

Please complete this form if you wish to apply to increase, decrease or cancel your Death only (including terminal illness), Death & TPD and/or Income protection insurance cover. Also use this form if you wish to alter your Income protection waiting period. If you are applying for insurance, applying to increase your existing insurance, applying for Income protection cover or applying to decrease your Income protection waiting period you **MUST** complete sections 6-9 of this form. Please complete in pen using **BLOCK** letters. Print 'X' to mark boxes where applicable. Please provide as much information as possible.



Now incorporating
hip
Health Industry Plan

Member Number								Date of Birth (DDMMYYYY)								Title							
																<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr							
Surname																							
Given Names																				Gender			
																				<input type="checkbox"/> Male <input type="checkbox"/> Female			
Residential Address																							
Town/Suburb/City																		State			Postcode		
Employer																							
Occupation																							
Are you a permanent resident of Australia? <input type="checkbox"/> Yes <input type="checkbox"/> No																							
In order to speed up the processing of this application our insurer MetLife may contact you directly for further information. Please include your area code.																							
Preferred Contact Number										Alternative Contact Number								Preferred Time of Contact					
																		<input type="checkbox"/> Morning (9am-12) <input type="checkbox"/> Afternoon (12-6pm)					
Employer																							

When you join Prime Super you automatically receive four (4) units of Death & TPD default cover. In this section you can apply for additional units of Death only (including terminal illness), Death & TPD and Income protection insurance.

Please indicate the type of additional cover you are applying for. ☐ Death only (including terminal illness) ☐ Death & TPD ☐ Income protection

Do you want the cover received in this application to replace your existing cover? ☐ Yes ☐ No

(If you choose no, any cover received in this application will be in addition to your existing cover and any existing cover will be matched to your election. This means if you're applying for fixed cover any existing unutilised cover will also be converted to fixed cover.)

Please choose between unitised cover and fixed cover. You must choose EITHER unitised cover or fixed cover. You cannot have a combination of both. You can only apply for a maximum of \$5 million Death only (including terminal illness) and/or \$3 million Death & TPD insurance.

Death only (including terminal illness) cover units or Death & TPD cover units

☐ **Fixed cover** Please insert the dollar amount of cover you require.

Death only (including terminal illness)	\$			Death & TPD	\$	
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What is your current gross monthly income? \$. (Please refer to the *Short-Form PDS – Superannuation* for the definition of income)

How much cover do you require per month? \$. (You can only insure up to 85% of your monthly income)

What waiting period would you like to apply for? ☐ 30 days ☐ 60 days ☐ 90 days

☐ I want to reduce my waiting period to ☐ 30 days ☐ 60 days ☐ 90 days

☐ I want to increase my waiting period to ☐ 60 days ☐ 90 days

SECTION 4 – OCCUPATIONAL RATINGS

[illegible]

What is the average number of hours you work in a week in your main occupation?	hours
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Please provide a brief description of your duties. _____

1. My work duties are of a clerical, administrative or management nature. ☐ Yes ☐ No

2. My work duties are undertaken within an office environment for 80 percent of the time (excluding travel time between offices). ☐ Yes ☐ No

3. Do your usual work duties require you to perform duties of a manual nature? ☐ Yes ☐ No

PROFESSIONAL

1. I hold a tertiary qualification relevant to my current occupation, am a member of a professional institute, or am a senior member of my organisation's executive team. ☐ Yes ☐ No

2. I earn in excess of \$100,000 per annum from my profession. ☐ Yes ☐ No

SECTION 5 – REDUCE/CANCEL YOUR EXISTING COVER

- | | Units of cover | Fixed cover |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Death only (including terminal illness) | <div style="display: flex; align-items: center;"> <input type="text"/> <input type="text"/> <input type="text"/> units </div> | <div style="display: flex; align-items: center;"> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> |
| Death & TPD | <div style="display: flex; align-items: center;"> <input type="text"/> <input type="text"/> <input type="text"/> units </div> | <div style="display: flex; align-items: center;"> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> |
| Income protection | Not applicable | <div style="display: flex; align-items: center;"> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> per month </div> |

2. I want to cancel my insurance cover within Prime Super.

Please choose **one** option:

☐ I am a **new** Prime Super member and wish to opt-out of Default insurance. I understand that this means I will have no insurance in the Fund and any premiums I have paid will be refunded to my member account. I understand that by requesting this I am opting out of insurance from the inception of my account and that I will not be eligible to make any retrospective insurance claims. If at some point in the future I choose to take out insurance through Prime Super, my application will be subject to the standard underwriting process which may include the need to provide detailed health and medical information.

To be eligible for this option, you must be cancelling your cover **within 60 days** from the date on your Welcome Letter from Prime Super. If it is after the 60 day period, you can still cancel your default insurance cover but any premiums paid will not be refunded to your member account.

☐ I have been a member of Prime Super for longer than 60 days and wish to **cancel** the following insurance I hold with Prime Super. I understand that any cancellation I request will only be effective once my application has been received and processed by the insurer.

☐ Death only (including terminal illness) ☐ Death & TPD (you cannot have more TPD cover than Death only) ☐ Income protection

Please go straight to Section 10.

SECTION 6 – INSURANCE HISTORY

Please note: If you are simply changing your occupational rating (Section 4) you do not need to complete Section 6.

1. Has an application for Life, Trauma, TPD or Disability (Income protection) insurance on your life ever been declined, deferred or accepted with a loading or exclusion or any other special terms or conditions? ☐ Yes ☐ No
2. Have you ever made a claim for, or received, sickness, accident or disability benefits, Workers' Compensation or any other form of compensation due to illness or injury? ☐ Yes ☐ No

SECTION 7 – MEDICAL DETAILS AND HISTORY

1. What is your height? cm
2. What is your weight? kg
3. Have you smoked in the last 12 months? ☐ Yes ☐ No
4. In the last 3 years have you suffered from, been diagnosed with or sought medical advice or treatment for: (please tick all boxes that apply)
- | | | |
|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Headache or Migraines (e.g. tension or cluster headaches or migraines) | <input type="checkbox"/> Lung or Breathing Conditions (e.g. asthma, sleep apnoea) | <input type="checkbox"/> Eyesight Conditions (other than mild short or far sightedness or colour blindness) |
| <input type="checkbox"/> Ear or Hearing Conditions (e.g. hearing loss, tinnitus or swimmers ear) | <input type="checkbox"/> Gout | <input type="checkbox"/> Trapped Nerves (incl. carpal tunnel syndrome, pinched nerve) |
| <input type="checkbox"/> Infectious Diseases (excluding colds and flus) | <input type="checkbox"/> Muscle, Tendon, or Ligament Problems | <input type="checkbox"/> None of the conditions listed above |

Please provide a brief description below:

5. In the last **5 years** have you suffered from, been diagnosed with or sought medical advice or treatment for: (please tick all boxes that apply)

☐ High Blood Pressure ☐ High Cholesterol ☐ Chronic Fatigue/Fibromyalgia

☐ None of the conditions listed above

Please provide a brief description below:

6. Have you **ever** suffered from, been diagnosed with or sought medical advice or treatment for: (please tick all boxes that apply)

<input type="checkbox"/> Bone, Joint or Limb Conditions	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Digestive Conditions
<input type="checkbox"/> Brain or Nerve Conditions (including stroke)	<input type="checkbox"/> Psychological or Emotional Conditions	<input type="checkbox"/> Cancer, Cyst, Growth, Polyps or Tumour
<input type="checkbox"/> Thyroid Conditions	<input type="checkbox"/> Skin Disorder (incl. skin lesions)	<input type="checkbox"/> Genital or Urinary Conditions
<input type="checkbox"/> Auto Immune Diseases	<input type="checkbox"/> Heart Related Conditions	<input type="checkbox"/> Kidney or Liver Conditions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Conditions	
<input type="checkbox"/> None of the conditions listed above		

Please provide a brief description below:

☐ Yes ☐ No

Name

[illegible][illegible][illegible][illegible]

1. Has any first degree blood relative (that is, your mother, father, any brother, sister, or child) either living or deceased been diagnosed, under the age of 55 years, with any of the following conditions: Alzheimer's Disease, Cancer, Dementia, Diabetes, Familial Polyposis, Heart Disease, Huntington's Disease, Polycystic Kidney Disease, Multiple Sclerosis, Muscular Dystrophy, Stroke or any inherited or hereditary disease?

☐ Yes ☐ No ☐ Unknown

Relationship to proposed insured	Age at diagnosis	Specific condition(s)

☐ Yes ☐ No

Country	Length of Stay

☐ Water Sports (Underwater diving, rock fishing)

☐ Aviation (other than as a fare paying passenger on a commercial airline)

☐ Combat Sports or Martial Arts (martial arts, boxing, fencing)

☐ Any activity not mentioned above
(e.g. abseiling, base jumping, caving, free climbing, outdoor rock climbing) (if selected please provide details below)

☐ Motor Sports (motorcycle, auto, motor boat)

☐ Hunting (of any kind)

☐ Field Sports (hockey or football of any code including soccer)

☐ Sky Sports (skydiving, hang gliding, parachuting, ballooning)

☐ Horse Sports (polo, horse riding, rodeo, dressage, jumping)

☐ None of the activities listed above

3. Have you within the last **5 years** used any drugs that were not prescribed to you (other than those drugs available over the counter) or have you exceeded the recommended dosage of any medication?

☐ Yes ☐ No

If **Yes**, please give details in the table below:

Drug/Medicine	Reasons for Use

4. On average, how many standard alcoholic drinks do you consume each week? (a standard drink is equivalent to either a 125ml glass of wine, a schooner of light beer, a middy/pot of full strength beer or a 30ml shot of spirits) _____ / week

5. Have you ever been advised by a health professional to reduce your alcohol consumption?

☐ Yes ☐ No

6. Do you currently have HIV (Human Immunodeficiency Virus) that causes AIDS (Acquired Immune Deficiency Syndrome)?

☐ Yes ☐ No

If No, are you in a high risk category for contracting HIV that causes AIDS?

☐ Yes ☐ No

7. Other than already disclosed in this application, do you presently suffer from any condition, injury or illness which you suspect may require medical advice or treatment in the future?

☐ Yes ☐ No

If **Yes**, please give details below

SECTION 10 – DUTY OF DISCLOSURE

Please note that your duty of disclosure continues until cover is accepted. Before you enter into a contract of life insurance with an Insurer, you have a duty, under the *Insurance Contracts Act 1984*, to disclose to the Insurer every matter that you know, or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to the Insurer before you vary or reinstate a contract of life insurance.

Your duty however does not require disclosure of a matter:

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

NON-DISCLOSURE

If you fail to comply with your duty of disclosure and the Insurer would not have entered into the contract on any terms if the failure had not occurred, the Insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract at any time. An Insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

YOUR PRIVACY WITH METLIFE INSURANCE LIMITED ABN 75 004 274 882 AFSL 238096 ('METLIFE' AND THE 'INSURER')

If you make a claim under this policy the Insurer may conduct investigations to assess the value and validity of the claim. This may involve the use of third parties, including investigation agents, legal advisors and the collection of personal and sensitive data that MetLife Insurance Limited believes is relevant. MetLife Insurance Limited complies with the *Privacy Act 1988* and the principles laid out in its privacy policy which details how MetLife collects, uses, protects and discloses your personal information generally. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

YOUR PRIVACY AS A MEMBER OF PRIME SUPER

The information you provide in this form is collected by and held for Prime Super by the fund Administrator, in accordance with the Australian Privacy Principles of the Privacy Act. Such information is usually disclosed to third parties, including the Insurer or medical consultant who may be involved with the assessment of this application, and is held by the fund Administrator and the Insurer. For further information about privacy or to obtain a free copy of our Privacy Policy, please visit our website www.primesuper.com.au or by contacting customer service on 1800 675 839, write to us at Locked Bag 5103, Parramatta, NSW 2124 or email us at administration@primesuper.com.au.

SECTION 11 – FETCH MY SUPER

The reality is, if you have ever changed jobs, you have probably **left money behind**. This is your money!

Let us **find it for you**, put it in your Prime Super account, then at least you know where **all your super** savings are!

All you have to do is provide us with your **consent** to do so below. We'll then use the ATO's Super Match facility to find any super you may have then send you the paperwork to sign and send back to us. It's that easy!

Please be aware that this process can take a **number of weeks** so please be patient. We will communicate with you regularly via email to keep you informed. If we don't have your email address on the system, please provide it in the *Personal details* section.

Tick the box to consent ☒

- ☐ I hereby authorise Prime Super to use my personal details, including my TFN, to search – now and forever – for any lost, unclaimed, inactive or active super I may have with other funds or the ATO, as permitted under the *Superannuation Industry (Supervision) Act 1993 (Cth) and Regulations*.

- ☐ I understand that all of the information I provide – including the TFN held by Prime Super – must be correct before this search can be conducted on my behalf. If the information is incorrect, Prime Super will notify me directly and I will be responsible for updating the information by calling **1800 675 839** or doing so directly via the secure section of the Prime Super website at **www.primesuper.com.au**

- ☐ I understand that the process of finding my super may take some time and it could be a number of weeks before I receive the paperwork in the mail.

Full Name _____

[illegible]

Member Signature _____

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SECTION 12 – DECLARATION

I declare that:

- I have read and understand my duty of disclosure and understand that this duty applies until formal notification of acceptance.
- My answers to the questions are true, and I have not deliberately withheld any information material to the proposed insurance.
- I agree to be bound by the terms and conditions set out in the Insurance Policy Document (between Prime Super and the Insurer).
- I consent to the collection, use and disclosure of personal information by MetLife and its service providers in order to assess my application and any claim under the policy.
- I have read and understood the Privacy Statement and agree to the collection, use and disclosure of personal information as described.
- I consent to MetLife seeking medical information from any doctor who I have consulted.
- I understand that any changes to my insurance cover (an increase or reduction/cancellation of cover) under a policy does not begin until acceptance by the insurer, of which I will be notified in writing.
- I have read the insurance section of the current *Short-Form PDS – Superannuation*.
- I authorise any hospital, physician or other person who has attended me to furnish MetLife or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, treatment, and copies of all hospital or medical records. I agree that a photocopy of this authorisation shall be considered as effective as the original.

[illegible][illegible]

Member Signature _____

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WHERE TO SEND THIS FORM

Once completed please return this form to us via mail, fax or email.

Mail Prime Super
Locked Bag 5103
Parramatta NSW 2124

Freecall 1800 675 839

Fax 1800 023 662

Email administration@primesuper.com.au

If you have any questions about this form or Prime Super please call us on **1800 675 839** (8.00am to 8.00pm Monday-Friday Sydney time).