Personal Statement
Member's Declaration

Insured's duty of disclosure

A person who enters into a life insurance contract in respect of your life has a duty, before entering into the contract, to tell us anything that he or she knows, or could reasonably be expected to know, which may affect our decision to provide the insurance and on what terms.

The person entering into the contract has this duty until we agree to provide the insurance. The person entering into the contract has the same duty before he or she extends, varies or reinstates the contract.

The person entering into the contract does not need to tell us anything that:
- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

For contracts of insurance entered into, renewed, extended, varied or reinstated from 28 December 2015, if you do not tell us something that you know, or could reasonably be expected to know, which may affect our decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to tell us something that he or she must tell us.

If the person entering the contract does not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate contracts of life insurance. If they do, we may apply the following rights separately to each type of cover.

If the person entering into the contract does not tell us anything he or she is required to, and we would not have provided the insurance if he or she had told us, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if he or she had told us everything he or she should have. However, if the contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if he or she had told us everything he or she should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

Personal Information

By completing this form you consent to any personal information, including any information that may be of a sensitive nature AIA Australia may collect about you (including from your responses in this Personal Statement), being handled in the manner outlined in AIA Australia's privacy policy. A copy of AIA Australia's privacy policy can be obtained by visiting aia.com.au.

A. Life Insured (Life insured to complete this section in full.)

1. Name — Title | Surname | Given Name | Gender M/F

2. Date of Birth (dd/mm/yy) **3.** Age next birthday

4. Residential Address — No. | Street; Suburb | State | Postcode

5. Mailing Address (if different to above) — Suburb | State | Postcode

We may need to contact you to clarify information you have provided in the application. If so we will contact you during business hours.
Please nominate a preferred local contact time: ☐ 8am – 11am ☐ 11am – 2pm ☐ 2pm – 6pm

6. Contact Details — Phone (home) | Phone (work) | Mobile; E-mail

7. Country of Birth

8. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia (as approved by the Department of Immigration and Citizenship)? ..... Yes ☐ No ☐

If 'No', are you applying for, or intending to apply for, Permanent Residency in Australia? ..... Yes ☐ No ☐

Please advise what type of visa you hold and expiry date.

B. Type of Insurance

(Please tick one)
☐ New
☐ Increase

(Please tick one)
☐ Death Only — Amount $
☐ Death & TPD — Amount $
☐ Income Protection — Amount $

Income Protection only:

Benefit Period: ☐ 2 years (to age 65 if earlier) ☐ To Age 65 ☐ Other – please specify ☐ years/other

Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other – please specify ☐ days

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

C. Personal History (Life insured to complete this section in full.)

1. (a) Do you have, or are you applying for life, disability or trauma insurance on your life (including any pending applications held with any insurer)? If 'Yes', please complete policy details below..... Yes ☐ No ☐

Policy Number	Commencing Date	Policy Owner	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

(b) Have you **ever** been declined, deferred or accepted on special terms for life, disability or trauma insurance? ..... Yes ☐ No ☐

(c) Have you **ever** claimed benefits from any source (excluding unemployment), e.g. Accident, Sickness, Workers Compensation, Social Security, Disability Income Insurance or Pension? If 'Yes' please give the name of the company, date, amount and reason for each claim below. ..... Yes ☐ No ☐

If you answered 'Yes' to 1(b) or 1(c) please provide details.

2. (a) Have you smoked tobacco or any other substance during the last twelve months? ..... Yes ☐ No ☐
If 'Yes', please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

(b) How many standard drinks do you consume per week on average?
One standard drink = one nip (30 ml) spirits, 100 ml wine, 10 oz/285 ml beer

(c) Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? ..... Yes ☐ No ☐
If 'Yes', please provide details.

3. (a) What is your height? cm (b) What is your weight? kg

4. **Females Only:** Are you pregnant? If 'Yes', please provide estimated date child is due. ...../...../..... ..... Yes ☐ No ☐

5. Do you intend to travel or reside overseas? If 'Yes', please state:..... Yes ☐ No ☐

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure
				/ /
				/ /

6. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike riding/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity?..... Yes ☐ No ☐
If 'Yes', please fill in **Section G** (Aviation or Activities/Pursuits Questionnaire).

Family History

7. Have any of your immediate family (father, mother, brother, sister) prior to the age of 60 (living or dead), ever suffered from heart disease, breast cancer, ovarian cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, mental disorder, stroke, Huntington's chorea or any hereditary disease? You are only required to disclose family history information pertaining to first degree blood related family members. If 'Yes', please provide details in the table below..... Yes ☐ No ☐

	Condition/Illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

D. Medical and Health History (Life insured to complete this section in full and complete relevant questionnaire.)

1. Have you **ever** suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

(a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. ..... Yes ☐ No ☐
If 'Yes', please complete Section H – **High Blood Pressure/High Cholesterol Questionnaire**.

(b) Asthma, chronic lung disease, sleep apnoea or other respiratory disorder. ..... Yes ☐ No ☐
If 'Yes', please complete Section I – **Asthma Questionnaire**.

(c) Indigestion, gastric or duodenal ulcer or any bowel disorder. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(d) Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder. ..... Yes ☐ No ☐
If 'Yes', please complete Section K – **Mental Health Questionnaire**.

(e) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(f) Arthritis, repetitive strain injury (RSI), fibromyalgia. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(g) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles. ..... Yes ☐ No ☐
If 'Yes', please complete Section L – **Spinal/Joints Disorder Questionnaire**.

(h) Psoriasis or eczema, skin disorder, defect in hearing or sight. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(i) Diabetes, abnormal blood sugar, gout or thyroid disorder. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections H to L).

(j) Cancer, cyst, lump, tumour or growth of any kind. ..... Yes ☐ No ☐

(k) Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone. ..... Yes ☐ No ☐

(l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia. ..... Yes ☐ No ☐

(m) Hepatitis B or C or are a Hepatitis B or C carrier, Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus. ..... Yes ☐ No ☐

Females only: Have you ever had or been advised to have treatment for:

(n) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? ..... Yes ☐ No ☐

(o) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries? ..... Yes ☐ No ☐

(p) Abnormal vaginal bleeding within the last 12 months? ..... Yes ☐ No ☐

(q) Any other illness, disease or disorder? **Do not include**: colds, flu, hayfever, dental related matters, uncomplicated pregnancies (including caesarean sections, miscarriage), abortions and menopause. ..... Yes ☐ No ☐

2. In the last 5 years have you:

(a) Had any medical examinations, consultations, X-rays, pathology tests or procedures? ..... Yes ☐ No ☐

(b) Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? ..... Yes ☐ No ☐

3. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? .. Yes ☐ No ☐

For each 'Yes' answer in questions 1j–1q, 2 and 3 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %*	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

D. Medical and Health History (continued)

(Life insured to complete this section in full and complete relevant questionnaire.)

4. Lifestyle Statement

(a) Have you ever injected yourself with any illicit drugs not prescribed by a medical practitioner?..... Yes ☐ No ☐

(b) In the past 5 years have you:

(i) Engaged in male to male sexual activity **without** a condom (except in a relationship between you and only one other person where neither of you has had sex **without** a condom with anyone else in the past 5 years) or

(ii) Had sex **without** a condom:
- with someone you know or suspect to be HIV positive or
- with someone who injects non prescribed drugs or
- with a sex worker or as a sex worker?..... Yes ☐ No ☐

E. Doctor's Details (Life insured to complete this section in full.)

1. (a) Details of your personal doctor.
IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.

Name:		
Address:		Postcode
Phone ( )	Fax ( )	Email (if known)

(b) What was the date of your last consultation? (Give approximate date if exact date unknown.) / /

(c) How long have you been attending the surgery/practice?

F. Present Occupation (Life insured to complete this section in full)

1. (a) What is your usual occupation?

(b) Do you perform any manual work? If 'Yes', please describe duties and percentage of time spent in each..... Yes ☐ No ☐

Type of work	% of time	Please describe your specific duties and where they are performed
Sendentary		
Light manual		
Heavy manual		

2. What is your annual income? $

If you have answered 'Yes' to Section D, question 1a–1i, please also complete a questionnaire for each condition (see Sections H to L).

Questionnaires (Life insured to complete – may be photocopied for additional activities/pursuits.)

G. Aviation Questionnaire

1. Please state the number of hours flown where applicable:

(a) **Private flying**

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

(b) **Commercial flying** (excluding large mainstream carriers, eg. Qantas)

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

(c) **Agricultural flying**

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

2. Are your flying activities:
☐ Recreational, or ☐ Required for your occupation?
Please provide details.

3. (a) Name of aircrafts flown.

(b) Make and model of the aircrafts.

(c) **If pilot only.**
(i) Age of the aircrafts flown.
(ii) Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced? ☐ Yes ☐ No

4. Do you fly or intend to fly outside Australia? If 'Yes', please provide details. ☐ Yes ☐ No

5. Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? If 'Yes', please provide details. ☐ Yes ☐ No

6. Have you ever been involved in any aviation accidents? If 'Yes', please provide details. ☐ Yes ☐ No

G. Activities/Pursuits Questionnaire

1. Please describe the activity or pursuit.

2. Please advise the number of times you engage in the activity per year.

3. How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4. What qualifications, certificates, licences, associations and club memberships do you hold?

5. How long have you been involved in this activity?

6. Where do you engage in this activity and in what locations?

7. Do you ever engage in this activity alone, or are you always with a group?

8. Do you compete in this activity? ☐ Yes ☐ No
If 'Yes', please advise the level of competition and names of events.

9. Do you receive any payments for your involvement in this activity? ☐ Yes ☐ No
If 'Yes', please advise details.

10. Please advise the maximum heights, speeds, depths the activity includes.

11. Are any of the above likely to change over the next 2 years? ☐ Yes ☐ No
If 'Yes', please provide full details.

12. Are you involved in any record attempts? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details.

14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15. Have you ever been involved in any accident/ mishap whilst participating in this activity? ☐ Yes ☐ No
If 'Yes', please provide details.

Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

H. High Blood Pressure/High Cholesterol Questionnaire

1. When was high blood pressure/ high cholesterol first diagnosed?

2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

Readings	Results	Date diagnosed
Blood Pressure		
Total Cholesterol		
HDL		
LDL		
Triglycerides		

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage

4. Are you still on treatment? ☐ Yes ☐ No
If 'No', when was treatment discontinued and why?

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Results

6. Regarding the monitoring of your condition:
   (a) Name of medical attendant:
   (b) How often do you attend for follow-up?
   (c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.
   (d) Have you suffered from any of the following conditions:
      (i) Eye disorder (other than short/long sightedness) ☐ Yes ☐ No
      (ii) Symptoms or disorder relating to heart or circulatory system ☐ Yes ☐ No
      (iii) Kidney disorder or protein in urine ☐ Yes ☐ No
      (iv) Dizziness, fainting episodes or stroke ☐ Yes ☐ No

   If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigations	Results

   (e) How long has your blood pressure/cholesterol been well controlled?
   ☐ < 6 months ☐ 6 months to 12 months ☐ > 12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application.

8. Please attach copies of any reports or results (eg. xray, pathology, ultrasound, etc) you may have.

I. Asthma Questionnaire

1. Date asthma first diagnosed. / /

2. How often do you experience symptoms?
eg. wheezing, breathlessness, chest tightness.
☐ Daily ☐ Weekly ☐ Monthly ☐ Other

3. When was your most recent episode of asthma? / /

4. Are you aware of any causes that trigger your symptoms?
eg. allergy, exercise.

5. Have you ever been off work due to asthma? ☐ Yes ☐ No
If 'Yes', please advise when, and for how long.

6. Name of medications.
   (a) Dosage
   (b) Frequency
   (c) When was the last time you received medication?
   (d) What additional treatment do you use to control an attack?

7. Have you ever required steroid therapy (by tablet or syrup)? ☐ Yes ☐ No
If 'Yes', please provide details.

8. Have you ever been in hospital or received emergency treatment for asthma? ☐ Yes ☐ No
If 'Yes', please state when, for how long and where?

9. Have you ever undergone a lung function test? ☐ Yes ☐ No
If 'Yes', please advise dates and highest and lowest readings, if known.

10. Have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please advise name and address of doctor of last consultation.

11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

J. Multi-Purpose Questionnaire

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?
   (b) Please state which side. ☐ Left ☐ Right ☐ Not applicable
3. The cause.
4. (a) Date symptoms commenced. / /
   (b) How long have you been free of symptoms?
   (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
   If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
   If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
   If 'Yes', advise names of medication(s), dosage(s) and frequency.
   Are you still taking this medication? ☐ Yes ☐ No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No
11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
    If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
    If 'Yes', please provide details.
13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
    If 'No', provide name and address of doctor who has full details.

J. Multi-Purpose Questionnaire

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?
   (b) Please state which side. ☐ Left ☐ Right ☐ Not applicable
3. The cause.
4. (a) Date symptoms commenced. / /
   (b) How long have you been free of symptoms?
   (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
   If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
   If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
   If 'Yes', advise names of medication(s), dosage(s) and frequency.
   Are you still taking this medication? ☐ Yes ☐ No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No
11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
    If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
    If 'Yes', please provide details.
13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
    If 'No', provide name and address of doctor who has full details.

Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

K. Mental Health Questionnaire

1. Please indicate the condition(s) you have had or received treatment for.

- ☐ Anxiety including generalised anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression or mild depression
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenic or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic fatigue
- ☐ Other (please specify)

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

Symptoms	Date from	Date to

3. (a) Has any reason for your condition been identified or are there any factors which trigger your condition?

(b) Have you ever had suicidal thoughts or attempted suicide? If 'Yes', please provide details. ☐ Yes ☐ No

4. (a) Date symptoms commenced. / /

(b) Date of last symptoms. / /

(c) Have you had any recurrences of this condition? ☐ Yes ☐ No

If 'Yes', how many times? ☐ When? / /

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased

(b) Are you currently receiving treatment? ☐ Yes ☐ No

(c) If 'Yes', please provide details.

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition? ☐ Yes ☐ No
If 'Yes', when and how long?

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? ☐ Yes ☐ No
If 'Yes', please provide details.

L. Spinal/Joints Disorder Questionnaire

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. left knee, right hip, shoulders, elbows etc).

2. Please state the precise diagnosis.

3. When did symptoms first occur?

4. (a) What was the cause?

(b) Please describe your symptoms.

(c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ☐ Yes ☐ No

(d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms? ☐ Yes ☐ No

(a) If 'No', date of last experienced symptoms. / /

(b) If 'Yes', how frequently have symptoms occurred since commencing treatment?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

(b) Are you still receiving treatment? ☐ Yes ☐ No

(i) If 'No', when did you cease treatment? / /

(ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

(c) Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor.

8. Have you had an operation for this condition or is an operation being considered? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long? ☐ Yes ☐ No

(b) Are your occupation duties restricted in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

(c) Is it necessary to avoid lifting or to restrict your daily activities in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

M. Declaration

- I declare that the information I provided in this Personal Statement (whether written in my hand or not) is true and correct and that no information material to the insurance has been withheld.
- I agree that any personal statements made (including this one) together with any relevant supporting documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I also understand that my duty to disclose continues after I have completed the insurance application until AIA Australia has accepted the risk. I understand AIA Australia may cancel the cover from inception or provide cover on amended terms if I do not comply with my duty of disclosure.
- I consent to AIA Australia collecting sensitive information, i.e. health information about me, for the purpose of the performance of this contract.
- I agree that cover will not commence until the premium is paid and AIA Australia has accepted the risk.
- I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at www.aia.com.au as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.

By submitting this application for underwritten cover, I elect for the Trustee to take out and maintain insurance cover in relation to my Future Super account, even if:

- my account is inactive (i.e. no contributions received) for a continuous period of sixteen months or longer;
- my account balance is less than $6,000; and/or
- I am under the age of 25.

I acknowledge that, by submitting this application on the submission date indicated, I have elected for the benefits to continue in accordance with superannuation law regardless of the factors above (subject to meeting the policy terms including premium requirements), and that I can cease the insurance by submitting a request to info@myfuturesuper.com.au[1]

I confirm the Declarations are true and accurate.

Signature ✗ Date / /

1. Insurance through superannuation can be tax effective and potentially cheaper than insurance funded through after-tax salary or savings. However, premiums incurred from unnecessary, unwanted, or unsuitable insurance cover can inappropriately erode member balances and, as a result, the savings available for members at retirement.

   It's important to note that you may have multiple superannuation accounts and may therefore be paying duplicate sets of premiums. For information on how to keep track of your super, you can visit the ATO website https://www.ato.gov.au/Individuals/Super/Growing-your-super/Keeping-track-of-your-super/

   Prior to making any decision in relation to insurance through Future Super you should determine whether the cover is right for you. Among other things, you should:
   - check if you have any other insurance cover;
   - check if the terms of cover, including the premiums, level of cover and any applicable restrictions or exclusions, are appropriate for your needs and circumstances; and consider speaking to a licensed or authorised financial adviser.

N. Authority to Release Medical Information

I, Name of Life Insured

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to AIA Australia Limited, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured ✗ Date / /

O. Privacy

Your privacy is important to us. The AIA Australia Privacy Policy sets out how your personal information (including sensitive information) is collected, used, handled and disclosed by us, and other important information. AIA Australia's current Privacy Policy is available at www.aia.com.au or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect personal and sensitive information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your personal and sensitive information from, and provide to, third parties in Australia and overseas, such as your financial adviser, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your personal and sensitive information under various laws including insurance, taxation, financial services and other laws set out in the AIA Australia Privacy Policy; and
- disclose personal and sensitive information to third parties which may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy.

If you do not provide the required personal and sensitive information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your personal information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's privacy policy.