hours next year? hours

2 Do you always use recognised landing areas? Yes ☐ No ☐

If **'No',** please provide details

3 Have you ever had an accident or been charged by the Civil Aviation Authority? Yes ☐ No ☐

If **'Yes',** please provide details

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4 Do you intend changing the scope of your licence or engaging in any form of aviation other than stated? Yes ☐ No ☐

If **'Yes',** please provide details

MOTOR RACING

1 Do you currently, or intend to, engage in any form of motor racing? Yes ☐ No ☐

If **'Yes',** please provide details

Type of vehicle

Engine size

Maximum speed obtained

kph OR mph

Number of races per annum

pa

Type of racing (eg circuit, rally, gymkhana etc)

Amateur ☐ OR Professional ☐

2 Have you ever suffered any injury whilst engaging in this sport? Yes ☐ No ☐

If **'Yes',** please provide details

OTHER

1 Please indicate if you are currently, or intend to, engage in any of the following activities:

- ☐ Combat sport
- ☐ Hang Gliding and paragliding
- ☐ Mountaineering, Rock Climbing and Abseiling
- ☐ Parachuting and Sky Diving
- ☐ Sailing, Yachting and Power Boat Racing
- ☐ Skiing, Snowboarding and Skating

If **'Yes',** to any of the above, please provide details

Number of times per annum?

pa

Maximum depth or height (if applicable)

metres

Amateur / Professional

Amateur ☐ OR Semi-professional ☐ OR Professional ☐

Competition

Yes ☐ No ☐

2 Have you ever suffered any injury whilst engaging in this activity? Yes ☐ No ☐

If **'Yes',** please provide details

DECLARATION AND AGREEMENT SECTION L

I, the Insured Person or legal representative of the Insured Person, declare and agree that:

- I have read and understood this completed form and declare that the statements made and the information completed on therein is true and correct as at the date I signed this form.
- I have read and understood the section titled 'Privacy Information' in the Additional Information Booklet and I agree to the various uses and disclosures of my personal information as set out in that section.
- This form will constitute part of my insurance(s) and the basis of my contract with the Insurer.
- I have read and understood my duty of disclosure, details of which are set out in the Additional Information Booklet provided to me.

Account holder signature

Date (dd/mm/yy) / /

MEDICAL AUTHORITY SECTION M

I (full name)

agree that any Medical Practitioner, health care professional, hospital or other health service provider, whether named by me or not, who has been consulted by me, shall be and is hereby authorised and directed by me, to divulge to the insurer, or agent acting on behalf of, all medical or surgical information he/she may have acquired with regard to myself. A photocopy of this shall be considered as valid as the original.

Account holder signature

Date (dd/mm/yy) / /

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