

CareSuper full personal statement

Please carefully read the information in your CareSuper Member Guide PDS before completing this Full Personal Statement. Complete this form if you are applying for Death only, Death and TPD or Income Protection cover:

- in excess of \$6,000 per month for Income Protection cover;
- in excess of \$800,000 for Death only or Death and TPD cover; or
- if you have answered 'Yes' to any of the questions in Section E of the Short Personal Health Statement of the Application for Insurance Form in the CareSuper Member Guide

A. Your details

Membership number	Date of birth (DD/MM/YYYY)*	Mr/Mrs/Ms/Miss/Dr*
Surname*		
Given names*		
Employer		
Occupation	Salary or yearly remuneration	
	\$	

B. Insurance history details

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?

No Yes Please provide details below

Fund or insurance company name	Date commenced	Terms offered and reason
	/ /	
	/ /	

2. Are you claiming or have you ever claimed a benefit from any source, eg. TPD benefit from any superannuation fund, workers compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?

No Yes Please provide details below

Benefit type/source/reason for claim	Claim date	Claim amount	Date claim finalised
	/ /	\$	/ /
	/ /	\$	/ /

C. Activities and pastimes

1. Do you currently engage in, or intend to engage in, any of the following sports or hazardous activities:

a. Flying (other than as a fare-paying passenger on a commercial airline)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
b. Underwater diving?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
c. Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
d. Football of any code (including touch football or tag)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
e. Any other sport or hazardous activities, eg. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports or recreations involving heights?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

If you have answered 'Yes' to any of the above questions, please answer the question below

What are the activity/ies you engage in?

At what level do you participate?

Recreational only (non-competition)	<input type="checkbox"/>
Recreational with competition	<input type="checkbox"/>
Semi-professional/professional	<input type="checkbox"/>

Number of times you participate on average in this activity/ies per annum (eg. hours flown, number of drives, events etc.)

Do you receive income from participating in this activity/ies?

No Yes

[See over >](#)

D. Personal health details



1. What is your height and current weight?

Height cm Weight kg

2. Have you smoked tobacco, or any other substance, at any time during the last twelve months?

No Yes Please indicate type (eg. cigarettes, cigars, etc.) and average amount smoked below

Substance smoked	Per day	Per week	Per year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Do you drink alcohol?

No Yes Please provide the average number of drinks consumed

Per day	Per week	Per year
<input type="text"/>	<input type="text"/>	<input type="text"/>

E. Family history



Have any of your immediate family (i.e. parents, brothers, sisters) suffered from or been diagnosed with any of the following?

- Heart problems, stroke, high blood pressure, diabetes
- Cancer (breast, ovarian, cervical, bowel or other)
- Depression or any mental illness

hereditary disorders such as

- Huntington's disease, muscular dystrophy, polycystic kidney, familial polyposis
- Any other inherited or hereditary disease

Unknown No Go to section F Yes Complete the following table

Family member	Condition	Approximate age at onset	Age at death (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

F. Doctor details



1. What is the name and address of the last doctor or medical centre you visited?

Full name of doctor Phone number () Facsimile number ()

Address State Postcode

2. a. What was the date of your last consultation? (please tick (✓) the appropriate box)

Within the last month	<input type="checkbox"/>	1–3 months ago	<input type="checkbox"/>	4–6 months ago	<input type="checkbox"/>
7–12 months ago	<input type="checkbox"/>	13 months to 2 years ago	<input type="checkbox"/>	Over 2 years ago	<input type="checkbox"/>

b. What was the reason for your consultation? (please specify reason for consultation)

c. What was the result/outcome from your last consultation? (please tick (✓) the appropriate box)

Referral to specialist/health professional	<input type="checkbox"/>
Tests conducted – results pending	<input type="checkbox"/>
Not fully recovered yet	<input type="checkbox"/>
Ongoing treatment (eg. ventolin inhaler)	<input type="checkbox"/>
Routine tests conducted – results all clear/normal	<input type="checkbox"/>
All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication)	<input type="checkbox"/>

3. Is the doctor/medical centre mentioned above your usual doctor/medical centre? No Yes



Return this completed form to:

CareSuper
GPO Box 1923
Melbourne VIC 3001

or call the CareSuperLine

1300 360 149

G. Lifestyle declaration

- To the best of your knowledge, is there any possibility that you have ever been infected with, or have you ever tested positive for, AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis, or are you in a high-risk category (eg. injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or, engaged the services of a prostitute)?

No Yes Please provide details below

Please note: If you answered 'Yes' to the declaration above, you will be asked to complete a **Specific lifestyle questionnaire**.

H. Medical history

- Have you ever had, or sought advice or treatment, experienced symptoms, or suffered from any of the following:

1. **Asthma, bronchitis** or any other lung complaint? No Yes
2. **Cysts, moles, sunspots** or skin lesions? No Yes
3. **Diabetes** or abnormal blood sugar? No Yes
4. **Back, neck, shoulder, knee, elbow complaints**, sciatica, disc or spine complaints, or injury of the joints, bones or muscles? No Yes
5. **Depression or mental disorder** (including but not limited to stress, anxiety, panic attacks, behavioural or nervous disorder)? No Yes
6. Chest pains, heart complaint, heart murmur, high blood pressure, raised cholesterol, palpitations or rheumatic fever? No Yes
7. Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder? No Yes
8. Cancer, tumour or melanoma? No Yes
9. Thyroid, glandular or pancreatic disorder? No Yes
10. Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder? No Yes
11. Any disorder of the gall bladder or liver (including hepatitis B, C or raised liver function)? No Yes
12. Varicose veins, haemorrhoids or hernia? No Yes
13. Disorder of the kidney, bladder or prostate, blood in urine or kidney stones? No Yes
14. Epilepsy, fits of any kind, fainting episodes, or recurring headaches or migraines? No Yes
15. Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder? No Yes
16. Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome? No Yes
17. Eczema, dermatitis, psoriasis, or any other skin disorder? No Yes
18. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? No Yes
19. Any impairment of sight (other than corrected by glasses or lenses) or blurred vision? No Yes
20. Any impairment of hearing, including tinnitus, or speech? No Yes
21. Any sexually transmitted diseases? No Yes
22. Any other illness, injury, disease or disorder not mentioned above? No Yes
23. Other than those conditions mentioned above, are you taking any regular prescribed medication (excluding contraceptives)? No Yes
24. Within the last three years, have you had:
 - Any blood tests which revealed an abnormality?
 - Any tests such as ECG, X-ray (excluding broken bones or joint strains), genetic test or ultrasound other than for pregnancy)?No Yes
25. Are you considering seeking medical advice, treatment, tests or surgery in the future? No Yes
26. **Questions 26 and 27 are for females only**
Are you currently pregnant? No Yes
 - If yes: due date for birth of baby? / /
27. Have you ever had any complications with pregnancy or childbirth (eg. diabetes, ectopic pregnancy)? No Yes
 - If yes: please provide details below

Please note:

- If you have answered 'Yes' to Question 1 to 5 above, we will ask you to complete a **Specific questionnaire** on the related condition.
- If you answered 'Yes' to question 6 to 25 above, please provide full details in **Section I – General health questionnaire** on page 4.

I. General health questionnaire



If you have answered 'Yes' to any part of questions 6 to 25 in Section H, please complete the table below. Please ensure you write the question number in the brackets above each column.

	Question ()	Question ()	Question ()
1. Name of condition	1. _____	2. _____	3. _____
2. Date symptoms first started	/ /	/ /	/ /
3. Date symptoms ceased (if applicable)	/ /	/ /	/ /
4. Are these symptoms ongoing?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
5. How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, yearly, one off, other (please specify)			
6. Severity of condition Please choose from one of the following: mild, moderate, severe, never had symptoms, symptoms ceased			
7. Did you take medication or have you had any other treatment (eg. physiotherapy or an operation) for this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
If 'Yes', name the treatment/condition			
8. Are you still on treatment, including medication?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
9. Have you ever been off work due to this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
If 'Yes', provide details. If there is insufficient space please attach an additional sheet			
10. If 'Yes', also state the total time off work in days, months and years	days	days	days
	months	month	months
	years	years	years
11. Have you had any residual, ongoing effects or restrictions as a result of this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
If 'Yes', please provide details and dates			
	/ /	/ /	/ /



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CareSuper
GPO Box 1923
Melbourne VIC 3001

or call the CareSuperLine

1300 360 149

J. Duty of disclosure

Your Duty Of Disclosure

Before you enter into, or become insured, under a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your insurance. Your duty, however, does not require disclosure of a matter:

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

Non-disclosure

If you fail to comply with your Duty of disclosure and the insurer would not have covered you on any terms if the failure had not occurred, the insurer may avoid the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may avoid your cover 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.

This section must be completed in all circumstances

K. Authorisation



I have read the Duty of disclosure in Section J of this Personal Statement and I am aware of the consequences of non-disclosure.

I understand that the Duty of disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers);
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me;
- any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

I declare that:

- the answers to all the questions and the declarations on this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance.

I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.

I have read and understand the privacy section of the CareSuper PDS. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.

I have read and understand the obligations outlined in the Duty of Disclosure in Section J of this page. A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Full name

Signature of life to be insured

Date

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