ANZ SMART CHOICE SUPER
INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

1 October 2023

Customer Services

Phone 13 12 87

Email smartchoice@insigniafinancial.com.au
Website www.anz.com/smartchoicesuper

INSTRUCTIONS

Zurich is the default insurer for the group life insurance provided under ANZ Smart Choice Super. ANZ Smart Choice Super is a suite of products consisting of ANZ Smart Choice Super and Pension, ANZ Smart Choice Super for employers and their employees and ANZ Smart Choice Super for QBE Management Services Pty Ltd and their employees (together "ANZ Smart Choice Super"). ANZ Smart Choice Super is part of the Retirement Portfolio Service ABN 61 808 189 263.

* Complete this form to apply for:

- Death and TPD cover or Death only cover for an amount over $1,000,000 (including any existing cover),
- Income Protection (IP) cover,
- where we have otherwise requested that you complete this form, or
- where you previously have submitted a Short-Form Personal Health Statement that was not accepted and you still wish to be considered.

The maximum amount of TPD cover you can apply for is $5,000,000.

When you complete and return this form, OnePath Custodians (the trustee of the Retirement Portfolio Service) will submit an application to the Insurer, for the Insurer to assess your request for cover.

Before proceeding with this application, it is important that you have read and understood the ANZ Smart Choice Super Product Disclosure Statement (PDS). Please follow all instructions carefully – you will be required to complete some or all of the questions in this form.

Complete and sign the form and return to:

ANZ Smart Choice Super
GPO Box 5107
Sydney NSW 2001

or scan and email to smartchoice@insigniafinancial.com.au.

Note that emails must be sent from the email address we hold on our records.

* This form should not be completed if a different insurer applies for an employer plan through ANZ Smart Choice Super for employers and their employees. Contact Customer Services on 13 12 87 for the relevant application form.

IMPORTANT NOTICE

If this application is declined:

- any existing insurance held by you on the date of this application will continue on the terms and conditions which applied as at the date of this application, including but not limited to any pre-existing condition exclusion(s) (where applicable);
- any information received by Zurich in relation to this application may be used by Zurich when assessing any existing or future insurance claim, and may operate as an exclusion of a claims or otherwise have an adverse impact on your claim.

If this application is accepted by Zurich, insurance cover will be provided according to the ANZ Smart Choice Super Policies, and any exclusion or loading imposed as part of the acceptance of this application will apply to the amount of cover stated in the Decision Note.

THE DUTY TO TAKE REASONABLE CARE

When applying for insurance, you have a legal duty to take reasonable care not to make a misrepresentation to the Insurer.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where the Insurer later investigates whether the information given to them was true. For example, the Insurer may do this when a claim is made.

About this application

When you apply for life insurance, the Insurer conducts a process called underwriting. It's how they decide whether they can provide cover, and if so on what terms and at what cost.

The Insurer will ask questions they need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to the Insurer in response to their questions is vital to their decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the Trustee may pass on to the Insurer personal information you provide to the Trustee. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the Trustee.

Guidance for answering the Insurer's questions

You are responsible for the information you provide to the Insurer. When answering their questions, you should:

- Think carefully about each question before answering. If you are unsure of the meaning of any question, please ask the Insurer before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume the Insurer will ask others such as your doctor.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts.

Before your cover starts, the insurer may ask you about any changes that mean you would now answer their questions differently, as any changes might require further assessment or investigation.

Notifying the Insurer

If, after your cover starts, you think you may not have met your duty, please tell the Insurer immediately and they will let you know whether it has any impact on your cover.

Telephone contact

After you submit your application, the Insurer may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into also applies during any phone contact with the Insurer.

If you need help

It's important that you understand this information and the questions the Insurer asks. Ask the Insurer for help if you have difficulty answering their questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, help is available and can be provided if required. You can have a support person you trust with you.

What can the Insurer do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to the Insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). They are intended to put the Insurer in the position they would have been in if the duty had been met.

For example, the Insurer may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including all of the following:

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific the Insurer's questions were and how clear the information they provided on the duty was
- what the Insurer would have done if the duty had been met – for example, whether they would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before the Insurer exercises any of these remedies, they will explain their reasons, how to respond and provide further information, and what you can do if you disagree.

1. PERSONAL DETAILS

Member number(s)

Name of employer

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Surname

First name

Date of birth D D M M Y Y Y Y ☐ Male ☐ Female

Residential address

Suburb/Town | State | Postcode

Country

Postage address (if different)

Suburb/Town | State | Postcode

Country

Home phone | Work phone

Mobile phone | Fax

Email

I authorise one of Zurich's underwriting staff or an authorised service provider to contact me by phone if further information is required.

I can be contacted during the following times: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any business day

Between am/pm and am/pm

Please tick your preferred contact method: ☐ home phone ☐ work phone ☐ mobile phone

2. AMOUNT OF COVER

Type of cover required	**Total amount of cover**
☐ Death Only (no maximum benefit limit applies)	$
☐ Death and Total and Permanent Disablement (TPD) (maximum insurance cover is for TPD is $5,000,000)	$

☐ Total and Permanent Disablement (if you already have Death cover) (maximum insurance cover is $5,000,000. Please note, total TPD Cover cannot exceed total Death Cover).

If your plan design allows you to apply for Death only or Death and TPD cover other than a fixed dollar amount, please specify the cover that you wish to apply for (i.e. Fixed or formula) below. In the event that no direction is provided below, your application will be assessed as a request for fixed cover.

☐ IP (monthly benefit). The monthly benefit may be the equivalent of up to 75% of your monthly salary, but cannot exceed $30,000 per month. $

Where your employer has not selected IP as part of your plan's insurance arrangements you are able to nominate your own waiting period.

Please nominate the waiting period: ☐ 30 days ☐ 60 days ☐ 90 days

Please nominate the benefit period: ☐ 2 years ☐ up to age 65

Do you want to include the superannuation contribution benefit? ☐ Yes ☐ No

If your plan design allows you to apply for an IP benefit design, waiting period or benefit period other than those provided for above, please specify below.

3. RESIDENCE AND TRAVEL DETAILS

1. Are you currently residing in Australia? ☐ Yes ☐ No

   If no, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No

   If **yes,** please proceed to question 3.

   If **no,** please advise what type of visa you hold

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

   If yes, please complete the following:

   Date of departure D D M M Y Y Y Y Duration of stay

   Destination(s) (country/cities)

   Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other, please specify

4. INSURANCE DETAILS

1. Are you covered by, or are you applying for, any other life, TPD, income protection or salary continuance cover with any company, including Zurich (other than this application), including benefits under superannuation or insurance benefits by your employer?
   ☐ Yes ☐ No

If you answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced	Will this policy be discontinued/ replaced?	Date last fully under-written (replacement policies only)
		$	D D / M M / Y Y Y Y	☐ Yes ☐ No	D D / M M / Y Y Y Y
		$	D D / M M / Y Y Y Y	☐ Yes ☐ No	D D / M M / Y Y Y Y
		$	D D / M M / Y Y Y Y	☐ Yes ☐ No	D D / M M / Y Y Y Y

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No

If **yes**, please provide name of company, alteration, type of cover, date and reason (if known).

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans' Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

5. OCCUPATION DETAILS

a. What is your usual occupation? | Industry

b. When did your present job/employment situation commence? D D M M Y Y Y Y | Years in industry

d. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases).

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary/Administration (e.g. filing, computer work, answering telephone, reception duties, etc.)		
Manual work – Light (e.g. driving, warehousing, surveying, lifting under 5 kgs, etc.)		
Manual work – heavy (e.g. bricklaying, lifting over 5 kgs, painting, carpentry, mechanic, etc).		
Hazardous collar* – Unqualified or hazardous manual work, which may include any of the following: • The use of heavy machinery • Carrying, lifting, pushing, pulling or operating heavy machinery for more than 80% of the day.		

* Not eligible for Income Protection cover.

e. How many hours (on average) do you work per week in your principal occupation (include hours worked at home)?

f. What is your current annual income earned through personal exertion, before tax, but excluding superannuation contributions and after the deduction of business expenses? $

g. Do you have more than one occupation? ☐ Yes ☐ No

If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s):

6. PASTIMES

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc.? ☐ Yes ☐ No
3. aviation/flying, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered yes to any of questions 1, 2 or 3 above, please complete the relevant questionnaire(s) on page 24.

7. PERSONAL HEALTH STATEMENT

1. What is your current height and weight? Height (cm) | Weight (kg)
2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No
   If **yes**, please provide details:
3. During the last 12 months have you smoked tobacco or any other substance or used any form of electronic cigarette? ☐ Yes ☐ No
   If **yes**, please state type and quantity per day:

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Chantix, etc.)? ☐ Yes ☐ No
   If **yes**, please state type(s) used and length of time you have been using this:

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No
   If **yes**, please state type, quantity per day and date ceased:

6. Do you consume alcohol? ☐ Yes ☐ No
   If **yes**, please state how many standard drinks you consume per day (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop or reduce your alcohol intake or stop smoking due to a medical condition? ☐ Yes ☐ No
   If **yes**, please provide details:

If you are required to a have a full medical examination, go to Section 10 on page 10.

8. FAMILY HISTORY

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, multiple sclerosis, motor neurone disease, cystic fibrosis, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to the age of 60 been diagnosed with: diabetes, heart disease, stroke, mental illness, haemochromatosis, breast cancer, bowel cancer, ovarian cancer, prostate cancer or any other cancer (please specify type)? ☐ Yes ☐ No

If you answered yes to either question 1 or 2, please complete the following table (if more room is required, use the space provided on page 25)

Relation	Condition/disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).

9. MEDICAL HISTORY

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. Asthma? ☐ Yes ☐ No
2. High blood pressure? ☐ Yes ☐ No
3. High cholesterol? ☐ Yes ☐ No
4. Diabetes? ☐ Yes ☐ No
5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No
6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No
7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No
8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered yes to any of the conditions in Questions 1– 8 above, please complete the relevant questionnaire on pages 15 to 24.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness, fainting of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No
19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No
20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? ☐ Yes ☐ No
22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No
23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No
24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No
25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No
26. Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)? ☐ Yes ☐ No
27. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No
28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc.) ☐ Yes ☐ No

29. A. Is the combined total of your existing insurance(s) detailed in section 4 Question 1, and any new insurance you are applying for with Zurich, more than any one of the following; $500,000 Death; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? ☐ Yes ☐ No

If you answered Yes to question 29 (A) please proceed to 29 (B), otherwise continue to question 30.

29. B. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you). ☐ Yes ☐ No

30. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No

31. Have you ever used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No

32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No

33. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition? ☐ Yes ☐ No

34. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

35. Females only

a. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date D D M M Y Y Y Y ☐ Yes ☐ No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered yes to any questions from 1– 35, please complete the following table. If there is not enough space here, please provide details on page 25.

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms D D M M Y Y Y Y Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms D D M M Y Y Y Y

Name and address of medical facility and attending doctor

10. USUAL DOCTOR OR MEDICAL CENTRE DETAILS

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone Fax

Address

Suburb/Town State Postcode

2. How many years have you been attending this doctor/medical centre? years months

   a. When was your last visit to this doctor/medical centre?

   b. Reason for check-up or consultation?

   c. Outcome including medication, treatment etc.

   d. Degree of recovery? %

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? ☐ Yes ☐ No

   If yes, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		

11. DECLARATION BY THE INSURED MEMBER

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to Zurich and/or the Medical Examiner are true and correct.
- I accept that where I have appointed a financial adviser or other intermediary to arrange and/or administer the arrangements on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
- I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statement set out in this form (refer to page 14), ANZ's Privacy Policy which is available at anz.com/privacy, OnePath Custodians' Privacy Policy which is available at onepath.com.au/superandinvestments/privacy-policy and Zurich's Privacy Policy which is available at zurich.com.au/important-information/privacy. If I have provided information about another person in this application (for example a beneficiary or life insured), I declare that I have the consent of that person to do so. I understand that ANZ, OnePath Custodians and Zurich require me to inform the person concerned that I have done so and direct them to the relevant Privacy Policies so they may understand the manner in which their personal information (including health and other sensitive information) may be used and disclosed by ANZ, OnePath Custodians and Zurich.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to Zurich in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis, that I have received, read and understood a copy of the ANZ Smart Choice Super Product Disclosure Statement(s) (PDS) and information on the type(s) of cover for which I am applying.
- I acknowledge that Zurich is not a related body corporate of OnePath Custodians.
- I acknowledge that if the insurer accepts an application for Choose Your Own or Voluntary Cover subject to special acceptance terms Cover will not commence until:
  - I accept the Special Acceptance terms within 21 days of the acceptance date; and
  - the premium received for the Choose Your Own Cover or Voluntary Cover is enough to cover the number of days from the acceptance date to the premium due date, by the third premium due date.
- I acknowledge that if this application is accepted by Zurich insurance cover will be provided according to the ANZ Smart Choice Super Policies and any exclusion or loading imposed as part of the acceptance of this application will apply to the amount of cover stated in the Decision Note.
- I acknowledge that if this application is declined, any of my existing cover on the date of this application will continue on same terms, including but not limited to any pre-existing condition exclusion(s).
- I acknowledge that any information received by Zurich in relation to this application may be used when assessing my existing or future claim, and may operate as an exclusion to my claim. This is irrespective of whether this application is accepted or declined.
- I understand that I may cancel my existing cover at any time.
- 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 won't be considered by the Insurer.

Name of insured member/applicant

Signature of insured member/applicant

Date D D M M 2 0 Y Y

12. DOCTORS AUTHORISATION

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, Zurich Australia Limited ABN 92 000 010 195 (Zurich), collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty to Take Reasonable Care under the *Insurance Contracts Act 1984* (Cth).

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Zurich, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Zurich asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Zurich can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Zurich is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date of birth D D M M Y Y Y Y

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Zurich, or to third parties they engage, only if Zurich has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Zurich can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Zurich is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date of birth D D M M Y Y Y Y

13. PRIVACY STATEMENT

Your personal information will be handled by OnePath Custodians, as issuer of this product, ANZ, as distributor of the Smart Choice Super and Pension product and Zurich, as group life insurer. Please read the information contained in this section carefully, as it describes how each of these parties will handle your personal information. In this section, any reference to your personal information includes any health or other sensitive information that OnePath Custodians, ANZ or Zurich may hold about you. Any or all of these parties may send you information on their products and services from time to time. If you do not wish to receive this information from any or all of these parties, please ensure you follow the separate opt out processes for the relevant party specified below.

OnePath Custodians Privacy Statement

OnePath Custodians Pty Limited ABN 12 008 508 496, RSE L0000673 (**OPC**), as issuer of this product, will collect your personal information when you deal with it, its agents, its related bodies corporate, including other members of the Insignia Financial Group, distributors of this product (such as ANZ), or suppliers acting on OPC's behalf.

OPC uses your personal information to issue and administer our products and services. If you do not provide us with your personal information, we may not be able to issue this product to you and/or administer your account.

OPC may disclose your personal information to related bodies corporate, relevant group life insurers, such as Zurich, and organisations, including those in an alliance with us, to distribute, manage and administer our products and services, carry out business functions, undertake analytics activities and as set out in OPC's Privacy Policy.

OPC may also use and disclose your personal information to send you information on its products and services from time to time. OPC may also disclose your personal information to its related companies, relevant group life insurers, such as Zurich and organisations, including those who are in an alliance with it, to enable those organisations to send you information about their products and services. You can opt out of OPC using and disclosing your information for this purpose at any time by calling Customer Services on 13 12 87.

OPC may also send your personal information overseas, as set out in OPC's Privacy Policy.

OPC's Privacy Policy, available at onepath.com.au/superandinvestments/privacy-policy, sets out how (i) you can access and/or correct your personal information; (ii) you can make a privacy complaint; and (iii) OPC deals with any privacy complaints.

ANZ Privacy Statement

ANZ is committed to ensuring the confidentiality and security of your personal information. As the distributor of the Smart Choice Super and Pension product, ANZ collects your personal information in order to distribute, manage and administer this product. Without your personal information, ANZ may not be able to process your application or provide you with the product you require.

ANZ may disclose your personal information to certain third parties, including OPC (as issuer of this product), Zurich (as life insurer), ANZ's related companies, organisations, including those in an alliance with us, to distribute, manage and administer our products and services, carry out business functions, undertake analytics activities and as otherwise set out in the ANZ Privacy Policy.

ANZ may send you information about its products and services from time to time. ANZ may also disclose your personal information to its related companies or alliance partners to enable them or ANZ to tell you about a product or service. You can opt out of ANZ using and disclosing your information for this purpose at any time by contacting ANZ Customer Services on 13 13 14.

Sometimes ANZ discloses your personal information overseas. The location varies, but includes the Philippines, India, Ireland, the UK, the USA, China and countries within the European Union.

ANZ's Privacy Policy, available at anz.com/privacy, sets out how (i) you can access and/or correct your personal information; (ii) you can make a privacy complaint; and (iii) ANZ deals with any privacy complaints.

Zurich Privacy Statement

Zurich Australia Limited ABN 92 000 010 195, AFSL 232510 (Zurich), as group life insurer, will collect your personal information when you deal with it, its agents, or its related bodies corporate, distributors of this product (such as ANZ), or suppliers acting on Zurich's behalf. Zurich uses your personal information to issue and administer our products and services. If you do not provide us with your personal information, we may not be able to issue this product to you and/or administer your account.

Zurich may disclose your personal information to related bodies corporate and organisations, including service providers and those in an alliance with us, to distribute, manage and administer our products and services, carry out business functions, enhance customer service, undertake analytics activities and as set out in Zurich's Privacy Policy.

Zurich may also use and disclose your personal information to send you information on its products and services from time to time. Zurich may also disclose your personal information to its related companies and organisations, including those who are in an alliance with it, to enable those organisations to send you information about their products and services. You can opt out of Zurich using and disclosing your information for this purpose at any time by contacting customer services on 133 667.

In disclosing or using your personal information as described above, Zurich may also send your personal information overseas, as set out in Zurich's Privacy Policy.

Zurich's Privacy Policy, available at zurich.com.au/important-information/privacy sets out how (i) you can access and/or correct your personal information; (ii) you can make a privacy complaint; and (iii) Zurich deals with any privacy complaints.

14. QUESTIONNAIRES

Asthma questionnaire

Only complete this questionnaire if you answered yes to question 1 in section 9.

1. When did you have your first episode of asthma? D D M M Y Y Y Y
2. When was your most recent episode of asthma? D D M M Y Y Y Y
3. Approximately how many episodes have occurred in the last 12 months?

4. Have you ever suffered from nocturnal asthma attacks? ☐ Yes ☐ No

If **yes**, please provide the frequency of these attacks and approximate date of last attack. D D M M Y Y Y Y

5. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ☐ Yes ☐ No

If **yes**, please provide details:

7. Have you sought medical treatment or advice for asthma? ☐ Yes ☐ No

If **yes**, please provide details:

Name of doctor/health professional

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

8. How has your doctor described your asthma? ☐ Mild ☐ Moderate ☐ Severe
9. Have you ever used any medication, including steroids? ☐ Yes ☐ No

If **yes**, please provide details:

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	

10. Have you ever been hospitalised due to asthma? ☐ Yes ☐ No

If **yes**, please provide details:

Date from D D M M Y Y Y Y Date to D D M M Y Y Y Y

Name and address of hospital

11. Have you ever had lung function tests performed? ☐ Yes ☐ No

If **yes**, please provide details:

Date	Test results
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	

Blood pressure questionnaire

Only complete this questionnaire if you answered yes to question 2 in section 9.

1. When was your high blood pressure first diagnosed? D D M M Y Y Y Y
2. What was your blood pressure reading at that time? Systolic Diastolic
3. Have you ever been treated by medication? ☐ Yes ☐ No

If **yes**, please provide details:

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	

4. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details:

Test performed	Date	Results
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town State Postcode

Date of last consultation D D M M Y Y Y Y

6. What was the date of your last blood pressure check? D D M M Y Y Y Y
7. What was your blood pressure reading at that time? Systolic Diastolic
8. How has your doctor described your blood pressure control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If other, please provide details:

9. What is the date of your next blood pressure check-up? D D M M Y Y Y Y

Cholesterol questionnaire

Only complete this questionnaire if you answered yes to question 3 in section 9.

1. When was your high cholesterol first diagnosed? D D M M Y Y Y Y

2. What were your cholesterol readings at that time?

Cholesterol	Triglycerides
HDL Cholesterol	LDL Cholesterol

3. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details.

Test performed	Date	Results
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

4a. Have you ever used any medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y			D D / M M / Y Y Y Y	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ☐ Yes ☐ No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town	State	Postcode

Date of last consultation D D M M Y Y Y Y

6. What was the date of your last cholesterol check? D D M M Y Y Y Y

7. What was your cholesterol readings at that time?

Cholesterol	Triglycerides
HDL Cholesterol	LDL Cholesterol

8. How has your doctor described your cholesterol control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If other, please provide details:

9. What is the date of your next cholesterol check-up? D D M M Y Y Y Y

Diabetes questionnaire

Only complete this questionnaire if you answered yes to question 4 in section 9.

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed? D D M M Y Y Y Y

3. How is your diabetes controlled?

- ☐ insulin – go to question 3
- ☐ diet only – go to question 4
- ☐ oral – list medications below and then go to question 4

4. How many times a day do you administer insulin?

- ☐ I'm on an insulin pump
- ☐ One or two times daily
- ☐ Three or more times daily

5. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If other, please provide details:

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details:

Condition	Date	Treatment
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details:

Date	Test results
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If no, please provide details:

Date	Test results
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	

8. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

Mental health questionnaire

Only complete this questionnaire if you answered yes to question 5 in section 9.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Other

If other, please describe:

2. Please complete the table below for all described conditions:

Condition	Describe your symptoms	Date	Date condition ceased
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates:

4. Are you currently symptom-free? ☐ Yes ☐ No

5. Date of last symptoms D D M M Y Y Y Y

6. Have you ever attempted suicide or self-harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital:

7. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details:

8. Have you ever had any time off work due to your conditions? ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

9. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details:

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced	Date ceased (if applicable)	Reason ceased
	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	

10. Do you feel that your conditions has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details:

11. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details:

Name of consultant

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

12. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details:

Name of institution

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

Doctors consulted

13. Does your usual doctor, as advised in section 10, have details of this condition(s)? ☐ Yes ☐ No

Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

Back/neck questionnaire

Only complete this questionnaire if you answered yes to question 6 in section 9.

1. When did your back/neck condition first occur? D D M M Y Y Y Y

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No

If **yes**, please provide details:

Tests	Results	Date of tests
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

6. Have you had recurrent or multiple episodes of the back/neck condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

7. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/ health professional	Type (e.g. doctor, chiropractor, physiotherapist etc.)	Date last consulted	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation etc.)
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	

8. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration:

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details:

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details:

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? D D M M Y Y Y Y

Arthritis/joint questionnaire

Only complete this questionnaire if you answered yes to question 7 in section 9.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Knee	☐	☐
Elbow	☐	☐	Wrist	☐	☐
Shoulder	☐	☐	Hip	☐	☐
Other	☐	☐	If other, state which joint		

2. When did this condition first occur? D D M M Y Y Y Y

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known:

5. Have you had recurrent or multiple episodes of the condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

6. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/ health professional	Type (e.g. doctor, chiropractor, physiotherapist etc.)	Date last consulted	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture, etc.)
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	

7. Have you had any time off work due to this condition? ☐ Yes ☐ No

If yes, please provide the dates and duration:

8. Do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If yes, please provide details:

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If yes, please provide details:

10. Are you still undergoing treatment? ☐ Yes ☐ No

If yes, please provide details:

11. Overall do you feel that your condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? D D M M Y Y Y Y

Cyst/mole/skin lesion questionnaire

Only complete this questionnaire if you answered yes to question 8 in section 9.

1. Please provide details in the table below:

Site (e.g. back, left leg, etc.)	Date diagnosed	Type (e.g. basal cell carcinoma, melanoma, cyst, mole, etc.)	Pathology results (e.g. malignant, benign, unknown, etc.)
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes,** please provide details for each:

Date of removal D D M M Y Y Y Y

By what method (e.g. surgically, frozen or burnt off)?

If **no,** please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required:

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details:

Tests/treatments/investigations	Date	Results
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name of institution

Address

Suburb/Town | State | Postcode

Date of last consultation D D M M Y Y Y Y

15. PASTIMES

Motorcycle/motor racing

Vehicle type	Races p.a.
Engine size	Max. speed (km/h)
Class	☐ Recreational ☐ Amateur ☐ Professional

Scuba/skin diving

Average depth (m)	Maximum depth (m)
Dives p.a.	Do you use explosives?

Do you dive in caves or potholes? If **yes**, give details: ☐ Yes ☐ No

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a. ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income from participating in Football/Soccer/Aussie Rules etc.? ☐ Yes ☐ No

If **yes**, provide amount and details:

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes**, state type and period held:

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

Please complete the table below.

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding, etc.)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

b. On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

ADDITIONAL NOTES/COMMENTS

ADDITIONAL NOTES/COMMENTS

PLA-28422 (54521) 0224