Request for Insurance/ Personal Statement

Please complete this form if you are applying for:

- **more than $1m Death & TPD cover,**
- **more than $8,000 per month in Income protection benefits, or**
- **you answered 'yes' to any of the Health/Lifestyle questions in the *Short-form Personal statement.***

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Part of your Community

Now incorporating hip Health Industry Plan

SECTION 1 – PERSONAL DETAILS

Member Number

Date of Birth (DDMMYYYY)

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

Surname

Given Names

Gender ☐ Male ☐ Female

Postal Address

Town/Suburb/City

State

Postcode

Phone Number (BH)

Phone Number (AH)

Mobile Number

Email

SECTION 2 – INSURANCE DETAILS

Please specify the type of insurance cover being applied for:

☐ Death only cover ☐ Death and TPD ☐ Income protection

SECTION 3 – EMPLOYMENT DETAILS

Current employer's name

What is your current occupation?

What professional or trade qualification do you have?

Date you started with your CURRENT employer (DDMMYYY)

What is your annual salary? $

MySuper APPROVED

we're an INDUSTRY Superfund

Issued by Prime Super Pty Ltd ABN 81 067 241 016 AFSL 219723 RSE L0000277 Trustee of Prime Super ABN 60 562 335 823 RN 1000276

PrimeH-161_0514 PS1025.2 04/14 ISS1

SECTION 4 – ADDITIONAL DETAILS

1. Are you in receipt of or have you ever made a claim for any type of accident or sickness (including lump sum total and permanent disablement, workers' compensation or third party insurance benefit) or have you ever applied for unemployment, sickness or accident benefits or other Centrelink or Veterans' Affairs Benefits? ☐ Yes ☐ No

If YES, please provide details below

2. Have you ever had an application for insurance on your life declined, postponed, cancelled, accepted with an exclusion or a higher than standard premium, or modified in any way? ☐ Yes ☐ No

If YES, please provide details below

3. Are you covered by, or are you applying for other life, disability, critical illness, or income protection insurance with any company including MLC (other than this application) – including benefits under superannuation? ☐ Yes ☐ No

If YES, give details for each. If there is not enough space here, please list at Question 18, page 5

Type of Insurance

Commencement Date (DDMMYYYY)

Company

Policy Number

If income protection

Sum Insured or Monthly Benefit

Waiting Period

Benefit Period

Is this application replacing this insurance? ☐ Yes ☐ No

$

4. Do you now engage or do you intend to engage in any of the following activities?

a. Flying as a pilot or crew in an aircraft ☐ Yes ☐ No

b. Motor car, motor cycle or motor boat racing ☐ Yes ☐ No

c. Underwater diving ☐ Yes ☐ No

If you answered YES to a, b or c, complete the *Supplementary Pastimes Questionnaire* on page 11

d. Football, parachuting, hang-gliding ☐ Yes ☐ No

e. Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain climbing, mountain biking, downhill mountain biking) ☐ Yes ☐ No

If you answered YES to d or e, give details for each below. If there is not enough space here, please list at Question 18, page 5

Activity ☐ Amateur ☐ Professional

Location

Events/Hours per year

Other details

SECTION 5 – HEALTH AND MEDICAL HISTORY

1. What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the doctor you last visited) If you have known this doctor for less than 12 months, please also advise your previous doctor's details at question 18 on page 5. **This question must be completed**

Doctor's name or medical centre

Address

Town/Suburb/City

State

Postcode

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

Business Phone Number

How long have you been attending this practice? years months

Please provide details of your last check-up or consultation. Date of last consultation (DDMMYYY)

Reason for last check-up or consultation

Result

Medication prescribed, referral given or tests ordered

2. Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition? ☐ Yes ☐ No

3. In the past three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?
Note – HIV risk situations are situations in which you have been potentially exposed to HIV infection. These situations include but are not limited to, intercourse with someone you know or suspect to be HIV positive, intravenous drug use, or unprotected anal intercourse, (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years) ☐ Yes ☐ No

If YES, a confidential questionnaire will be sent out to you to complete and return to MLC's Chief Underwriter.

4. Have you ever had any of the following conditions?

a. Asthma (questionnaire on page 12) ☐ Yes ☐ No

b. any cyst, mole or skin lesion requiring medical advice or treatment (questionnaire on page 12) ☐ Yes ☐ No

c. a strained back, sciatica, whiplash, spondylitis or any other back, neck or spinal problem (if applying for GSC or TPD, questionnaire on page 15, otherwise give details at question 16) ☐ Yes ☐ No

d. any disorder of the bones, joints or muscles, arthritis, gout or repetitive strain injury (questionnaire on page 16) ☐ Yes ☐ No

e. treatment or counselling for depression, or any nervous, anxiety, stress or mental disorder (questionnaire on page 14) ☐ Yes ☐ No

f. high blood pressure or high cholesterol (questionnaire on page 13) ☐ Yes ☐ No

If you answer YES to a, b, c, d, e and/or f, please complete and submit the relevant supplementary questionnaire from pages 10 to 15.

5. Further medical requirements may be necessary to assess your application (eg. Blood tests, Medical exam).
Do you wish MLC to arrange these? ☐ Yes ☐ No

If **NO**, you will be advised what requirements to organise.

If **YES**, MLC's provider will contact you directly.

6. Do you drink alcohol? ☐ Yes ☐ No

Number of standard drinks:

per day **or** per week **Note:** 1 standard drink = 1 glass of beer/wine/nip of spirit

7. Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months? ☐ Yes ☐ No

What type? eg cigarettes, gum, patch Daily quantity

8. What is your height? cm What is your weight? kg

9. Do you currently have or have you ever had any of the following? **If you answered YES to any item in this question please give details at Question 16.**

a. Heart complaint ☐ Yes ☐ No

b. Epilepsy or any neurological disorder ☐ Yes ☐ No

c. Stroke or vascular disorder ☐ Yes ☐ No

d. Lung complaint ☐ Yes ☐ No

e. Diabetes, bowel, kidney or bladder disorder ☐ Yes ☐ No

f. Alcohol or drug dependence ☐ Yes ☐ No

g. Professional advice to reduce alcohol consumption ☐ Yes ☐ No

h. Migraine, persistent headache or chronic fatigue ☐ Yes ☐ No

i. Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease ☐ Yes ☐ No

j. Cancer or leukaemia ☐ Yes ☐ No

k. Haemophilia or blood disorder ☐ Yes ☐ No

l. Thyroid disorder ☐ Yes ☐ No

m. Liver disorder, hepatitis or test indicating past or present hepatitis infection ☐ Yes ☐ No

n. Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat ☐ Yes ☐ No

o. Any other operation, disability, illness or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned ☐ Yes ☐ No

10. Other than already stated, have you in the last 5 years:

a. Taken any prescribed medication on a regular or ongoing basis? (Other than for colds or flu) ☐ Yes ☐ No

b. Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist? ☐ Yes ☐ No

If you answered YES to any item in this question please give details at Question 16.

11. Do you currently have any other disability, illness, injury or symptoms not already mentioned? ☐ Yes ☐ No

If you answered YES to this question please give details at Question 16.

12. Are you contemplating seeking any medical advice, test, investigation or treatment? ☐ Yes ☐ No

If you answered YES to this question please give details at Question 16.

Males: Go to Question 16.

Females Only

13. Have you had any complications of pregnancy or childbirth? ☐ Yes ☐ No

If YES give details at Question 16.

14. Are you currently pregnant? ☐ Yes ☐ No

Date due (DDMMYYYY)

15. Have you ever had an abnormal pap smear? ☐ Yes ☐ No

When (DDMMYYYY)

Treatment

Date (DDMMYYYY)

Result of most recent pap smear

16. Did you answer **YES** to any item in Questions 4(c), 9, 10, 11, 12 and 13?

☐ No Go to next question

☐ Yes Give full and accurate details below of each instance. If you are completing any of the questionnaires at the back of this application, you do not need to give the same details here. If there is not enough space here, please list at question 18.

Question number in Section 5	Illness, injury, condition or test	Test results	When did it start?	When did it cease?	Type of treatment and when treatment ceased	How long off work?	Have you completely recovered?	Name and address of institution and attending person

17. Have any of your parents, brothers or sisters (living or deceased) suffered from any of the following? ☐ Yes ☐ No

- Cancer (specify type and site)
- Diabetes
- Huntington's disease
- Familial polyposis
- Heart disease
- Kidney disease
- Motor neurone disease
- Any other hereditary disorder
- Stroke
- Rheumatoid arthritis
- Muscular dystrophy
- Multiple sclerosis

If YES, please provide details below

Relationship	Medical condition	Cancer type and site	Age condition began	Age at death (if applicable)

18. Further information

You can use this space to provide further information. Please note the page and question number the additional information refers to.

Page Number	Question Number	Further Information

SECTION 7 – DUTY OF DISCLOSURE AND DECLARATION

Read this section carefully before signing.

DUTY OF DISCLOSURE

Insurance Contracts Act 1984

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 which 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 such a contract of life insurance is extended, varied or reinstated.

Your duty, however, does not require a disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer;
- That is of common knowledge;
- That your insurer knows or, in the ordinary course of business, ought to know;
- For which your duty of compliance 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 three 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 three years of entering into it, elect not to avoid it but 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 Duty of Disclosure continues until the Contract of Life Insurance has been accepted by the insurer and confirmation in writing is issued. It also applies if you seek to extend, vary or reinstate the Contract.

DECLARATION

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

I understand and agree that:

a. I have read the Duty of Disclosure set out on above. I understand that, until MLC accepts this application, I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to MLC's acceptance of this application and that if I fail to comply with my duty of disclosure MLC may (as permitted by law) decline to pay, or reduce our liability to pay, the benefits under this policy;

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

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

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

e. This insurance application is not effective until MLC accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;

f. I was actively at work performing the normal duties of my occupation when I applied for this insurance;

g. All statements and declarations given by me on this form are true and correct; and

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

I authorise MLC to:

a. Collect further medical information from any doctor, medical centre, hospital or any other health service provider identified by me in this application for the purpose of assessing my application for insurance; and

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

c. Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at question 1 of section 5, Health and Medical History; and

d. Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at question 1 of section 5, Health and Medical History unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

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

YOUR PRIVACY WITH MLC LIMITED ABN 90 000 000 102 AFSL 230694 ('MLC' AND THE 'INSURER')

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

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

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.

CONSENT

I consent that where my application is declined, loaded and/or an exclusion is applied, **MLC** may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance. I understand that I can withdraw this consent at any time by contacting **MLC** on **(02) 8908 6111** or email **group_insurance@mlc.com.au**

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

I acknowledge that MLC Group Insurance does not represent a deposit with or liability of NAB Limited or any other member of the National Group of companies (other than a liability of MLC Limited). Neither NAB Limited, nor any other company in the National Group of Companies (other than MLC Limited as insurer) guarantees or accepts liability in respect of MLC Group Insurance.

Signature of Life to be Insured

Date (DDMMYYYY)

YOU MUST SIGN THE MEDICAL AUTHORITY ON PAGE 8.

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

☐ No Please return pages 1 to 8 of the completed form.

☐ Yes Please return pages 1 to 16 of the completed form INCLUDING any completed questionnaires.

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).

This page has been intentionally left blank

(Do not detach)

Medical Authority

Please sign and date
MLC Limited
ABN 90 000 000 402 AFSL 230694

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Authority to obtain a report from a medical practitioner or hospital.

I request and authorise any doctor/hospital/clinic to supply MLC and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction.

A photocopy of this authorisation shall be as valid as the original.

Print Name

If married, what is your maiden name?

Signature of Life to be Insured

Date (DDMMYYYY)

Pathology Request for Insurance

This must be completed when a blood test is required.

MLC Limited
ABN 90 000 000 402
AFSL 230694

MLC Nominees Pty Limited (Trustee)
ABN 93 002 814 959 AFSL 230702
RSE L0002998

The Universal Super Scheme
ABN 44 928 361 101 R1056778
Superannuation Fund Number 281 440 944

Life to be Insured's Details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

Date of Birth (DDMMYYYY)

Gender ☐ Male ☐ Female

Surname

Given Names

Policy name

Policy number

Family doctor or hospital – name and address

Town/Suburb/City

State

Postcode

Report and account to	**Collection date and time**	**Tests required**
Chief Medical Officer MLC Group Insurance PO Box 200 North Sydney NSW 2059 Phone: 133 442	Date of Birth (DDMMYYYY) Time of appointment	☐ Multiple Biochemical Analysis 20 (Chol. (HDL & LDL), Trigs., Glucose, Creat., Uric acid, LFTs, Electrolytes), and Hepatitis B and C serology ☐ HIV Antibodies ☐ Other (specify)

Life to be Insured's consent (not to be signed prior to attendance)

I give my consent to the tests nominated above including any reflex testing for Hepatitis B and C to be performed. Where one is for the presence of antibodies to the AIDS virus (HIV), I acknowledge that I have read the material provided by MLC (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to MLC Limited and to my family doctor as shown above.

☐ No
☐ Yes

Signature of Life to be Insured

Date (DDMMYYYY)

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

INFORMATION ABOUT THE HIV ANTIBODY BLOOD TEST

To fully assess this application for insurance, we may request you undergo an HIV antibody blood test. This test could be arranged through your own doctor, by consulting a doctor arranged by us or directly with the pathology laboratory. This test is completely voluntary. However, if you refuse the test, it could affect our willingness to accept this application.

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV) which destroys some of the white blood cells in our bodies. These white blood cells help protect our bodies against infection and cancers. Some people infected with HIV therefore suffer infections or cancers and, in some cases, direct damage to the brain by the virus. The most recent evidence suggests that the virus will persist in the body indefinitely. As yet, there is no cure for AIDS.

Following infection, there may be mild flu-like symptoms or no symptoms at all. The body subsequently manufactures antibodies to the virus, usually within 8 to 12 weeks, but occasionally longer. These antibodies can be detected by a blood test and this is the test proposed. The infected individual may remain free of symptoms for many years, but during this time may pass on the infection to others. The first symptoms may include weight loss, fever, swollen glands, diarrhoea, coughs, cancer or nervous system diseases.

A positive result

If the result of the HIV antibody test is positive, this means:

1. You have been infected by HIV,
2. You can pass this infection:
   (a) to any unprotected sexual partner,
   (b) to anyone receiving your blood, donated organs or semen,
   (c) if you are an intravenous drug user, to anyone sharing syringes or needles with you,
   (d) if you are a woman, to a baby during pregnancy, and perhaps at birth or by breast feeding.

There is no evidence that the virus can be spread by other types of contact, such as touching, sharing eating utensils, coughing, sneezing or from mosquito bites.

3. Full AIDS is notifiable throughout Australia. In some States and Territories, HIV infection and other early stages of the disease are also notifiable to the health authority. In most cases, notification is by name and address, though in some States, it is by code.
4. Knowing that you are HIV antibody positive has legal consequences in all States and Territories, although they vary. It may exclude you from some jobs and from access to some services. It can be an offence to knowingly transmit the virus or put someone at risk of infection through sexual activity. There are quarantine provisions which may be used if the authorities consider it appropriate.
5. In many cases, the full effects of AIDS will develop at some stage and the long-term outlook is still uncertain. As a result, life and disability insurance is unlikely to be available to anyone infected with HIV.

If the result of the test is positive, it is important that you receive appropriate counselling from a doctor. You are asked to nominate your family doctor to give you this counselling in the consent declaration contained in the Application form, see Section 5. You may wish to nominate an alternative doctor. We will pass a positive result on to that doctor for onward communication to you.

A negative result

If the result of the HIV antibody test is negative, this means, either that you have not been infected or that you have been infected recently but your body has not yet had time to manufacture antibodies. However, you should be alert to the risk of becoming infected and refrain from activities which make that possible – particularly unsafe sexual practices and sharing of syringes or needles.

The choice is yours

You may choose not to have the test for a variety of reasons, eg you may feel you would not be able to cope with the knowledge of a positive result and the medical implications which follow, or you may be concerned about the social implications (discrimination, stigma, etc). You may feel that you would like more information first, in which case you are advised to seek advice from your own doctor. If you do not have one, or would prefer advice from elsewhere, you should see a specialist counsellor on the subject. Government and community organisations provide AIDS counselling services.

If you choose to have the test arranged by us, we are concerned to protect your privacy. The result will be sent under confidential cover to our Chief Medical Officer. A positive result will not be transferred to our general records on your application for insurance.

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

Supplementary Pastimes Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

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UNDERWATER DIVING

1. Do you hold a diving qualification? ☐ Yes ☐ No

If **YES**, type of qualification and time held _____

_____

_____

2. How many dives do you make per year? _____

3. What is the average depth of dives? _____ metres

4. What is the maximum depth of dives? _____ metres

5. Do you ever dive alone? ☐ Yes ☐ No

6. Do you dive in caves, potholes, or at night? ☐ Yes ☐ No

If **YES**, give details _____

_____

_____

7. Do you use mixed gases to dive? ☐ Yes ☐ No

If **YES**, give details _____

_____

_____

8. Have you ever had an accident whilst diving or suffered an injury? ☐ Yes ☐ No

If **YES**, give details _____

_____

_____

MOTOR CAR, CYCLE OR BOAT RACING

9. What vehicle type do you race? _____

_____

10. In what events and categories do you race?
(Please use CAMS category descriptions where applicable)

_____

_____

11. What is the engine size? _____

12. What maximum speed is reached? _____

13. How many times do you race per year? _____

AVIATION

14. Do you hold an aviation licence? _____

☐ No **Go to Question 16**

☐ Yes

If **YES**, type of licence and period of time held _____

_____

15. Do you intend to change the scope of your licence, or engage in any other form of aviation other than as shown in question 14 above? ☐ Yes ☐ No

If **YES**, Give details, including the qualifications you intend to obtain

_____

_____

_____

16. Please complete number of flying hours in the following table

	Last year		Future average	
	Crew	Passenger	Crew	Passenger
Commercial Airline				
Charter				
Private				
Aero club / Flying school				
Agriculture				
Ultralight				
Helicopter				

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

Supplementary Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

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ASTHMA QUESTIONNAIRE

1. When did you have your first episode? _____

2. How frequently do you need to use medication (inhalers, tablets, etc.)?

3. Approximately how many episodes occur per year? _____

4. When was your most recent episode? _____

5. How much time have you lost from work due to asthma in the past 12 months?

6. Have you ever been hospitalised for this condition or needed to attend a hospital, casualty or doctor's surgery for urgent treatment? ☐ Yes ☐ No

If **YES**, please provide names of hospitals, doctors and dates

7. Have you consulted any other doctor for this condition? ☐ Yes ☐ No

If **YES**, please provide names of hospitals, doctors and dates

8. Are you now taking medication or have you used any medication (including steroids) within the last 12 months? ☐ Yes ☐ No

If **YES**, please provide name of drug, daily dosage and date ceased (if applicable)

9. Do you record your own peak flow levels? ☐ Yes ☐ No

Please provide details of how often you record your own peak flow levels and on average what the results are.

CYST / MOLE / SKIN LESION QUESTIONNAIRE

1. Site _____

2. Date diagnosed (DDMMYYYY) ☐☐☐☐☐☐☐☐

3. Type _____

4. Was the cyst/mole/skin lesion removed? ☐ Yes ☐ No

If **YES**, when? _____

By what method? (eg surgically, freezing or otherwise)

5. Were any special tests, investigations or treatments required? ☐ Yes ☐ No

If **YES**, please provide details _____

6. Was the growth reported to be malignant or benign by your treating doctor?

☐ Malignant ☐ Benign

Please forward copies of any histopathology reports you have.

7. Have you been or are you required to attend for any further treatment or follow-up since the original removal including re-excision of the lesion? ☐ Yes ☐ No

If **YES**, please provide details of date(s) and what was advised

8. Name and address of doctor consulted

Doctor's Name

Address

Suburb

Postcode

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

Supplementary High Blood Pressure / High Cholesterol Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

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1. (a) What was your last blood pressure/cholesterol reading, and when was this taken?

Blood pressure

Systolic ☐☐☐ Diastolic ☐☐☐ Date (DDMMYYYY) ☐☐☐☐☐☐☐☐

Cholesterol

Systolic ☐☐☐ Date (DDMMYYYY) ☐☐☐☐☐☐☐☐

(b) Is this reading consistent with others when checked? ☐ Yes ☐ No

If **NO**, what is your typical reading?

_____

2. When are you due for your next checkup? _____

_____

3. How often are you required to attend your doctor for review/checkups?

☐ Monthly ☐ Quarterly ☐ Twice yearly ☐ Annually

4. When were you first told you had raised blood pressure/raised cholesterol levels?

_____

5. Are you currently taking medication for your blood pressure/cholesterol levels? ☐ Yes ☐ No

If **NO**, **go to Question 7**

If **YES**, provide names of medication and daily dosage

_____

_____

_____

6. Has your treatment (type or dosage) been changed within the last 12 months? ☐ Yes ☐ No

If **NO**, **go to Question 8**

If **YES**, when was it changed?

_____

What was changed?

_____

Why was it changed?

_____

7. Have you ever been prescribed medication for blood pressure/cholesterol? ☐ Yes ☐ No

If **NO**, how has the condition been managed?

_____

If **YES**, when and why did you cease taking this?

_____

8. What was your last blood pressure/cholesterol reading at the time of diagnosis?

Blood pressure (eg 120/80) Systolic ☐☐☐ Diastolic ☐☐☐

Cholesterol Reading ☐☐☐☐☐☐☐

9. Have you ever undergone or been referred for any other investigations: eg ECG (resting or exercise stress), Echocardiogram, 24 hr Holter monitoring, urinalysis? ☐ Yes ☐ No

If **YES**, what were the results?

_____

Who holds the results of any investigations (eg GP)?

_____

10. Has an underlying cause been found for your raised bloodpressure/cholesterol? ☐ Yes ☐ No

If **YES**, please provide full details

_____

Please return this completed form to Prime Super Locked Bag 5103 Parramatta NSW 2124
Telephone 1800 675 839 Fax 1800 023 662 Email administration@primesuper.com.au Web www.primesuper.com.au

Supplementary Mental Health Questionnaire

Complete this questionnaire only if requested to do so. To be completed by the Life to be Insured. If there is not enough space here please complete additional details at Question 18, page 5.

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1. Please indicate the conditions you have had or received treatment for?

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including Anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Other Please describe _____

2. Please describe your symptoms including the date they started and how long they lasted

_____

_____

_____

3. Has any reason for your condition been identified? ☐ Yes ☐ No

If **YES**, please provide details

_____

_____

_____

4. When was your condition first diagnosed? _____

5. Have you had any recurrences of this condition? ☐ Yes ☐ No

If **YES**, how many times? _____

When? _____

6. Have you ever received any counselling or treatment for this condition? (eg medication, CBT, hospitalisation) ☐ Yes ☐ No

If **YES**, please provide details below

Type of treatment	Date commenced	Date ceased

7. Are you currently receiving treatment? ☐ Yes ☐ No

If **NO**, When did you cease treatment? Date (DDMMYYYY) ☐☐☐☐☐☐☐☐

If **YES**, please advise details:

_____

_____

8. Please provide the names and addresses of doctors you have consulted including the date first and last consulted. Please complete additional details at Question 18, page 5.

Doctor's Name

Address

Suburb Postcode

Date first consulted ☐☐☐☐☐☐ Date last consulted ☐☐☐☐☐☐

9. Has your condition ever caused you to lose time from work? ☐ Yes ☐ No

If **YES**, please provide details

_____

_____

_____

10. Are you limited in your ability to work or to perform your activities of daily living as a result of this condition? ☐ Yes ☐ No

If **YES**, please provide details

_____

_____

_____

11. Do you continue to experience symptoms? ☐ Yes ☐ No

If **NO**, go to Question 12

If **YES**, go to Question 13

12. When did you last experience symptoms? _____

_____

13. Describe your symptoms? _____

_____

_____

_____

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Supplementary Back/Neck Disorder Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

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1. When did you first suffer from a back/neck disorder?

2. What is the cause of your back/neck disorder?

3. What is/was the exact nature of the back/neck disorder including symptoms?

4. What area of your back/neck is affected?

5. Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted and approximate dates.

Name

Address

Suburb Postcode

Approximate dates (DDMMYYYY) –

Name

Address

Suburb Postcode

Approximate dates (DDMMYYYY) –

6. Have you undergone any x-ray, scan or other test? ☐ Yes ☐ No

If **YES**, Please provide details and results

7. What treatment have you had? (eg physiotherapy, medication, brace, surgery)

8. Are you still undergoing treatment? ☐ Yes ☐ No

If **NO**, when did treatment cease? Date (DDMMYYYY)

9. When did you last experience symptoms?

10. Do you continue to experience symptoms? ☐ Yes ☐ No

If **NO**, **go to Question 13**

11. What are your current symptoms?

12. How often do you experience symptoms?

13. Have you lost time from work due to this disorder?

a. In the last 12 months? ☐ Yes ☐ No

If **NO**, **go to b**

Date from (DDMMYYYY) Date to (DDMMYYYY)

–

–

–

b. Prior to the last 12 months? ☐ Yes ☐ No

If **YES**, please provide full details of all periods of time off work including dates

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Supplementary Joint/Musculoskeletal Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

PRIME SUPER
Part of your Community

Now incorporating hip Health Industry Plan

1. Which joint(s) or area(s) of the body are affected?
(Advise if left or right joint, where applicable)

2. What is/was the nature of the joint disorder, including symptoms?

3. What is the cause of the disorder?

4. When did the symptoms first occur?

5. When did you last experience symptoms?

6. Do you continue to experience symptoms? ☐ Yes ☐ No

If **NO**, go to Question 9

7. What are your current symptoms?

8. How often do you experience symptoms?

9. What treatment have you had?

10. Are you still undergoing treatment? ☐ Yes ☐ No

If **NO**, when did treatment cease? Date (DDMMYYYY)

11. Have you had an x-ray or other test? ☐ Yes ☐ No

If **YES**, please provide details, including dates and results

12. Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted.

Name

Address

Suburb Postcode

Name

Address

Suburb Postcode

13. Have you lost time from work due to this disorder?

a. In the last 12 months? ☐ Yes ☐ No

If **NO**, go to b

Date from Date to

b. Prior to the last 12 months? ☐ Yes ☐ No

If **YES**, please provide full details of all periods of time off work including dates

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