

# Corporate insurance application form



## IMPORTANT

Please refer to the **Corporate Insurance PDS** and your relevant **Corporate Insurance Guide** to determine which of the options you are eligible to apply for on this form.

You can use this form to apply to change your occupational category (if it's available through your employer). You can apply to change your occupational category at [caresuper.com.au/mycategory](https://caresuper.com.au/mycategory).

If you wish to opt out or reduce your level of default cover, please call on **1300 360 149**. Please do not complete this form.

Complete this form in blue or black pen using BLOCK LETTERS and tick  where applicable.

## 1. YOUR PERSONAL DETAILS

Member account number \_\_\_\_\_ Date of birth (DD/MM/YYYY) \_\_\_\_\_ Title \_\_\_\_\_

Surname \_\_\_\_\_

Given names \_\_\_\_\_

Residential address (required) \_\_\_\_\_

Suburb \_\_\_\_\_ State/territory \_\_\_\_\_ Postcode \_\_\_\_\_

Postal address (if different from above) \_\_\_\_\_

Suburb \_\_\_\_\_ State/territory \_\_\_\_\_ Postcode \_\_\_\_\_

Mobile \_\_\_\_\_ Daytime telephone \_\_\_\_\_

Email \_\_\_\_\_

Gender  Male  Female

Employer name \_\_\_\_\_

Occupation \_\_\_\_\_

What industry do you work in? \_\_\_\_\_ Total income per year (gross\*) \$ \_\_\_\_\_

\*including overtime, commission, bonuses and shift allowances and excluding mandated employer contributions.

Do you work at least 15 hours per week?  Yes  No

## 2. TAILOR YOUR INSURANCE

Please refer to the Corporate Insurance PDS and your relevant Corporate Insurance Guide to determine which of the options you are eligible to apply for below. If your application is denied, your existing cover will continue.

I would like to apply for cover in addition to my existing cover as follows:

### Additional death cover:

\_\_\_\_\_ units OR \$ \_\_\_\_\_ (fixed cover)

### Additional TPD cover:

\_\_\_\_\_ units OR \$ \_\_\_\_\_ (fixed cover)

### Additional Income protection cover: please (✓) tick applicable box)

\_\_\_\_\_ units with a waiting period of

30 days (default)     60 days     90 days

and a benefit period:

2 years (default)     5 years     to age 65 (if eligible)

Please tick (✓) if applicable:

- I understand that this cover will be in addition to any existing death and TPD cover that I have with CareSuper, and that benefits from all sources will be limited to the maximum benefits allowed under the policy as described in the relevant **Corporate Insurance Guide**.
- I understand that any income protection cover applied for on this form will cancel and replace my existing income protection cover with CareSuper.

## 3. PERSONAL HEALTH STATEMENT

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.

### HONESTY STATEMENT

You are applying to enter into a contract of insurance.

As such, you have a duty to disclose all relevant information. Failing to provide the insurer with full and accurate information could result in your insurance cover being cancelled and any claim for benefits could be denied, so it is vital you answer all questions fully and accurately.

Although we ask you specific questions via a personal statement, you should also tell us about any other information that will impact on the insurer's decision to offer you insurance cover, regardless of whether you deem it to be material or important. This includes current medical issues that require investigation, medication or treatment, even if a diagnosis has not been made.

This obligation applies to all insurance cover relating to this application. This means you could be placed in a position where you have no insurance cover if we later find you have not answered all questions fully and accurately.

Your duty of disclosure continues until you receive written confirmation your application has been accepted. You must contact the insurer if there is any change in your health or circumstances that are relevant to the insurer's decision on your application.

The full duty of disclosure is contained within this document and it is important you read it carefully. Having read the above, I declare the information I am about to provide is honest, true and complete.

\_\_\_\_\_  
Full name

\_\_\_\_\_  
Member's signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date (DD/MM/YYYY)



You must sign and date this form.

### 3A. ABOUT YOUR INSURANCE HISTORY

Please tick (✓) **Yes** or **No** for each question.

1. Has an application for death, trauma or total & permanent disability (TPD) insurance on your life ever been declined, deferred or accepted with a loading or exclusion or any other special condition or terms?  Yes  No
2. Are you contemplating or have you ever made a claim for or received sickness, accident or disability benefits, workers' compensation, or any other form of compensation due to illness or injury?  Yes  No
3. Have you been paid, are you currently claiming for or are you contemplating a claim for a terminal illness benefit?  Yes  No
4. Do you currently have or are you applying for insurance with MetLife (in addition to this application) or any other insurance company or superannuation fund?  Yes  No

If 'yes' please provide details in the table below.

Product/Type	Total amount of cover	To be replaced by this cover?
Death	\$ _____	<input type="radio"/> Yes <input type="radio"/> No
TPD	\$ _____	<input type="radio"/> Yes <input type="radio"/> No
Income protection	\$ _____	<input type="radio"/> Yes <input type="radio"/> No

### 3B. ABOUT YOUR HEALTH

1. What is your height? \_\_\_\_\_ cm      What is your weight? \_\_\_\_\_ kg
2. Have you smoked any substance in the last 12 months?  Yes  No

3. In the last **three years** have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?

Please tick (✓) all boxes that apply.

- |  |   |
|--|---|
| <input type="radio"/> Headache or migraine (e.g. tension or cluster headaches or migraines)                        | <input type="radio"/> Muscle, tendon or ligament problems                                       |
| <input type="radio"/> Lung or breathing conditions (e.g. asthma, sleep apnoea)                                     | <input type="radio"/> Trapped nerves (e.g. carpal tunnel syndrome, pinched nerve, tennis elbow) |
| <input type="radio"/> Eyesight conditions (does not include contact lenses or glasses for near or far sightedness) | <input type="radio"/> Infectious diseases (excludes cold and flu)                               |
| <input type="radio"/> Ear or hearing conditions (e.g. hearing loss, tinnitus or swimmer's ear)                     | <input type="radio"/> Gout  |
|  | <input type="radio"/> None of the above conditions  |

If you have selected any of the above conditions in question 3, please provide details in the table below.

Condition	Details (including dates, symptoms, treatment)

4. In the last five years have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?

Please tick (✓) all boxes that apply.

- |  |  |
|--|--|
| <input type="radio"/> High blood pressure          | <input type="radio"/> High cholesterol |
| <input type="radio"/> Chronic fatigue              | <input type="radio"/> Fibromyalgia     |
| <input type="radio"/> None of the above conditions |  |

If you have selected any of the above conditions in question 4, please provide details in the table below.

Condition	Details (including dates, symptoms, treatment)

5. Have you ever suffered from, been diagnosed with or sought medical advice or treatment for any of the following?

Please tick (✓) all boxes that apply.

- |  |   |
|--|---|
| <input type="radio"/> Bone, joint or limb conditions               | <input type="radio"/> Urinary or gender specific conditions and abnormal findings |
| <input type="radio"/> Back pain                                    | <input type="radio"/> Autoimmune conditions                                       |
| <input type="radio"/> Digestive conditions                         | <input type="radio"/> Heart-related conditions                                    |
| <input type="radio"/> Brain or nerve conditions (including stroke) | <input type="radio"/> Kidney or liver conditions                                  |
| <input type="radio"/> Psychological or emotional conditions        | <input type="radio"/> Diabetes  |
| <input type="radio"/> Cancer, cyst, growth, lump, polyps or tumour | <input type="radio"/> Blood conditions  |
| <input type="radio"/> Thyroid conditions                           | <input type="radio"/> None of the above conditions                                |
| <input type="radio"/> Skin conditions                              |   |

If you have selected any of the above conditions in question 5, please provide details in the table below.

Condition	Details (including dates, symptoms, treatment)

6. Are you currently pregnant? (Females only)  Yes  No

7. What is the name of your usual doctor/medical centre?

\_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

Suburb

\_\_\_\_\_

State/territory

\_\_\_\_\_

Postcode

\_\_\_\_\_

Contact number

### 3C. ABOUT YOUR FAMILY HISTORY

1. Has your mother, father, any brother, sister or child been diagnosed under the age of 55 years, with any of the following conditions: Alzheimer's disease, cancer, dementia, diabetes, familial polyposis, heart disease, Huntington's disease, motor neurone disease, muscular dystrophy, stroke, or any inherited or hereditary diseases?  Yes  No  Unknown

Note: You are only required to disclose family history information pertaining to first degree blood-related family members, living or deceased.

If 'yes', please provide details in the table below.

Relationship	Age at diagnosis	Specific conditions

### 3D. ABOUT YOUR LIFESTYLE

1. Do you intend to travel to any country outside Australia in the next six months?  Yes  No  
If 'yes' please provide details in the table below.

Country	Length of stay

2. Do you regularly engage in or intend to engage in any of the following activities?  
Please tick (✓) all boxes that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Water sports (e.g. underwater diving, rock fishing)                      | <input type="checkbox"/> Combat sports or martial arts (e.g. martial arts, boxing, fencing)                            |
| <input type="checkbox"/> Motor sports (e.g. motorcycle, auto, motorboat)                          | <input type="checkbox"/> Field sports (e.g. hockey or football including touch or tag and soccer)                      |
| <input type="checkbox"/> Sky sports (e.g. skydiving, hang gliding, parachuting, ballooning)       | <input type="checkbox"/> Hunting (of any kind)   |
| <input type="checkbox"/> Aviation (other than as a fare-paying passenger on a commercial airline) | <input type="checkbox"/> Any other hazardous activity not mentioned (e.g. base jumping, caving, outdoor rock climbing) |
| <input type="checkbox"/> Horse sports (e.g. polo, horse riding, rodeo, dressage, jumping)         | <input type="checkbox"/> None of the above activities  |

Please provide details for any activities you have selected above:

Activity	Details

3. Have you within the last five years used any drugs that were not prescribed to you (other than over the counter drugs) or have you exceeded the recommended dosage of any medication?  Yes  No

Drug/Medicine	Reason for use

4. On average, how many standard alcoholic drinks do you consume each week (a standard drink is equivalent to either 125ml glass of wine, a schooner of light beer, a midday/pot of full strength beer or a 30ml shot of spirits)? \_\_\_\_\_ per week

5. Have you ever been advised by a health professional to reduce your alcohol consumption?  Yes  No

6. Are you infected with HIV (Human Immunodeficiency Virus), the virus which can cause/lead to AIDS (Acquired Immune Deficiency Syndrome)?  Yes  No  
If 'no', have you been referred for or waiting on an HIV test result and/or taking preventative medication?  Yes  No

7. Other than already disclosed in this application, do you presently suffer from any condition, injury or illness, which you suspect may require medical advice or treatment in the future?  Yes  No  
If 'yes', please provide details below.

Condition	Details (including dates, symptoms, treatment)

## 4. DECLARATION

### 4A. INSURANCE DUTY OF DISCLOSURE

Before CareSuper enters into an insurance contract in respect of a member, it has a duty to tell the insurer anything it knows or could reasonably be expected to know that may affect the insurer's decision to provide the insurance and on what terms.

CareSuper has this duty of disclosure until the insurance is provided. CareSuper has the same duty before it extends, varies or reinstates the contract.

CareSuper does not need to tell the insurer anything that:

- Reduces the risk of the insurance
- Is common knowledge
- The insurer knows or should know as an insurer, or
- The insurer waives the duty to tell the insurer about.

#### **If you as a member of CareSuper do not tell the insurer something**

If you, as the person whose life is to be insured as a member of CareSuper, do not tell the insurer something you know or could reasonably be expected to know that may affect the insurer's decision to cover you and on what terms, this may be treated as a failure by CareSuper.

#### **If CareSuper does not tell the insurer something about you**

If CareSuper does not tell the insurer something it is required to and the insurer would not have provided you with the insurance if it had been told, the insurer may avoid the contract within three years of entering into it.

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

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

If the failure to comply with the duty of disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

In exercising its rights, the insurer may consider whether different types of cover can constitute separate contracts of insurance, and may apply its rights separately to each type of cover.

### 4B. PRIVACY OF YOUR PERSONAL INFORMATION

#### **How CareSuper handles your personal information**

CareSuper collects your personal information to establish and administer your superannuation account. If you choose not to provide your personal information CareSuper may not be able to process your insurance application or administer your superannuation account, or provide you with some services offered by CareSuper.

By signing this form, I confirm:

- I have read CareSuper's Privacy Policy, available at [caresuper.com.au/privacypolicy](https://caresuper.com.au/privacypolicy) and the insurer's Privacy Policy available at [metlife.com.au/privacy](https://metlife.com.au/privacy).
- I understand how CareSuper intends to handle my personal information and acknowledge that my personal information will only be used for the purposes specified.
- I consent to the collection and use of my personal information by the Trustee to establish and administer my superannuation account.

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

### 4C. TELEPHONE UNDERWRITING

My preferred contact time is:     Morning (9am-12pm)                       Afternoon (12pm-6pm)

#### 4D. DOCTOR'S DETAILS

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

\_\_\_\_\_  
Name of doctor

\_\_\_\_\_  
Doctor's address

\_\_\_\_\_  
Suburb

\_\_\_\_\_  
State/territory

\_\_\_\_\_  
Postcode

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Fax number

By providing these details and signing this form, I give CareSuper permission to contact my doctor above in relation to my health information.

#### 4E. SIGN THIS FORM

I have read the duty of disclosure in this insurance application 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 insurer 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 any body holding information on me.
- 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.

I declare that:

- The answers to all the questions and the declarations on this Personal Statement are true and correct.
- I have not withheld any information which may affect the insurer'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 obligations outlined in the duty of disclosure in section 4a on page 6.
- I have read and understood 'privacy of your personal information' in section 4b on page 6. I acknowledge and consent to the use and disclosure of my personal information as detailed in that section.
- I have read and understood the **Corporate Insurance PDS** and the relevant incorporated **Corporate Insurance Guide**. I acknowledge that no cover commences until this application is accepted by the insurer.
- 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.

\_\_\_\_\_  
Full name

\_\_\_\_\_  
Member's signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (DD/MM/YYYY)

As a member of CareSuper you may ask to see the information the insurer holds about you, and have it corrected if required by calling **1300 360 149**.

#### ! IMPORTANT

Any increase in insurance cover under a new member option will not be payable if the death, terminal illness or disablement is caused directly or indirectly by an illness, injury or medical condition relating to a pre-existing condition that occurred during the 5 years before applying for the increased cover.

**Please ensure you initial any errors and amendments made on this form.**



#### YOU MUST SIGN AND DATE THIS FORM

The form won't be valid if you don't sign it.

#### ONCE YOU'RE DONE

Return this completed form to:

**CareSuper  
Locked Bag 20019  
Melbourne VIC 3001**

For more information call **1300 360 149**.