Personal statement

Information sheet

When to use this form

Use this form for the following products issued by N.M. Superannuation Pty Ltd:

- SignatureSuper® members with Simple Protection, Tailored Protection, Business Protection or Rollover Protection insurance cover.
- Resolution Life stand alone group – Group Life (GL) and Group Salary Continuance (GSC) insurance cover.

> ! Please read these instructions carefully before starting this application.

What you need to tell us

When you apply for insurance

When you apply for insurance, the insurer conducts a process called underwriting. It's how the insurer decides 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 in response to their questions is vital to their decision.

The duty to take reasonable care not to make a misrepresentation

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which doesn't fairly reflect the truth.

You have the same duty if anything changes, or you remember more information, while the insurer is processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same duty to take reasonable care not to make a misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

The insurer may later investigate the answers given in your application, including at the time of a claim.

If you don't meet your legal duty

If you don't meet your duty to take reasonable care not to make a misrepresentation, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Note: There may be circumstances where the insurer later investigates whether the information given to them was true, eg the insurer may do this when a claim is made.

If there is a failure to comply with the duty to take reasonable care not to make a misrepresentation, 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 it would've been in if the duty had been met. Therefore, if the person who answers the insurers questions doesn't take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- The insurer may **treat the contract (or your cover) as if it never existed**—the insurer can only do this within three years of your cover starting.
- The insurer may **reduce the amount you've been insured for**—to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told them everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.

Issue date: 1 July 2022
Issued by N.M. Superannuation Pty Ltd ABN 31 008 428 322 (trustee), which is part of the AMP group (AMP).
The insurer of this plan is Resolution Life Australasia Limited ABN 84 079 300 379 (insurer), which is part of the Resolution Life Group.

– The insurer may **vary your cover**—to take into account the information you didn't tell them and put the insurer in the same position as it would've been if you'd told the insurer. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.
– Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

– Whether the person who answered the insurer's questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific their questions were and how clear the information they provided on the duty was.
– What the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms.
– Whether the misrepresentation was fraudulent, and
– In some cases, how long it has been since the cover started.

Before the insurer exercise any of these remedies, they will let you know their reasons and the information they rely on and give you an opportunity to provide an explanation.

If the insurer decides to exercise one of these remedies, they will advise you of their decision and the process to have this reviewed or make a complaint if you disagree with their decision.

Guidance for answering our questions

When answering the insurer's questions, please:

– Think carefully about each question before you answer. If you're unsure of the meaning of any question, please ask AMP before you respond.
– Answer every question that the insurer ask you.
– Don't assume that AMP will contact your doctor for any medical information.
– Answer truthfully, accurately and completely. If you're unsure about whether you should include information, please include it or check with AMP.
– Review your application carefully. If someone else helped prepare your application (eg your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

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

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact AMP immediately.

Genetic test approach

You only need to tell us about any genetic testing you've had or intend having if the total combined sum insured with all life insurers for the benefit(s) being applied for is over the Genetic Test Standard financial limits. You can choose to tell us about a genetic test that you have had where the result was favourable.

However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

Note: Resolution Life complies with the Genetic Test Standard, a copy of the standard can be found at **fsc.org.au/resources/standards**.

For members of superannuation funds

If the insurance you are applying for is offered under your superannuation fund, before you complete and sign this application form you should refer to the current product disclosure statement (PDS) issued by the trustee of your superannuation fund.

The PDS contains important information to help you understand the product and to decide whether it is appropriate for your needs.

Privacy – use and disclosure of personal information

The privacy of your personal information is important to us.

We collect and hold personal information about you so we can provide you with financial products and services and assist you with your ongoing financial needs. If we do not collect this information, we may not be able to provide you with these products and services. We may also use your personal information for other purposes, such as enhancing our customer service and product options, and to inform you of opportunities which may be beneficial to you via direct marketing. Please contact us if you do not want to receive this information.

Personal information may be shared with business areas or companies within the AMP group. We may also provide information to local and overseas entities which provide AMP with administrative, financial, research or other services, other insurers and credit providers, financial advisers, brokers and other organisations authorised by AMP to assist in reviewing customer needs. A list of countries where these providers are likely to be located can be accessed via our **privacy policy**.

We may also disclose personal information to courts, tribunals and disputes resolution bodies, government agencies, and other bodies we are required to provide information to under the law.

The AMP privacy policy (available at **amp.com.au/privacy**) provides more information about how we manage and protect your personal information. It sets out how you can access and correct your information, how you may complain about a breach of privacy and our process for resolving privacy related enquiries and complaints.

Our primary purpose in collecting information about your health is to assess the application for new or additional insurance. We may also use this information for directly related purposes such as deciding whether we need more information from you, arranging reinsurance, assessing future applications for new or altered insurance, and assessing and administering claims.

We will generally collect health information from someone else, such as a doctor, with consent. We need this information to assess the insurance application. If you choose not to provide such consent, we may not be able to process the application.

We may disclose this type of information to:

- the trustees and administrators of your superannuation fund
- the financial adviser or broker responsible for the plan (if any)
- the insurer of the plan
- reinsurers
- medical practitioners
- any person we consider necessary to assist in either the assessment of claims under your Plan or the resolution of complaints
- if required by law, tribunals or government bodies, and
- anyone you have authorised.

Definitions in this application

'**You**' refers to the person to be insured.

'**The insurer**' refers to Resolution Life Australasia Limited.

'**We**', '**Us**' or '**Our**', refers to AMP Limited.

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Please keep this information sheet for your records—
don't return it with your completed form(s).

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Personal statement

Use this form for the following products issued by N.M. Superannuation Pty Ltd:

- SignatureSuper® members with Simple Protection, Tailored Protection, Business Protection or Rollover Protection insurance cover.
- Resolution Life stand alone group – Group Life (GL) and Group Salary Continuance (GSC) insurance cover.

What cover is the person applying for?

- ☐ Death Only
- ☐ Death and Total and Permanent Disability (TPD)
- ☐ Group Salary Continuance (GSC)/Total but Temporary Disability (TTD)/ Income protection (IP)

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

Adviser contact details

Name of company (ie the company you work for)

Contact name

Business phone number

Fax number

Email address

Member details

Title

Given name(s)

Family name

Previous name(s) (if applicable)

Gender ☐ Male ☐ Female

Marital status

Date of birth D D M M Y Y Y Y

Country of birth

Occupation title

Industry

Residential address

Suburb

State

Postcode

Country

Plan name

Plan number

Account number

Reason for underwriting request (eg cover is over the automatic acceptance limit of $X per month for GSC)

Date joined company D D M M Y Y Y Y

Date joined fund D D M M Y Y Y Y

Annual salary $

Effective date of salary D D M M Y Y Y Y

Current Death cover

Additional Death cover requested

Total Death cover

Current TPD cover

Additional TPD cover requested

Total TPD cover

Issue date: 1 July 2022

Member details continued

Current salary continuance cover (per month)	Additional salary continuance cover requested (per month)	Total salary continuance cover (per month)

Important: You have a duty to take reasonable care not to make a misrepresentation. All information is relevant to the insurer's decision to accept your application. The insurer relies on this information to assess your application. Any incorrect information may affect your entitlement to benefits. Please see the information sheet for details of the duty to take reasonable care not to make a misrepresentation.

Your contact details

The insurer may need to contact you between 8.00am and 7.00pm regarding the details of your application.

Daytime phone number	Hours you can be contacted	After hours phone number	Hours you can be contacted

Mobile phone number	Hours you can be contacted	Email address

Residency and travel details

1. a. Are you an Australian citizen or a permanent resident of Australia?

☐ No, proceed to question **1b**

☐ Yes, go to question **2**

b. Are you a New Zealand citizen?

☐ No, please provide details:

☐ Yes, go to question **2**

i. Which country has issued your current passport?

ii. How long have you lived in Australia? years months

iii. What type of visa do you hold?

iv. Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

If **'no'**, do you intend applying for an Australian permanent residency? ☐ No ☐ Yes

If **'yes'**, please advise the date you can make that application. D D M M Y Y Y Y

If applicable, do you have your family residing with you in Australia? ☐ No ☐ Yes

2. In the next 12 months, do you intend to leave Australia and go live in another country? ☐ No ☐ Yes

If **'yes'**, please provide details:

Where	Duration

3. Do you intend to travel outside Australia or New Zealand for holiday or business purposes? ☐ No ☐ Yes

If **'yes'**, please provide details:

Where	When	Duration

Insurance details

4. Other than this application, are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company**? **Note:** This includes benefits under superannuation, business or credit insurance or benefits provided by an employer. ☐ No ☐ Yes

If **'yes'**, please provide details:

Name of company	Type of cover	Sum insured ($)	Date commenced	To be replaced?
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes

(!) **Important notes:** If this application for insurance is intended to replace the existing plan(s) listed in the table above or insurance cover held within the AMP group that is being converted/replaced:

1 When the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim you make to AMP for the insurance applied for and accepted may not be considered.

2 Under takeover terms, the insurance cover to be replaced must have been fully underwritten and not have been accepted under modified or limited underwriting requirements or on takeover terms previously.

3 If the existing insurance is held with us or another company within the AMP group of companies, you authorise:
- us to cancel, or to instruct the other insurer to cancel, that insurance effective the date that the new insurance commences, and
- the other insurer (if any) to cancel that insurance at our request on the basis of this authority.

5. Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way? ☐ No ☐ Yes

If **'yes'**, please provide full details including reason, date, company name and type of cover:

6. In the last five years have you, or do you intend in the next 12 months, to claim unemployment benefits? ☐ No ☐ Yes

If **'yes'**, please provide details:

Benefit type	Date
	/ /

7. Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings? If **'yes'**, please provide details: ☐ No ☐ Yes

Company/benefit type	Reason	Benefit amount ($)	Date
			/ /
			/ /
			/ /

Personal habits

8. a. Have you ever been a smoker or used any sort of tobacco products (including e-cigarettes and/or nicotine replacement products)? ☐ No ☐ Yes

If **'no'**, go to question **9**

If **'yes'**, please advise which of the following apply and quantity consumed.

☐ Cigarettes **Quantity per:** day week month

☐ Tobacco pipes **Quantity per:** day week month

☐ Cigars **Quantity per:** day week month

☐ Nicotine replacement products (please provide details on next page)

☐ E-cigarettes (please provide details on next page)

☐ Other **Please specify substance smoked:**

Member details continued

Personal habits continued

If you have indicated that you use nicotine replacement products, e-cigarettes or any other substance, please answer the following questions.

i. How often are or were these nicotine patches, e-cigarettes or other nicotine products used, replaced or refilled?

ii. What strength? mgs

b. If you have stopped smoking, using tobacco, nicotine replacement products or other substances, please advise when?

month year

c. Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? If **'yes'**, please advise the name of the condition and any treatment received: ☐ No ☐ Yes

Condition

Treatment

9. How many standard drinks containing alcohol do you consume per week on average? [standard drink = 1 nip/30ml of spirits, 1 x 100ml glass of wine, 1 x 250 ml glass of beer] standard glasses per week

10. Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? ☐ No ☐ Yes

If **'yes'**, please advise your alcohol intake amount at that time, reason you were advised and details of any treatment:

11. Have you ever used cocaine, marijuana, ecstasy, heroin or any other recreational drugs, or drugs not prescribed by a doctor? (You don't need to tell us about any paracetamol, anti-histamines or any other over-the-counter medication.) If **'yes'**, please give details, including the type of drug and the date(s) used: ☐ No ☐ Yes

Your health details

Doctor details

12. Name and address of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Name	Address	Phone number

If you have known your doctor for less than two years, please provide details of the previous doctor.

Name	Address	Phone number

13. Date of last consultation with any doctor

D D M M Y Y Y Y

14. Name of doctor that you saw (if same as above, write 'As above')

15. Please advise reason for your last consultation

16. Please advise results/outcome of your last consultation

17. Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes

If 'yes', please provide full details

Personal health history

18. a. What is your: Height ☐ Weight ☐

b. Has your weight varied in the last 12 months? ☐ No ☐ Yes

If **'yes'**, please cross one of the following and provide the amount and the reason: ☐ Gain ☐ Loss

Amount ☐ kg Reason ☐

19. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

a. **Back or neck pain, injury or disorder including slipped disc, sciatica, whiplash** or any other **condition of the neck, middle or lower back** ☐ No ☐ Yes

b. **Disorder, pain or injury of the wrist, elbow, shoulder, hip, knee, ankle** or any other **joints, or arthritis or gout** ☐ No ☐ Yes

c. Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis) ☐ No ☐ Yes

d. **Depression**, **adjustment disorder**, **post-traumatic stress disorder**, **post natal depression**, **major depression** or any other **mood or depressive disorder** ☐ No ☐ Yes

e. **Panic attacks, anxiety**, **attention deficit disorder**, **eating disorder**, **obsessive compulsive disorder** or any other **anxiety disorder** ☐ No ☐ Yes

f. **Schizophrenia**, **psychotic or personality disorder**, **manic or bipolar disorder** or any other **mental health disorder** ☐ No ☐ Yes

g. **Stress**, **fatigue, insomnia** or **sleeplessness** ☐ No ☐ Yes

h. **Chronic fatigue or chronic pain syndrome** ☐ No ☐ Yes

i. Fibromyalgia, fibrositis or myalgia ☐ No ☐ Yes

j. Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury ☐ No ☐ Yes

k. Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy ☐ No ☐ Yes

l. Epilepsy, fit or blackout, migraine or recurrent headaches ☐ No ☐ Yes

m. Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face ☐ No ☐ Yes

n. **High blood pressure or raised cholesterol** (including being advised to take medication or have your levels monitored) ☐ No ☐ Yes

o. Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain ☐ No ☐ Yes

p. Disorder of the blood including anaemia or haemophilia ☐ No ☐ Yes

q. **Asthma** ☐ No ☐ Yes

r. Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder ☐ No ☐ Yes

s. Disorder of the thyroid ☐ No ☐ Yes

t. Diabetes, sugar in the urine or raised blood sugar levels ☐ No ☐ Yes

u. Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones ☐ No ☐ Yes

v. Disorder of the digestive system, gall bladder, stomach, bowel or liver including any changes to your usual bowel habits, hepatitis, haemochromatosis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, irritable bowel syndrome or hernia ☐ No ☐ Yes

w. Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision) ☐ No ☐ Yes

x. Disorder of the ears or speech including hearing loss or tinnitus ☐ No ☐ Yes

y. Disorder of the skin including psoriasis, eczema or dermatitis ☐ No ☐ Yes

z. Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or **skin cancer** or any malignant condition ☐ No ☐ Yes

aa. **Cyst, skin lesion, growth, lump** (including breast lump), **mole or freckle** that has bled, become painful, changed colour or increased in size ☐ No ☐ Yes

ab. Any sexually transmitted infection or disease ☐ No ☐ Yes

(!) If you answered **'yes'** to any of the items in 19, please provide details in the following table, **except** for any condition in bold text above, you need to complete the relevant health questionnaire(s) in section 28 instead. If you answered **'no'** to all items, go to 20.

Personal health history continued

Item no. eg 'f'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

20. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

Males only

a. Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or increase in night urination. ☐ No ☐ Yes

Females only

b. Are you currently pregnant? If **'yes'**, please advise expected delivery date D D M M Y Y Y Y ☐ No ☐ Yes

c. Have you ever had any complications with pregnancy or childbirth? If **'yes'**, please provide details below, including whether resolved after delivery. ☐ No ☐ Yes

d. Have you ever had an **abnormal cervical screening or pap smear test, positive HPV test** or biopsy of the cervix or uterus? ☐ No ☐ Yes

(!) If you answered **'yes'** to any of the items in 20, please provide details in the table below, **except** for any condition in bold text above, for which you should complete the relevant **detailed health questionnaire** in section **28**.

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment and/or results of investigations	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)
	/ /				
	/ /				
	/ /				

Females only – continued

e. Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

f. Have you ever had a breast lump, thickening, unexplained pain or change in the breast or nipples (even if you have not seen a doctor about it)? ☐ No ☐ Yes

Personal health history continued

If **'yes'** for **'e'** or **'f'** please complete table below

Item number	Date	Reason	Results	Follow up required	Name of Doctor	Pending follow up	When
	/ /			☐ No ☐ Yes			/ /
	/ /			☐ No ☐ Yes			/ /

21. Other than what you have already told us in this application, have you in the last **five years** (not including colds or flu):

a. Attended any other medical appointment (eg counselling), or had any other test (eg X-ray, blood) including surveillance tests (eg ultrasounds or colonoscopies), surgery either in Australia or overseas, any preventative or prophylactic treatment (eg a mastectomy), with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists? ☐ No ☐ Yes
Important: Please refer to the **genetic test approach** in the **information sheet** when answering this question.

b. Used or are you currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition? ☐ No ☐ Yes

c. Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than three consecutive days? ☐ No ☐ Yes

(!) If you answered **'yes'** to any of the items in 21, please provide details in the table below. If you answered **'no'** to all items above go to 22.

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery (%)
	/ /			/ /		
	/ /			/ /		
	/ /			/ /		

22. Other than what you have already told us in this application:

a. Have you ever been admitted to hospital for any reason? ☐ No ☐ Yes

b. Are you experiencing any symptoms or complaints for which you have not consulted a doctor? ☐ No ☐ Yes

c. Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery either in Australia or overseas? ☐ No ☐ Yes

If you answered **'yes'** to any of the items above please provide details:

d. Have you, within the last month, **travelled overseas** or **had contact with someone who has recently returned from overseas** or **been exposed to someone suffering/later diagnosed with COVID-19 (also known as coronavirus)**? ☐ No ☐ Yes

e. Have you been **tested for COVID-19**? ☐ No ☐ Yes

(!) If you answered **'yes'** to any of the items in 22 d or e, you need to complete the **COVID-19 (coronavirus) questionnaire** in section 28.

Personal health history continued

23. a. Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection (eg some signs of HIV/AIDS are: unexplained weight loss, swollen glands or persistent diarrhoea)? ☐ No ☐ Yes

b. In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? ☐ No ☐ Yes

Note: HIV risk situations include but are not limited to:
- sex with or as a sex worker
- sex with an intravenous drug user
- contact with someone else's blood (eg through injection or scratch with a used needle)
- anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least three years).

(If you answered **'yes'** to any part of 23 the insurer will send you a confidential questionnaire to complete.)

Family history

24. Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted—go to next question.

☐ Yes—please cross all that apply and provide the details further below:

☐ Breast and/or ovarian cancer
☐ Prostate cancer
☐ Lynch syndrome, familial polyposis or bowel/colon cancer
☐ Polycystic kidney disease, renal cell cancer or kidney cancer
☐ Diabetes
☐ Stroke
☐ Heart attack
☐ Cardiomyopathy
☐ Haemochromatosis
☐ Muscular dystrophy
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Motor neurone disease
☐ Huntington's disease
☐ Alzheimer's disease or any other type of dementia
☐ Any other cancer or any other heart condition
☐ Any hereditary disorder or condition that runs in families

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

25. a. Are you required to have any regular screening due to your family history? ☐ No ☐ Yes

Note: You are only required to disclose family information relating to first-degree blood related family members—living or deceased (mother, father, sisters, brothers or your children).

If **'yes'**, please complete the table below:

Type of regular screening eg mammogram, Prostate Specific Antigen, colonoscopy	How often is this screening performed?	Date of last test	Results including any abnormalities	Doctor consulted
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

Family history continued

b. Are any tests or investigations pending? ☐ No ☐ Yes

If **'yes'** please give details of which tests are pending and when these will be performed.

Sports and pastimes details

26. Have you in the last 12 months, do you currently, or do you intend to take part in any of the following activities?

a. **Aviation (other than a fare paying passenger on a licensed public service)** ☐ No ☐ Yes
b. **Motor racing (including car, bike and boat)** ☐ No ☐ Yes
c. **Underwater diving** ☐ No ☐ Yes
d. Football ☐ No ☐ Yes
e. Motor bike riding, including quad bike riding, trail bike riding and commuting (please specify below) ☐ No ☐ Yes
f. Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports) ☐ No ☐ Yes

ⓘ If you answered **'yes'** to items d, e or f, please provide details of each activity in the table below. For any activity in bold text above please complete the relevant section of 27. If you answered **'no'** to all items above, go to 28.

Item no. eg 'f'	Activity/sport and location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?	Competitive/ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive

27. Detailed sports and pastimes questionnaires

ⓘ Only complete the relevant sections of this question if you answered **'yes'** to 26 a, b or c.

a. Aviation questionnaire

1. Do you hold a Department of Transport licence to fly aircraft? ☐ No ☐ Yes
   If **'yes'**, please state type of licence and period held:
2. Do you intend to change the scope of your present licence? ☐ No ☐ Yes
   If **'yes'**, please provide details:
3. Have you ever had an accident or been charged with violating civil aviation regulations? ☐ No ☐ Yes
   If **'yes'**, please provide details:
4. Do you always use recognised Department of Transport airfields? ☐ No ☐ Yes
   If **'no'**, please provide details:
5. Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft, aerobatics):

27. Detailed sports and pastimes questionnaires continued

a. Aviation questionnaire continued

6. Please provide details of the number of hours flown:
   i. in total as a pilot
   ii. in the last 12 months
   iii. expected each year in the future
7. Do you intend to engage in any form of aviation other than the above? (eg ballooning, paragliding) ☐ No ☐ Yes
   If **'yes'**, please provide details:

b. Motor racing questionnaire

1. What type(s) of motor sports activities do you participate in (eg circuit racing, drag racing, formula racing, karting, rallies, speedway, stock car racing, time trials)?
2. What type(s) of motor vehicles do you drive or crew? Please state the make, model, year of manufacture, engine size, category, group and class details:
3. Please state the nature of your participation:
   ☐ Recreational ☐ Competitive ☐ Sponsored ☐ Amateur ☐ Professional
4. Number of events you participate in: Last 12 months Next 12 months (expected)
5. Where have you, or do you intend to compete or race? Please provide the name of all organised events:
6. What maximum speeds do you reach?
7. Please provide details of your licences/certifications and memberships attained:

Licence/certification or membership details	When attained/ joined
	/ /
	/ /

8. Have you ever had your licence restricted or suspended for any reason? ☐ No ☐ Yes
   If **'yes'**, please provide details:

c. Underwater diving questionnaire

1. What type of diving activities do you participate in (eg snorkelling, scuba diving, free diving)?
2. What diving certification do you hold?
3. Average depth you dive to metres
4. Maximum depth you dive to metres
5. Number of times you dive per year
6. ☐ Professional ☐ Amateur
7. Do your diving activities include pothole, cave or sink hole diving, wreck exploration or any other hazardous diving? ☐ No ☐ Yes
   If **'yes'**, please provide details, including how often:

Sports and pastimes details continued

27. Detailed sports and pastimes questionnaires continued

c. **Underwater diving questionnaire** continued

8. Do you ever dive alone? ☐ No ☐ Yes

   If **'yes'**, please provide details, including where and how often:

9. Have you ever had a diving accident or sickness? ☐ No ☐ Yes

   If **'yes'**, please provide details:

Health questionnaires

28. Detailed health questionnaires

(!) Only complete the relevant health questionnaires, if you answered **'yes'** to any items in bold text in 19 and 20.

a. **Back or neck disorder questionnaire**

1. What was the diagnosis given for your pain/disorder?

   If no diagnosis, proceed to question **2**

2. What part(s) of the back were or are affected? (select all that apply)
   a. ☐ Neck
   b. ☐ Middle
   c. ☐ Lower

3. Have you experienced any of the following (select all that apply): ☐ No ☐ Yes
   a. ☐ Radiation or spread of pain down either the leg or arm (including shooting, stabbing or burning pain)
   b. ☐ Loss of feeling
   c. ☐ Loss of strength
   d. ☐ Pins and needles

   If **'yes'**, give details:

4. a. When did you first have symptoms?

   Date D D M M Y Y Y Y

   b. When was the last time you had symptoms?

   Date D D M M Y Y Y Y

   c. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

   d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

5. When you have pain, how would you rate your pain? Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt?

28. Detailed health questionnaires continued

a. Back or neck disorder questionnaire continued

6. a. Do you know the cause of your pain? ☐ No ☐ Yes

   If **'yes'** › proceed to question **b**

   If **'no'** › proceed to question **7**

   b. What do you think was the cause of your pain (select all that apply)?

   i. ☐ Work

   ii. ☐ Sport

   iii. ☐ Other

   iv. ☐ Unknown

   If you selected any of the above – please provide details:

7. a. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

   If **'yes'**, please provide the details of the total number of days or weeks you had off work

   b. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/disorder? ☐ No ☐ Yes

   If **'yes'**, please provide the details

   If you have answered **'yes'** to 7a or 7b please complete 7c

   c. Please advise which statements apply to you: (select all that apply)

   I had time off work or restricted hours or duties because:

   i. ☐ My work aggravated my pain

   ii. ☐ My work is too heavy for me

   iii. ☐ I think my work may cause further injury or pain

   iv. ☐ Other

   If you selected any of the above – please provide details:

8. a. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

   If **'no'**, please provide the details:

   b. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

   If **'yes'**, please provide the details:

9. Have you ever had investigations such as an X-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

   If **'yes'**, please provide details in the table below:

Date	Investigation	Results(i)	Part of body (eg lower back)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

28. Detailed health questionnaires continued

a. Back or neck disorder questionnaire continued

10. a. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below:

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If **'yes'**, please provide the details in the table below:

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

11. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

If **'yes'**, please provide details:

28. Detailed health questionnaires continued

b. Disorder or injury of the joints questionnaire

1. What was the diagnosis given for your pain/disorder?

   If no diagnosis, proceed to question **2**

2. Please complete one questionnaire for each joint affected

   Note: If both left and right joint is affected please complete one questionnaire for each joint

   In which joint did you or do you have the pain, injury or disorder? (select all that apply)

☐ Shoulder	☐ right	☐ left	☐ Elbow	☐ right	☐ left
☐ Wrist	☐ right	☐ left	☐ Hip	☐ right	☐ left
☐ Knee	☐ right	☐ left	☐ Ankle	☐ right	☐ left

   ☐ Other – please advise which joint right/Left:

3. Have you experienced any of the following (select all that apply): ☐ No ☐ Yes

   a. ☐ Radiation or spread of the pain
   b. ☐ Loss of feeling or strength
   c. ☐ Loss of range of movement
   d. ☐ Pins and needles
   e. ☐ Weakness or instability
   f. ☐ Swelling or
   g. ☐ Other – please advise:

   If selected any of the above, please give details:

4. a. When did you first have symptoms?

      Date D D M M Y Y Y Y

   b. When was the last time you had symptoms?

      Date D D M M Y Y Y Y

   c. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

   d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

5. When you have pain, how would you rate your pain? Scale 0-5 with 0 being no pain and 5 being the worst pain you ever felt?

28. Detailed health questionnaires continued

b. Disorder or injury of the joints questionnaire continued

6. a. Do you know the cause of your pain? ☐ No ☐ Yes

   If **'yes'** > proceed to question **b**

   If **'no'** > proceed to question **7**

   b. What do you think was the cause of your pain (select all that apply)?

   i. ☐ Work

   ii. ☐ Sport

   iii. ☐ Other

   iv. ☐ Unknown

   If you selected i–iii provide details:

7. a. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

   If **'yes'**, please provide the details of the total number of days or weeks you had off work

   b. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/disorder? ☐ No ☐ Yes

   If **'yes'**, please provide the details

   If you have answered yes to 7a or 7b please complete 7c

   c. Please advise which statements apply to you: (select all that apply)

   I had time off work or restricted hours or duties because:

   i. ☐ My work aggravated my pain

   ii. ☐ My work is too heavy for me

   iii. ☐ I think my work may cause further injury or pain

   iv. ☐ Other

   If you selected any of the above – please provide details:

8. a. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

   If **'no'**, please provide the details:

   b. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

   If **'yes'**, please provide the details:

9. Have you ever had investigations such as an X-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

   If **'yes'**, please provide details in the table below:

Date	Investigation	Results(i)	Part of body (eg right shoulder)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession

28. Detailed health questionnaires continued

b. Disorder or injury of the joints questionnaire continued

10. a. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below:

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If **'yes'**, please provide the details in the table below:

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

11. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

If **'yes'**, please provide details:

28. Detailed health questionnaires continued

c. Mental health disorders questionnaire

1. Which of the following mental health disorder(s) do you have or have you had or received treatment or advice for? (select all that apply):
   - ☐ Anxiety, generalised anxiety or panic disorder
   - ☐ Adjustment disorder or post traumatic stress disorder
   - ☐ Obsessive compulsive disorder or attention deficit disorder
   - ☐ Anorexia, bulimia or any other eating disorder
   - ☐ Post natal depression
   - ☐ Depression including major depression, mood or any other depressive disorder
   - ☐ Manic depression or bipolar disorder
   - ☐ Schizophrenia or any other psychotic or personality disorder
   - ☐ Alcohol or substance abuse disorder
   - ☐ Other, please provide details.

2. Please describe your symptoms.

3. What do you think caused your symptoms?

4. When did you first experience symptoms and how long did they last?

5. Has this condition(s) ever required you to take time off work or does/did it impact your ability to perform your normal duties at work? For example, did you need to reduce the number of hours you worked or were your responsibilities or duties changed in any way? ☐ No ☐ Yes

   If **'yes'**, please provide details including time away from work and if there were any changes to your duties

6. Has this condition(s) ever affected your relationships, your ability to socialise with friends or family, your ability to sleep, eat, exercise or play sport? ☐ No ☐ Yes

   If **'yes'**, please provide details.

7. How many episodes of this condition have you experienced? For example, if you were depressed and recovered twice in three years the insurer would say you had two episodes of depression.

8. When was the last time you experienced symptoms?

28. Detailed health questionnaires continued

c. Mental health disorders questionnaire continued

9. Have you ever received any treatment for this condition? ☐ No ☐ Yes

   If **'yes'**, please provide the details in the table below:

Type of treatment, eg counselling or medication etc	Name of medication (if applicable)	Dosage/ frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

10. Have you or are you being treated for this condition by a general practitioner, psychologist, psychiatrist, counsellor or any other therapist? ☐ No ☐ Yes

    If **'yes'**, please provide the details in the table below:

Field of practice, eg Psychologist or therapist etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

11. Are you still receiving treatment for this condition(s)? ☐ No ☐ Yes

    If **'no'**, please advise when you stopped treatment and was it at the direction of your treating health professional?

12. Have you ever not followed the advice of your treating health professional in relation to prescribed medication or other recommended treatment for this condition(s)? ☐ No ☐ Yes

    If **'yes'**, please provide details:

13. Have you ever been hospitalised or an in-patient at a hospital or clinic for this condition(s)? ☐ No ☐ Yes

    If **'yes'**, please provide details in the table below:

Name of hospital/clinic	Dates of hospitalisation	Treatment received
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

14. Have you ever thought about or tried to harm yourself or take your own life? ☐ No ☐ Yes

    If **'yes'**, please provide the name and address of your doctor that would have the details:

15. Have any first-degree blood related family members (father, mother, brother, sister) had a mental health disorder? ☐ No ☐ Yes

    Note: You are only required to disclose family information relating to first-degree blood related family members—living or deceased (father, mother, brother, sister).

28. Detailed health questionnaires continued

d. Stress, fatigue, insomnia and/or sleeplessness questionnaire

1. Which of the following do you have or have you had or received treatment or advice for? (select all that apply)
   - ☐ Stress
   - ☐ Fatigue
   - ☐ Insomnia and/or sleeplessness
2. Did you see a doctor or other health professional for this condition(s)? ☐ No ☐ Yes
3. Were you diagnosed with anxiety, depression or any other mental health disorder? ☐ No ☐ Yes

   If **'yes'**, please go to the **mental health questionnaire**.

   If **'no'**, please continue to complete this questionnaire.
4. Did this condition(s) affect you to the point where you experienced any of the following (select all that apply):
   - ☐ physical symptoms such as headache, dizziness, soreness or irritability
   - ☐ you found it difficult to go to work or were unable to go to work
   - ☐ it had an impact on your relationships
   - ☐ your ability to sleep, eat, or think clearly
   - ☐ problems with concentration, memory or tiredness during the day
   - ☐ it caused you to use alcohol or drugs that were not prescribed for you by a doctor

   If you have answered **'yes'** to any of the above, please provide full details including how much time you had away from work:
5. What do you think caused your symptoms?
6. When did you first experience symptoms and how long did they last?
7. When was the last time you experienced symptoms?
8. How many episodes of this condition have you experienced? For example, if you were stressed and recovered twice in three years we would say you had two episodes of stress.
9. Have you ever been treated for this condition(s)? ☐ No ☐ Yes

   If **'yes'**, please provide full details including type of treatment, name of medication (if applicable) and dates the treatment started and ceased:
10. Please advise how often you see or saw your treating health professional for this condition and provide their name(s) and address(es):

28. Detailed health questionnaires continued

e. High blood pressure or raised cholesterol questionnaire

1. Please indicate which of the following have been raised/high: ☐ Blood pressure ☐ Cholesterol ☐ Both
2. a. When did you first find that your readings/levels were raised or were you advised to have your reading/levels monitored or noted?

   b. What was your reading/level at the time noted in 2a?

   Blood pressure ___/___ Cholesterol ___
3. a. What was the last blood pressure/cholesterol reading, and when was this taken?

   Blood pressure ___/___ Date D D M M Y Y Y Y

   Cholesterol reading ___ Date D D M M Y Y Y Y

   b. Is the reading above consistent with others when checked? ☐ No ☐ Yes

   If **'no'**, what is a typical reading?
4. How often are you required to see your doctor for reviews/check-ups?

   ☐ Monthly ☐ Quarterly ☐ Twice-yearly ☐ Annually ☐ Other—details:
5. When is your next check-up due? D D M M Y Y Y Y
6. Are you currently taking any medication for your blood pressure/cholesterol levels?

   ☐ No, go to question **8** ☐ Yes, please provide the name of any medication you take and the daily dosage

Condition	Medication	Daily dosage
Blood pressure		
Cholesterol		

7. Has your treatment type or dosage changed within the last 12 months?

   ☐ No, go to question **9** ☐ Yes, please provide the details below and continue to question **9**

When was it changed?	What was changed?	Why was it changed?

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

   If **'no'**, how has the condition been managed?

   If **'yes'**, when and why have you ceased taking this medication?
9. Have you undergone or been referred for any other investigations (eg resting or exercise ECG, 24hr holter monitor, urinalysis, echocardiogram)? ☐ No ☐ Yes

   If **'yes'**, please provide details:
10. Has any underlying cause been found for your raised blood pressure/cholesterol? ☐ No ☐ Yes

    If **'yes'**, please provide details:

28. Detailed health questionnaires continued

f. Asthma questionnaire

1. When was your asthma diagnosed? D D M M Y Y Y Y
2. When did you **first** have symptoms? D D M M Y Y Y Y
3. When did you **last** have symptoms? D D M M Y Y Y Y
4. Approximately how many times per year do you or did you get symptoms?
5. Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma (eg dust, sawdust, pollen, grass)? ☐ No ☐ Yes
   If **'yes'**, please provide details:
6. In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma? ☐ No ☐ Yes
   If **'yes'**, please provide details including the number of times and days:
7. Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (eg aerosol spray, tablets or injections, amounts and number of times per day):
8. Have you ever been treated for your asthma with steroids (eg Prednisone)? ☐ No ☐ Yes
   If **'yes'**, please provide details, including dates:
9. Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma? ☐ No ☐ Yes
   If **'yes'**, please provide details:
10. In the last three years, have you had or been advised to have a chest X-ray or respiratory function test? ☐ No ☐ Yes
    If **'yes'**, please provide dates and results:
11. Have you ever had any complications or other conditions related to your asthma (eg cardiac or respiratory arrest, heart disease, chest deformities)? ☐ No ☐ Yes
    If **'yes'**, please provide details:
12. a. Please provide details of the doctor who you consult for your asthma:

    b. When did you **last** consult this doctor for asthma? D D M M Y Y Y Y

28. Detailed health questionnaires continued

g. Cyst, mole, skin lesion questionnaire

1. Please indicate in the relevant box(es), the condition(s) you've had or received treatment for:

- ☐ Mole or naevi
- ☐ Basal Cell Carcinoma (BCC)
- ☐ Hyperkeratosis, solar keratosis or Squamous Cell Carcinoma (SCC)
- ☐ Sebaceous cyst/ lipoma/ fatty cyst just under the skin
- ☐ Melanoma
- ☐ Other lesions (please describe below):

2. Please advise the location(s) of the skin lesion(s):

3. Has the lesion(s) been fully removed? ☐ No ☐ Yes

If **'yes'**, please advise the method and date(s) of removal (eg frozen, 'burnt', lasered off or surgically removed):

If surgically removed, please also advise the pathology results?

If **'no'**, please advise the reason why it has not been removed?

4. Are any follow ups required? ☐ No ☐ Yes

If **'yes'**, please advise details including frequency

5. Give details of your most recent visit to a doctor or hospital relating to this condition:

Date	Medical provider	Address
/ /		

h. Abnormal cervical screening or pap smear test or positive HPV test questionnaire

1. Please indicate in box(es), the relevant condition(s) and or result(s) you've had or received treatment for:

- ☐ Intermediate risk result
- ☐ CIN 1
- ☐ Higher risk result
- ☐ CIN 2
- ☐ Unsatisfactory result
- ☐ CIN 3
- ☐ Carcinoma
- ☐ Atypia or change (caused by infection or irritation)
- ☐ Human Papilloma Virus (HPV)
- ☐ Other abnormality

2. What date was the condition(s) diagnosed?

Condition(s)	Date
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

3. Did you receive any treatment? ☐ Yes ☐ No

If 'Yes' please confirm dates, type of treatment (eg colposcopy, biopsy, laser, LLETZ/loop excision) and results?

4. Have you had a follow up cervical screening or pap smear test? ☐ Yes ☐ No ☐ Awaiting follow up

If 'Yes', please provide all dates and results since the abnormal result?

28. Detailed health questionnaires continued

h. Abnormal cervical screening or pap smear test or positive HPV test questionnaire continued

5. Provide details of your most recent visit to a doctor or hospital relating to the condition/result:

Date D D M M Y Y Y Y

Medical provider

Address

6. When is your next screening due?

i. Diabetes questionnaire

1. Which of the following best describes your condition: (select all that apply)

☐ Type 2 Diabetes ☐ Glucose Intolerance ☐ Type 1 Diabetes
☐ Diabetes Insipidus ☐ Gestational Diabetes ☐ Insulin Resistant
☐ Not sure

2. How long ago were you diagnosed with this condition?

3. How is this condition treated? (select all that apply)

☐ Diet ☐ Oral medication ☐ Insulin
☐ Other:

Please advise details including name of medication, dosage used per day:

4. Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)? ☐ No ☐ Yes

If **'yes'**, please provide details:

5. Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition? ☐ No ☐ Yes

If **'yes'**, please provide details:

6. When did you last have this condition checked by a medical practitioner?

D D M M Y Y Y Y

7. What was the date and the result of your last Glycosylated Haemoglobin test?

8. For gestational diabetes: What was the date and result of your last Glucose Tolerance test?

9. Please provide your doctor's details, including name and address:

Date	Doctor	Address
/ /		
/ /		
/ /		

28. Detailed health questionnaires continued

j. COVID-19 (coronavirus) questionnaire

1. Which of the following apply to the potential risks you've been exposed to within the last month (select all that apply)?
   - ☐ Travelled overseas
   - ☐ Had contact with someone who has recently returned from overseas
   - ☐ Was exposed to someone who suffered and was later diagnosed with COVID-19
2. When did you or the other person return from overseas or when were you exposed? D D M M Y Y Y Y
3. Have you completed the required 14 days self-quarantine/isolation? ☐ No ☐ Yes
4. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? ☐ No ☐ Yes

   If **'yes'**, please provide details:

5. a. If you've been tested for COVID-19 what was the result?
   - ☐ Positive
   - ☐ Negative

   b. If you tested **'positive'** did you have a following COVID-19 test result which was negative? ☐ No ☐ Yes

   c. If you tested **'positive'** were you hospitalised? ☐ No ☐ Yes

   If **'yes'** please provide details in the table below:

Period in hospital	Hospital name and address	Treatment received	Did you spend time in intensive care?
/ / to / /			☐ No ☐ Yes If **'yes'**, number days ____ days

6. If you had symptoms or tested **'positive'** to COVID-19, have you fully recovered with no continuing or residual symptoms or complications? ☐ No ☐ Yes

   If **'no'**, please provide details:

Occupation details

Please complete questions 29 to 42 if you're applying for total and permanent disablement or salary continuance insurance cover.

If you're not applying for either of these please complete the **declaration**, **consent and signature** and **medical authority** sections of this form.

29. Please give details of your current and previous occupation or jobs over the last five years. If you have a second occupation, please give details in question **39**.

	From	To	Occupation	Employer
Current principal occupation	/ /	Present		
		Cross which is applicable	☐ Employed by own company ☐ Partnership ☐ Employee	☐ Self-employed ☐ Contractor
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Partnership ☐ Employee	☐ Self-employed ☐ Contractor
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Partnership ☐ Employee	☐ Self-employed ☐ Contractor
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Partnership ☐ Employee	☐ Self-employed ☐ Contractor
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Partnership ☐ Employee	☐ Self-employed ☐ Contractor

30. In the last five years have you ceased or do you intend to cease working for reasons other than holidays (eg unemployment or end of contract)? ☐ No ☐ Yes

If **'yes'**, please provide details:

31. How many hours per week do you spend working in your main occupation? hours

32. How many weeks per year do you spend working in your main occupation? weeks per year

33. In your **main** occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	(%)
Sedentary/Administrative		
Supervising manual work		
Light manual		
Heavy manual		
Home duties (include details of dependants including ages and any other relevant information)		
Other (including hazardous duties, eg handling dangerous substances, working at heights/underground/offshore, refinery)		
	Total duties	0 %

Occupation details continued

34. a. What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

b. When did you qualify/graduate? D D M M Y Y Y Y

c. Please give details of any other qualifications you hold:

35. Do you ever work from home? ☐ No ☐ Yes

If **'yes'**, provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients:

36. Do you intend to change your occupation or employment status? ☐ No ☐ Yes

If **'yes'**, please provide details below:

37. Have you ever been bankrupt or entered into a personal insolvency arrangement? ☐ No ☐ Yes

If **'yes'**, please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable.

38. Has any business that you have, or have had ownership of, ever been liquidated or been placed under administration? ☐ No ☐ Yes

If **'yes'**, please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable.

39. Do you have any other occupations or jobs? ☐ No ☐ Yes

If **'yes'**, please provide details below including specific duties:

40. Number of hours per week worked and annual income derived from your other occupations or jobs. hours $

(!) Only complete 41 if you work in the mining or oil and gas industry.

41. Questions to be completed by individuals working in the mining, oil and gas industries:

a. Please advise the type of resource mined/extracted/refined at the mine/plant/platform:

Metal	Coal	Oil	Gas	Other

b. How do you travel to and from your work location?

☐ Commute to your work location daily from home ☐ Fly in fly out to your work location

☐ Other, please provide details:

c. Please complete the table below regarding your salary and any allowances paid for the last two financial years:

	Last financial year ($)	**Year immediately prior to last ($)**
Salary (including super)		
Bonus		
Allowances (eg site allowance, living away from home allowance, travel allowance)		
Other		

Income details

42. Insurable income

What is Insurable income? This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work. It does not include investment or interest income.

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, the insurer may call for evidence of your income and business expenses.

If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section below. OR If you are **an employee**, please complete the 'For employees' section on page 28.

For self-employed or contractor (sole trader, partnership, employee of own company or trust)

a. Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available. **Do not include any amounts paid to you that are paid from past profits, capital or loans.**

Tax year ending	Gross income for entire business ($)	Less all expenses incurred in earning that income ($)	Equals net business income before tax ($)	Wages/salary ($)	Drawings/ director's fees paid to you ($)	Your total income ($)
30 / 06 /						
30 / 06 /						

b. Did your business contribute to a complying superannuation fund on your behalf? ☐ No ☐ Yes

If **'yes'**, how much or what percentage?

c. What percentage of the business do you own? % If not 100% owner, please provide percentage ownership and roles/duties of the other owners. Please include details of any income splitting arrangements:

d. How many people do you employ?

e. What proportion of total business income is from your personal exertion? %

f. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes

If **'yes'**, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

Income details continued

42. Insurable income continued

g. If you were to become disabled, would any of your income (eg investment income and trail/renewal commission) continue? If **'yes'**, please provide the following details: ☐ No ☐ Yes

i. What type and amount of income would continue if you were not working and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) in relation to this entitlement and when it may cease? ☐ No ☐ Yes
If **'yes'**, please provide further details:

h. Has your business had a net operating loss over either of the last two financial years? ☐ No ☐ Yes
If **'yes'**, please provide copies of your full company accounts for the last two financial years, including any associated entities.

i. So far this financial year, is your business trading profitably? If **'no'**, please provide details in the space below: ☐ No ☐ Yes

> ! If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section on page 27. **OR** If you are **an employee**, please complete the 'For employees' section below.

For employees

> ! Only complete this section if you are an employee and do not have any ownership in your employer's business.

j. Please indicate your current employment status:
☐ Permanent full-time ☐ Permanent part-time ☐ Casual or non-permanent ☐ Not currently employed
☐ Other, please specify:

k. Please give details of your total remuneration package from all sources currently and for the last two financial years.

	Current ($)	Last financial year ($)	Year immediately prior to last ($)
Salary			
Bonuses			
Commissions			
Regular overtime			
Superannuation			
Total	**$ 0.00**	**$ 0.00**	**$ 0.00**

l. What rate of superannuation guarantee is your employer contributing on your behalf? %

m. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes
If **'yes'**, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

Income details continued

42. Insurable income continued

n. If you were to become disabled, would any of your income (including investment income) continue? ☐ No ☐ Yes

If **'yes'**, please answer i and ii:

i. What is the income amount that would continue, for how long, and the source (eg salary, sick pay in excess of 100 days, company profits, investments, rental) and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) that determines when this entitlement will cease? ☐ No ☐ Yes

If **'yes'**, please provide details:

Declaration, consent and signatures

I acknowledge and declare that:

- I've read and understood the duty to take reasonable care not to make a misrepresentation section in the information sheet, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy.
- I understand that if the questions aren't answered truthfully, accurately and completely the insurance I've applied for may be avoided (treated as if it never existed) or altered and if I've made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted.
- I give the insurer permission to seek any medical or financial information needed in connection with the application or any plan issued as a result. I understand that if I withhold consent, AMP may not be able to provide the products and services requested.
- I've read and understood the privacy – use and disclosure of personal information section in the attached information sheet. I consent to my personal information being collected and used in accordance with the privacy disclosure statement. I acknowledge that I can opt out from the use of that information for the purpose of direct marketing by telephoning **AMP**.

Signature

Given name(s) | Family name | Date of birth (D D M M Y Y Y Y)

Address | Suburb | State | Postcode

Signature

✗

Date signed (D D M M Y Y Y Y)

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Medical authority

Please read the privacy – use and disclosure of personal information in the declarations and consent section of the PDS.

Authority for the insurer to release medical information to usual doctor

Only complete this section if you authorise the insurer to release medical information to your doctor upon an adverse assessment of your application.

Family name | Given name(s) | Date of birth (D D M M Y Y Y Y)

I, _____ _____ _____ authorise the insurer to advise Doctor _____ of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise the insurer to provide copies of the relevant health evidence to the doctor noted above.

Signature

✗ _____

Date signed (D D M M Y Y Y Y)

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