CareSuper

Corporate insurance application form

IMPORTANT

Please refer to the **Corporate Insurance PDS** and your **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).

If you've not previously held standard cover with CareSuper, you can apply to have it commence on your account without providing medical evidence as soon as you're eligible (subject to terms and conditions). Complete and return the form at **caresuper.com.au/insuranceelectionform**

If you wish to opt out or reduce (if eligible) your level of standard 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 ◯ A gender not listed here

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

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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 category.

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 relevant **Corporate Insurance Guide** 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.

Check the occupational category that applies to you. This will determine your 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.

3. 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 fixed cover in addition to my existing cover as follows:

Additional death cover:

$ ___ ___ ___ ___ ___ ___

Additional TPD cover:

$ ___ ___ ___ ___ ___ ___

◯ I would like to index my fixed cover by 5% annually to account for inflation

◯ 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**.

Change my income protection cover to:

$ ___ ___ ___ ___ ___ ___ per month

with a benefit period of: (please (✔) tick applicable box)

◯ 2 years (default) ◯ 5 years

and a waiting period of:

◯ 30 days (default) ◯ 60 days ◯ 90 days

Please tick (✔) if applicable:

◯ I understand that any income protection cover applied for on this form will cancel and replace my existing income protection cover with CareSuper.

4. 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.

4A. 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.

✕ _____ ___ ___ / ___ ___ / ___ ___ ___ ___

Member's signature Date (DD/MM/YYYY)

_____

Full name

4B. 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	$ ___ ___ ___ ___ ___ ___ ___	◯ Yes ◯ No
TPD	$ ___ ___ ___ ___ ___ ___ ___	◯ Yes ◯ No
Income protection	$ ___ ___ ___ ___ ___ ___ ___	◯ Yes ◯ No

4C. 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
- ◯ Chronic fatigue
- ◯ None of the above conditions
- ◯ High cholesterol
- ◯ Fibromyalgia

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? (Females only) ◯ Yes ◯ No

4D. 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

4E. 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)

5. DECLARATION

5A. TELEPHONE UNDERWRITING

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

5B. 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**.

5C. 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 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 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.

5D. 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**.

6. 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 5C.
- I have read and understood 'Privacy of your personal information' in section 5D. 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.

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**

✕ _____

Member's signature

__ __ / __ __ / __ __ __ __

Date (DD/MM/YYYY)

_____

Full name

Save form | Print form | Clear form