

insurance application form

If you wish to transfer your existing insurance, please complete the **Transfer your insurance form** instead of this form.

Complete this form if you wish to apply for the Office or Professional category and/or one of the Package Choices or Tailored insurance options. Please complete the form in blue or black pen and block letters. If you do not complete this form, your insurance with CareSuper will comprise two units of Death and TPD cover under the General scale.

Determine the category that applies to you. This will determine your premiums and the maximum Income Protection benefit you can apply for without completing a health assessment.

1. Personal details

→

CareSuper member number	Date of birth (DD/MM/YYYY)	Mr/Mrs/Ms/Miss/Dr
Surname		
Given names		
Address		
Suburb/town	State	Postcode
Telephone (home)	Telephone (work)	
Mobile number	Email address	
Employer name		
Occupation		
Duties performed		

Are you currently employed (at the date of signing this document) and working normal hours and not absent from your normal duties due to illness or injury? Yes No

2. Occupational Categories

→ CareSuper offers three different categories of cover to reflect the different levels of risk associated with our members' occupations. Please complete (X) the following questions to determine the scale that applies to you:

- Are the duties of your occupation limited to professional, managerial, administrative, clerical, secretarial or similar 'white collar' nature tasks that do not involve manual work and are undertaken entirely within an office environment (excluding travel time from one office environment to another)? Yes No
- Are you earning in excess of \$80,000 from your profession? Yes No
- Do you hold a tertiary qualification or are you a member of a professional institute or registered government body? Yes No
 - Are you in a management role? Please refer to 'manager' under the TPD definition in the Member Guide PDS for guidance when answering question 3b. Yes No

If you answer No to Q1, you qualify as General.
 If you answer Yes to at least Q1, you qualify as Office.
 If you answer Yes to Q1 and Q2 and either Q3a or 3b, you qualify as Professional.

Note:

- Your level of cover will be reviewed each time you complete a new application form or apply to vary your insurance cover
- If you do not complete this section 2, your cover will automatically default to the General category if you are a new member.

[See over >](#)



Note

When you make an application for Tailored cover it will automatically replace any cover held, so when applying for tailored cover please ensure that you nominate the total amount of cover you require. If your application is declined, your prior cover will continue.

If you would like to opt out of or decrease your current insurance, do not fill out this form. You will need to inform us in writing.



Important

To be eligible for Income Protection insurance cover, you must be earning in excess of \$16,000 per year on an ongoing basis.

Please mark (x) in the appropriate box.



Return this completed form to:

CareSuper
GPO Box 1923
Melbourne VIC 3001

For more information call the CareSuperLine

1300 360 149

3. Package Choices

Please choose (x) either Default (no application required), one Standard Package OR a Tailored option. If you are a new member and do not make an eligible selection, your cover will be set as the default cover for the General category.

Default cover: Death and TPD 2 units – you do not need to complete this form to receive default level cover

Standard packages – no health assessment required, new members only (existing members will need to choose the Tailored option below):

- Standard package 1: Death & TPD (2 units) plus Income Protection (complete Section 4)
- Standard package 2: Death only (4 units) plus Income Protection (complete Section 4)
- Standard package 3: Death only (4 units)

Tailored insurance – subject to insurer's approval, health assessment required:

- I would like _____ units of Death and TPD in total and/or
- I would like \$ _____ .00 Fixed cover (minimum \$10,000)
- I would like to index my Fixed cover (if applicable) by 5% annually to account for inflation.

Please note, your total Death and TPD cover cannot exceed \$2,000,000. TPD cover cannot exceed your Death cover.

I would like Income Protection cover – complete Section 4 to indicate the level of cover

4. Income protection

My annual gross salary (excluding super mandated by the SGC) is \$ _____ .00.

New members only

You only need to complete the section below if you have chosen Standard Package option 1 or 2 or have requested Income Protection under the Tailored insurance option.

Note: if your annual salary level exceeds the maximum cover for your occupational category and you wish to apply for cover at this level, you will need to select Tailored cover and complete the Short personal health statement.

Existing members only

I would like to apply for _____ units of Income Protection cover (no minimum).

Waiting period – all members

Please indicate (x) the waiting period you are willing to accept (refer to page 22 for details):

30 days 60 days 90 days

Type of cover	Mark box (x)	Annual salary range	Units of Income Protection Insurance	Maximum monthly benefit payable
	<input type="checkbox"/>	\$16,001 – 18,000	3	\$1275
	<input type="checkbox"/>	\$18,001 – 24,000	4	\$1700
	<input type="checkbox"/>	\$24,001 – 30,000	5	\$2125
	<input type="checkbox"/>	\$30,001 – 36,000	6	\$2550
	<input type="checkbox"/>	\$36,001 – 42,000	7	\$2975
	<input type="checkbox"/>	\$42,001 – 48,000	8	\$3400
	<input type="checkbox"/>	\$48,001 – 54,000	9	\$3825
	<input type="checkbox"/>	\$54,001 – 60,000	10	\$4250
	<input type="checkbox"/>	\$60,001 – 66,000	11	\$4675
	<input type="checkbox"/>	\$66,001 – 72,000	12	\$5100
	<input type="checkbox"/>	\$72,001 – 78,000	13	\$5525
	<input type="checkbox"/>	\$78,001 – 84,000	14	\$5950
	<input type="checkbox"/>	\$84,001 – 90,000	15	\$6375
	<input type="checkbox"/>	\$90,001 – 96,000	16	\$6800
	<input type="checkbox"/>	\$96,001 – 102,000	17	\$7225
	<input type="checkbox"/>	\$102,001 – 108,000	18	\$7650
	<input type="checkbox"/>	\$108,001 – 114,000	19	\$8075
	<input type="checkbox"/>	\$114,001 – 120,000	20	\$8500
	<input type="checkbox"/>	\$120,001 – 126,000	21	\$8925
	<input type="checkbox"/>	\$126,001 – 132,000	22	\$9350
	<input type="checkbox"/>	\$132,001 – 138,000	23	\$9775
	<input type="checkbox"/>	\$138,001 – 144,000	24	\$10200
	<input type="checkbox"/>	Salaries above \$144,001	Subject to insurer assessment	Subject to insurer assessment

Note: 30 days is the default waiting period if you do not make a selection. The cost decreases if you are prepared to wait longer to receive a benefit. If you wish to reduce the waiting period in the future you will need to complete a new application form, including the Short Personal Health Statement.

Please mark (X) Yes or No for each question.

(If additional details are required, please attach a separate sheet.)



Default cover and Package Choices do not require a health assessment. However, applications for the Package Choice options must be received within 60 days of the date of your 'Welcome to the fund' letter being issued to you.

Tailored insurance options require you to complete the additional Short Personal Health Statement.

5. Short Personal Health Statement

→ Important instructions

1. If you are a new member applying for Package Choice options, DO NOT complete Section 5. Go to Section 6 and sign and date the application form.
2. If you are applying for Tailored insurance complete Section 5 then sign and date Section 6.
3. If you are applying for Death only or Death and TPD cover in excess of \$800,000 or Income Protection in excess of \$6,000 benefit per month, DO NOT complete section 5. Please call the CareSuperLine on 1300 360 149 to obtain the Full personal health statement required for cover in excess of the above amounts.

Only complete this section if you are applying for Tailored insurance. If you are applying for a Package Choice option please go to section 6.

This information will be treated in strict confidence and will be used or disclosed only for matters relating to your insurance entitlements. If this section is not completed the insurer will be unable to process your insurance application and your requested level of insurance cover may be denied. **You must complete ALL questions.**

Should you answer 'Yes' to any of the questions in Section 5, please DO NOT continue to complete Section 5, please call the CareSuperLine on 1300 360 149 to obtain the **Full personal health statement**.

	Yes	No
1. Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you claiming or have you ever claimed a benefit from any source – e.g. TPD benefit from any superannuation fund, Worker's Compensation, disability pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you at the date of this application: <ul style="list-style-type: none"> • off work due to sickness, illness or injury, or • restricted from carrying out all of the usual duties of your current employment? 	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you lost the sight of an eye or the total and permanent loss of the use of a limb ('limb' includes whole hand and whole foot)?	<input type="checkbox"/>	<input type="checkbox"/>
5. What is your: Height <input style="width: 100px;" type="text"/> cm Weight <input style="width: 100px;" type="text"/> kg		
6. Excluding the contraceptive pill and inhaled asthma medication, within the last year have you been advised to take or been given prescribed medication by a medical practitioner that has intended to be used for 3 months or longer (including but not limited to blood pressure, diabetes, oral steroids for asthma or depression medication)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been unable to work because of sickness or injury for more than 2 consecutive weeks in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you undergone any medical treatment, investigation or an operation, suffered from, or are contemplating surgery for, any illness or injury that would affect your long-term health and require ongoing medical supervision? This includes but is not limited to: <ul style="list-style-type: none"> • Cancer or diabetes • High blood pressure or cholesterol or any heart complaint • Alcohol or drug abuse • Stroke, paralysis, neurological disorder or multiple sclerosis. 	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been infected with or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or Hepatitis B and C?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any medical advice or undergone any medical treatment, investigation or an operation, suffered from, or contemplating surgery for, any of the following: <ul style="list-style-type: none"> • Any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last 12 months AND/OR any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints • Depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, behavioural or nervous disorder) • Chest pain, asthma, bronchitis or any other lung complaint, requiring hospitalisation within the last 5 years • Disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel, or liver • Epilepsy. 	<input type="checkbox"/>	<input type="checkbox"/>

Turn over to sign



Important

As a member of CareSuper you may ask to see the information the insurer holds about you and have it corrected if required. CareSuper's insurer for Death, TPD and Income Protection is CommInsure. CommInsure is a registered business name of The Colonial Mutual Life Assurance Society Limited
 ABN 12 004 021 809
 AFSL 235035 (CMLA)

You must sign and date this form.



Return this completed form to:

CareSuper
 GPO Box 1923
 Melbourne VIC 3001

For more information call the CareSuperLine

1300 360 149

6. Declaration



I declare that I

- I agree to allow CareSuper to quote my TFN for legislatively approved superannuation and taxation purposes.
- I have read and understood the Member Guide PDS. I acknowledge that no cover commences until this application is accepted by the insurer (CommInsure)
- I have read and carefully considered the questions in the personal health statement above and all answers provided are true and correct (including those not in my own handwriting)
- I have told the insurer everything I know that could affect their decision to accept my application
- I have read the Duty of Disclosure (below) and am aware of the consequences of non-disclosure under the Insurance Contracts Act 1984
- I understand that the Duty of Disclosure (below) continues after I have completed this statement until my application for cover has been accepted by the insurer in writing
- I am not restricted by injury or illness from carrying out all of my normal work duties or from working normal hours.

Furthermore:

- I acknowledge that if I do not complete this application correctly, or I do not sign and date this form, my application will be invalid and will not be considered by the insurer.
- I authorise any hospital, doctor or other person who has treated or examined me to give to the Insurer any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports. A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Privacy

In completing this Insurance application form:

- I confirm that I have read CareSuper's Privacy Statement on page 41 of the Member Guide PDS and I understand how CareSuper intends to handle my personal information
- I consent to the use and disclosure of my health and other personal information for the purposes of assessing my eligibility for insurance cover
- I acknowledge that if I make a claim for an insurance benefit I will need to provide additional information in accordance with the claims procedures of CareSuper and the insurer.

If you have any questions about your rights under the privacy legislation, please call CareSuper on 1300 360 149.

Important note

Your duty of disclosure

Before you enter into a contract of insurance with a Life Insurer you have a duty, under the insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk for the insurance and if so on what terms. You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate a contract of life insurance.

Your duty does not require you to disclose any matter:

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

Non-disclosure

If you fail to comply with your duty, and the Insurer would not have entered into the contract on any

terms if the failure had not occurred, the Insurer may void the contract within the first three years of entering into it.

If your non-disclosure is fraudulent, the insurer may void the contract at any time.

An insurer who is entitled to avoid your cover may, within three years of issuing it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.



Full name

CareSuper member number (if known)

Member's signature

Date (DD/MM/YYYY)