

Insurance Request Form

For members in the Personal Division



Use this form if you would like to purchase or amend your Death and/or Total and Permanent Disablement cover. You will also need to fill in a *Personal Statement Form* and Privacy Consent. Please visit our website or call our Helpline on 1800 555 667 for the appropriate forms.

1. Your personal details

We will use these details to calculate your benefits, and to send you updates on your super and for other communications. If your details change please advise us by calling the Russell SuperSolution Helpline or visiting the website at www.russell.com.au/super

Title (Mr Mrs Ms Dr):	<input type="text"/>	Surname:	<input type="text"/>	First name(s):	<input type="text"/>	
Address:	<input type="text"/>				Postcode:	<input type="text"/>
Work telephone:	<input type="text"/>	Home telephone:	<input type="text"/>			
Mobile telephone*:	<input type="text"/>	Date of birth:	<input type="text"/>			
Member number:	<input type="text"/>	Email*:	<input type="text"/>			

* By providing your email address and/or mobile phone number you are confirming that you would like to, where possible, receive future communications electronically by viewing personal information about your super online through the log in area and by receiving news and updates about superannuation via email and/or SMS. Remember, you can call the Helpline to request a hard copy of a particular communication to be sent to you by post or to request to receive future communications in this manner.

2. Your insurance cover

The insurance cover available to you as a member of the Russell SuperSolution Master Trust ("Russell SuperSolution") is an important safety net for you and your family.

Details of the Death and Total and Permanent Disablement (TPD) insurance cover available are provided in the *Your Super Guide* booklet.

You may purchase any number of units of Death only or Death and TPD cover, subject to acceptance of your medical evidence supplied to the insurer. Maximum cover available is \$5 million for Death and \$2 million for TPD.

The premium for this cover will be deducted from your Russell SuperSolution account.

3. Your insurance choice

Please enter your required insurance details below. If you elect to reduce your cover, please remember that if you later decide to increase your cover, the increase will be subject to acceptance of medical evidence.

Current number of units of Death cover	<input type="text"/>	➤	New number of units of Death cover	<input type="text"/>
Current number of units of TPD cover	<input type="text"/>		New number of units of TPD cover	<input type="text"/>

Note: You may not have more units of TPD cover than Death cover, but you may have more units of Death cover than TPD cover.

I wish to cancel my insurance cover.

4. Your declaration

I understand:

- » that I can change the number of units I have at any time
- » any reduction in cover will be processed as soon as practicable after this form is received by Russell SuperSolution
- » the provision of insurance cover is subject to acceptance by the insurer
- » if I have insurance cover, a premium based on the number of units of cover will be deducted from my Russell SuperSolution account.

I have read and considered the current Product Disclosure Statement for my division of Russell SuperSolution.

Signature: _____

Date:



Member's Personal Statement

Policy number	<input type="text"/>
Member number	<input type="text"/>
Plan administrator	<input type="text"/>

YOUR DUTY OF DISCLOSURE

Before you enter into 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 insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before you extend, vary or reinstate a contract of life 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 his business, ought to know;
- disclosure of which is waived by the insurer.

The duty of disclosure applies even after this Application is completed until TAL advises acceptance of insurance.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into 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.

All questions on this Personal Statement are relevant as to whether or not TAL accepts the risk and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dot or dash is not acceptable.

1. PERSONAL DETAILS

(please print answers clearly)

Name of plan	<input type="text"/>	Policy number	<input type="text"/>
Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other		<input type="text"/>
Surname	<input type="text"/>	Given name	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	(DD/MM/YYYY)	Gender M <input type="checkbox"/> F <input type="checkbox"/>
May TAL contact you directly to clarify or gather information in relation to this application?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, preferred method of contact:		Email <input type="checkbox"/> Phone <input type="checkbox"/> Contact time	<input type="text"/>
Email address	<input type="text"/>	Phone No.	(<input type="text"/>) <input type="text"/>

2. OCCUPATION DETAILS

1. Self employed Employee full-time OR Part-time hours p/week weeks p/year
2. Your occupation Industry
3. Duties performed
4. Annual salary (includes packaged items but excludes bonuses/commission) \$

3. INSURANCE APPLICATION

Death sum insured TPD sum insured

Monthly income benefit \$ Benefit period Waiting period

1. Is this an increase? Yes No
2. Have you ever held or applied for any life, disability, accident & sickness or trauma insurance, that was declined, postponed, had the premium increased or modified, or had a current policy cancelled or renewal refused? Yes No
3. Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? Yes No
4. Do you have, or are you applying for, any other life or disability cover? Yes No

If yes to 2, 3 and or 4, please provide full details below.

Name of company	Cover type	Sum insured	Date of application	Accepted	Loaded	Exclusion	Declined	To be replaced?			
								Yes	No		
		\$	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		\$	/ /					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		\$	/ /					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

4. HABITS AND ACTIVITIES

1. Do you drink alcohol? Yes No

If yes, state type and daily quantity.

2. Have you smoked in the past 12 months? Yes No

If yes, state form and daily quantity.

3. Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? Yes No

If yes, complete a drug use or alcohol consumption questionnaire.

4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or any other extreme sport? Yes No

If yes, please complete a sports and pastimes statement.

5. Do you intend travelling outside Australia within the next two years? Yes No

If yes, please provide details below (where, when, duration and reason).

6. Are you an Australian or New Zealand citizen? Yes No
7. Do you hold an Australian Permanent Resident's Visa? Yes No

If no to 6 and 7, please provide details.

5. PERSONAL STATEMENT

1. Please state your: Height (cm) Weight (kg)
2. Name and address of your usual doctor or medical centre
- Surname Given name
- Address
- State Postcode
3. Details of last medical consultation with your usual doctor or medical centre
- Date (DD/MM/YYYY)
- Reason
- Outcome/results
4. If you have attended that doctor for less than 12 months, name and address of previous doctor
- Surname Given name
- Address
- State Postcode
5. A. Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquilisers? Yes No
- B. Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation? Yes No
- C. Have you EVER had any blood tests which revealed an abnormality e.g. raised blood sugar, liver function, renal function results, or anaemia, etc? Yes No
- D. Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future? Yes No

Please provide full details for all 'Yes' answers.

Question	Dates (from /to)	Name / Address of doctor, hospital or clinic	Condition, medications, treatments & time off work	Recovery %

6. PERSONAL STATEMENT (GENERAL MEDICAL QUESTIONS)

Please provide details for all 'Yes' answers in General Medical Questionnaire at Section 7.

1. Have you ever had, been advised that you had, or received advice or treatment for any of the following:
- A. High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? Yes No
 - B. Bowel, stomach or intestinal problem, gall bladder or liver disease? Yes No
 - C. Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks? Yes No
 - D. Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition? Yes No
 - E. Diabetes, sugar in urine, pancreatic or thyroid problem? Yes No
 - F. Cancer, tumour, melanoma, sunspots, mole or growth of any kind? Yes No
 - G. Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? Yes No
 - H. Impairment of sight, hearing or speech? Yes No
 - I. Asthma, bronchitis, or any lung complaint? Yes No
 - J. Leukaemia, haemochromatosis, or any blood problems? Yes No
 - K. Kidney, or bladder problems? Yes No
 - L. Psoriasis, eczema, or any skin problem? Yes No
 - M. Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? Yes No
 - N. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No
 - O. Have you ever engaged in any activity/ies reasonably accepted to having an increased risk of exposure to the HIV/AIDS virus? Yes No

Females only

- P. Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal Pap smear, etc)? Yes No
- Q. Have you ever had any complications of pregnancy or childbirth? Yes No
- R. Are you currently pregnant? Yes No

If yes, what is the expected delivery date?

- S. Have you ever had a breast lump (even if you have not seen a doctor about it)? Yes No

2. Family History

Have any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's Chorea or any hereditary disease?

Yes No

3. Please give details of your family medical history.

Relative	Living relatives		Deceased relatives	
	Current age	Specify current state of health	Age at death	Specify cause of death
Mother				
Father				
Sisters				
Brothers				

7. GENERAL MEDICAL QUESTIONNAIRE

Please provide details for all 'Yes' answers in Section 6 A to S. Please complete on a separate sheet if required.

Question No.	Q.	Q.	Q.	Q.
Specific condition				
A. Date symptoms first started and description of symptoms.				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				
H. What advice/treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment.				
J. Date treatment/medication ceased.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%).				
M. Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

8. PRIVACY

Privacy laws are designed to protect the privacy of individuals. The way in which we collect, use, disclose and handle your information is described in the TAL Privacy Policy available at www.tal.com.au. If you have any questions regarding your privacy or would like to obtain a copy of our Privacy Policy please contact our Privacy Officer.

9. DECLARATION

I acknowledge that I have read the notice of my duty of disclosure and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this Application and any supplementary application or personal statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Member, authorise and direct any medical or other practitioner to divulge at any time to TAL Life Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history, acquired in the course of professional attendance or consultation.

A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TAL Life Limited to its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information collected on this form or future forms in relation to this insurance.

Full name of Member

Signature of Member

Date

10. MEDICAL AUTHORITY

I agree that any medical practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of Member

Signature of Member

Date

Please return the completed form to:

TAL Life Limited, PO Box 142, Milsons Point NSW 1565. 80 Alfred Street South, Milsons Point NSW 2061

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