

Insurance application form



INSTRUCTIONS

Before completing this form please read the CareSuper **Member Guide PDS** and incorporated **Insurance Guide**.

- To apply to change your occupational category, complete the form at caresuper.com.au/mycategory.
- To apply to have standard age-based cover commence on your account as soon as you become eligible and without requiring health evidence (Employee Plan members only), you can complete the form at caresuper.com.au/insuranceelectionform
- To apply for a **New Member Option (Employee Plan members only)**, complete sections 1, 2, 3, 6 and 7.
- To apply for tailored cover including cover above a New Member Option, complete sections 1, 2, 4, 5, 6 and 7 and follow all instructions.
- If you wish to opt out or reduce your level of cover, please call **1300 360 149**, go to MemberOnline, or complete the form at caresuper.com.au/reduceinsurance. 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 _____

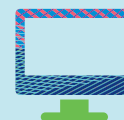
Gender Male Female A gender not listed here

Employer name _____

Occupation _____

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

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



APPLY ONLINE

You can apply to change your cover (if eligible) in the Insurance section of MemberOnline at caresuper.com.au/login

2. OCCUPATIONAL CATEGORIES

CareSuper offers three different categories of cover to reflect the different levels of risk associated with our members' occupations. Please complete (✓) the following questions to determine whether you can change your occupation code.

Are you:

- a) Off work because you're ill, injured or have had an accident? Yes No
- b) Unable to perform all of the duties of your usual occupation, without any restrictions, on a full-time basis (at least 35 hours per week), regardless of whether you are currently working full-time, part-time or casually? Yes No
- c) In your usual occupation, but your duties have changed or been modified in the last 12 months because of accident, illness or injury? Yes No

If you answer 'yes' to any of the above questions, you are not eligible to change your occupational category.

If you answer 'no' to all of the above questions, please complete (✓) the following questions to determine the category that applies to you.

1. Are the duties of your occupation limited to professional, managerial, administrative, clerical, secretarial or similar 'white collar' tasks which do not involve manual work and are undertaken entirely within an office environment (excluding travel time from one office environment to another)? Yes No
2. Are you earning in excess of \$100,000 per year from your profession? (Please see the **Insurance Guide** at caresuper.com.au/pds for a definition of 'total income') Yes No
3. a) Do you hold a tertiary qualification or are you a member of a professional institute or registered as a practising member of your profession by a government body? Yes No

OR

- b) Are you in a management role? Yes No

If you answered no to Q1, you qualify for the **General** occupational category.
If you answered yes to Q1, you qualify for the **Office** occupational category.
If you answered yes to Q1 and Q2, and to either Q3a or Q3b, you qualify for the **Professional** occupational category.

- Your occupational category 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 and you have not changed your cover, your current occupational category will continue to apply to your cover.

3. NEW MEMBER OPTIONS

(for Employee Plan members only)

New Member Options cover is open for 90 days from the date you join CareSuper.

Please choose a New Member Option by ticking (✓) your choice(s) if desired.

Provided you are under age 60 and your application is received within 90 days of joining, you can apply to increase your age-based death and TPD cover or add income protection cover by answering the questions below.

1. Are you:
- a) Off work because you are unemployed, ill, injured or have had an accident? Yes No
- b) Unable to perform all of the duties of your usual occupation, without any restrictions, on a full-time basis (at least 35 hours per week), regardless of whether you are currently working full-time, part-time or casually? Yes No
- c) In your usual occupation, but your duties have changed or been modified in the last 12 months because of accident, illness or injury? Yes No



Check the occupational category that applies to you. This will determine your insurance fees or the cover amount that will apply to you.



IMPORTANT

If you currently work part-time and your full-time equivalent salary is more than \$100,000 p.a. you're eligible to answer "yes" to question 2.

! IMPORTANT

Generally you are an Employee Plan member if your employer pays super guarantee contributions on your behalf. You are a Personal Plan member if you are responsible for paying your own super. Personal Plan members should not complete section 3 of this form.

Call us on **1300 360 149** if you're not sure what type of membership you have.

2. Have you:
- a) In the last 12 months, been away from work for more than 10 working days in a row because you were ill or injured, or Yes No
 - b) Been advised by, or discussed with your medical practitioner that because of an illness or injury you'll need to take at least 10 working days in a row off work (regardless if diagnosed) in the next 12 months? Yes No
3. Have you been diagnosed with an illness or injury that reduces your life expectancy to less than 24 months? Yes No
4. Have you ever been declined death, TPD or income protection cover, or been excluded from insurance cover for a specific medical condition or injury? Yes No
5. Have you ever made or satisfied the requirements to make a claim for an injury, illness or condition either in Australia or overseas through:
- a) CareSuper or another super fund Yes No
 - b) Workers' compensation Yes No
 - c) An illness benefit or invalid pension Yes No
 - d) An insurance policy that provides terminal illness, TPD, or income protection cover (including accident or illness cover), or Yes No
 - e) A common law settlement? Yes No

If you answered yes to any one of the above questions, you are not eligible for cover through the New Member Options. Please complete sections 5 and 6.

If you answered no to all of the above questions, please choose your New Member Options by ticking (✓) your choices below.

CHOOSE YOUR NEW MEMBER OPTIONS

Death and TPD cover

You can choose to increase the standard age-based death and TPD cover scale or fix your cover at a set dollar amount. Maximum cover limits apply to both age-based and fixed cover – either way you can increase your total death and TPD cover up to the lesser of 7 times your total annual income or \$750,000. **Please choose a New Member Option by ticking (✓) your choice(s).**

My total income* (including overtime, commission, bonuses and shift allowances, but excluding employer contributions) is: \$ _____

*Refer to the **Insurance Guide** for the definition of total income.

Age-based cover

I would like to increase my standard age-based cover level to a multiple of:

- | Death cover: | TPD cover: |
|-----------------------------|-----------------------------|
| <input type="radio"/> 1.25 | <input type="radio"/> 1.25 |
| <input type="radio"/> 1.50 | <input type="radio"/> 1.50 |
| <input type="radio"/> 1.75* | <input type="radio"/> 1.75* |
| <input type="radio"/> 2.00* | <input type="radio"/> 2.00* |

*Applicable to General and Office occupational category members.

OR

Fixed cover

- I would like to increase my total death and TPD cover up to 7 times my total income (maximum limit of \$750,000). Refer to the **Insurance Guide** for the full definition of total income.

I want my total amount of **fixed cover** to be: Death \$ _____

TPD* \$ _____

- I would like to index my fixed cover annually by 5%

*Under New Member Options, TPD cover must be less than or equal to death cover. Please see the **Insurance Guide** for details.

INCOME PROTECTION

Income protection cover provides a temporary replacement income if you are unable to work due to illness or injury (specific conditions apply).

If you want to apply for income protection cover above what is offered through the New Member Options, you will also need to complete section 6 – the Personal health statement. Depending on your occupational category, maximum benefit amounts will apply.

My total income* (including overtime, commission, bonuses and shift allowances and excluding mandated employer contributions) is: \$ _____

*Refer to the **Insurance Guide** for the definition of total income.

The amount of income protection cover you can apply for is capped at 85% of your income.

If your income is less than \$16,000 p.a. you can still be eligible for income protection cover if you work 15 hours or more per week. Please tick (✓) this box if this applies to you.

I would like to apply for \$ _____ per month of income protection cover.

EXAMPLE – HOW TO CALCULATE 85% OF INCOME

Lucy earns a before-tax income of \$81,000 per annum excluding employer super contributions. She is in the Office occupational category.

Lucy decides to apply for the maximum amount of cover which is:

$\$81,000 \times 0.85 \div 12 = \$5,737.50$ per month

Lucy can apply for up to \$5,800 income protection cover per month.

Refer to the **Insurance Guide** at caresuper.com.au/pds for more information on how to calculate how much income protection cover you want.

Your cover amount will automatically increase by 5% on 1 July each year to account for inflation. Premiums will be based on the increased cover.

BENEFIT PERIOD

Please indicate by ticking (✓) the benefit period you would like. A 2-year benefit period will apply if you do not make a selection.

2 years 5 years

WAITING PERIOD

Please indicate by ticking (✓) the waiting period you would like to select (refer to the **Insurance Guide** for details). The 30-day waiting period will apply if you do not make a selection.

30 days 60 days 90 days

Note: If you wish to reduce the waiting period or increase the benefit period in the future, you will need to complete a new application form, including the Personal health statement.

! IMPORTANT

To be eligible for income protection cover, you must be aged under 65 and:

- Be earning at least \$16,000 per year on an ongoing basis, or
- Working 15 hours or more per week.



You can apply for income protection as a New Member Option within 90 days of joining by answering a few health questions.

Depending on your occupational category, the maximum benefit amounts will apply under New Member Options cover:

General: Up to \$61,200 p.a. (\$5,100 per month)

Office: Up to \$86,700 p.a. (\$7,225 per month)

Professional: Up to \$122,400 p.a. (\$10,200 per month)

4. TAILOR YOUR INSURANCE

DEATH AND TPD COVER

Fixed cover

You can apply for fixed death and TPD cover in multiples of \$1,000. A minimum of \$10,000 applies. You can have more TPD cover than death cover.

Please enter the amounts of fixed cover you require below, and tick (✓) further options as appropriate:

Death cover \$ _____

TPD cover \$ _____

I would like to index my fixed cover annually by 5%.

Choose (✓) one of the following options:

I want to add this cover to my existing level of cover.

OR

I want this cover to replace my existing cover.

Age-based cover

I want to fix my current age-based cover so that my amount of cover stays the same.

I do not have insurance cover with CareSuper and I would like to apply for standard age-based cover.

See the **Insurance Guide** for information about the level of cover and insurance fees.

INCOME PROTECTION

Refer to the **Insurance Guide** for more information on how to calculate how much income protection cover you want, up to 85% of income.

If your total income exceeds \$423,530, your income protection cover will be subject to maximum benefit restrictions.

I would like to apply for \$ _____ per month of income protection cover.

Benefit period: 2 years (default) 5 years

Waiting period: 30 days (default) 60 days 90 days

My total income* (including overtime, commission, bonuses and shift allowances, but excluding employer contributions) is: \$ _____

* Refer to the **Insurance Guide** for the definition of total income.



This section is for members who are applying for cover outside of the New Member Options. An application to increase your insurance cover requires a health assessment and is subject to the insurer's approval.

To calculate your annual insurance fee, divide your required level of cover by \$1,000 and multiply the rate for your age, gender and occupational category.

Note: The maximum income protection benefit is 85% of the first \$423,530 p.a. of income, plus 60% of the next \$200,000 p.a. of income for the first two years of the benefit period, regardless of the benefit period.

Income protection benefit payments

For cover up to \$30,000 per month, for each \$85 of benefit \$75 is paid as income and \$10 is paid to your super account.

For cover between \$30,000 and \$40,000, for each \$60 of benefit \$50 is paid as income and \$10 to your super account.

See the **Insurance Guide** for more information about how your benefit may be paid, including if you suffer an illness or injury.

5. 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, including amounts transferred from another fund or insurance arrangement. 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.

X

Member's signature

Date (DD/MM/YYYY)

Full name

5A. 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

IMPORTANT INSTRUCTIONS

1. If you've applied for a New Member Option, don't complete section 5 unless you're applying to increase your cover above what is offered through the New Member Options. Go to section 6 and 7 and sign and date the application form.
2. If you are applying for tailored insurance cover, you must complete section 5.

5B. 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.

- Headache or migraine (e.g. tension or cluster headaches or migraines)
- Lung or breathing conditions (e.g. asthma, sleep apnoea)
- Eyesight conditions (does not include contact lenses or glasses for near or far sightedness)
- Ear or hearing conditions (e.g. hearing loss, tinnitus or swimmer’s ear)
- Muscle, tendon or ligament problems
- Trapped nerves (e.g. carpal tunnel syndrome, pinched nerve, tennis elbow)
- Infectious diseases (excludes cold and flu)
- Gout
- 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.

- High blood pressure
- High cholesterol
- Chronic fatigue
- Fibromyalgia
- 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.

- Bone, joint or limb conditions
- Back pain
- Digestive conditions
- Brain or nerve conditions (including stroke)
- Psychological or emotional conditions
- Cancer, cyst, growth, lump, polyps or tumour
- Thyroid conditions
- Skin conditions
- Urinary or gender specific conditions and abnormal findings
- Autoimmune conditions
- Heart-related conditions
- Kidney or liver conditions
- Diabetes
- Blood conditions
- None of the above 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? Yes No

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

Name

Address

Suburb

State/territory

Postcode

Contact number

5C. 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

5D. 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.

- Water sports (e.g. underwater diving, rock fishing)
- Motor sports (e.g. motorcycle, auto, motorboat)
- Sky sports (e.g. skydiving, hang gliding, parachuting, ballooning)
- Aviation (other than as a fare-paying passenger on a commercial airline)
- Horse sports (e.g. polo, horse riding, rodeo, dressage, jumping)
- Combat sports or martial arts (e.g. martial arts, boxing, fencing)
- Field sports (e.g. hockey or football including touch or tag and soccer)
- Hunting (of any kind)
- Any other hazardous activity not mentioned (e.g. base jumping, caving, outdoor rock climbing)
- 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 middy/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)

6. DECLARATION

6A. TELEPHONE UNDERWRITING

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

6B. 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.

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**.

6C. 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 void the contract within three years of entering into it.

If the insurer chooses not to void 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 fee 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 void 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.

6D. 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 and the insurer's Privacy Policy, available at 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**.

7. CONFIRM YOUR REQUEST

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 Health 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 6C.
- I have read and understood 'Privacy of your personal information' in section 6D. I acknowledge and consent to the use and disclosure of my personal information as detailed in that section.
- I have read and understood the **CareSuper Member Guide PDS** and the incorporated **Insurance Guide**. I acknowledge that, if this application is accepted by the insurer, cover will commence from the date of acceptance.
- 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.

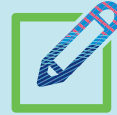


Member's signature

Date (DD/MM/YYYY)

Full name

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



YOU MUST PRINT AND THEN SIGN THIS FORM

The form won't be valid if you don't sign and date it. (We cannot accept digital signatures.)

ONCE YOU'RE DONE

Return this completed form and any supporting documents by:

1. Attaching and submitting it online at: **caresuper.com.au/getintouch**
2. Posting it to:
**CareSuper
Locked Bag 20019
Melbourne VIC 3001**

For more information call **1300 360 149**