

ANZ SMART CHOICE SUPER INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT



1 February 2020

Customer Services

Phone 13 12 87

Email anzsmartchoice@anz.com

Website anz.com/smartchoice

INSTRUCTIONS

OnePath Life 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 \$3,000,000.

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 anzsmartchoice@anz.com

* 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 OnePath Life in relation to this application may be used by OnePath Life 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 OnePath Life, 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.

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THE TRUSTEE'S DUTY OF DISCLOSURE

The Trustee, who enters into a life insurance contract in respect of your life, has a duty, before entering into the contract, to tell the Insurer anything that it knows, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms.

The Trustee has this duty until the Insurer agrees to provide the insurance.

The Trustee has the same duty before it extends, varies or reinstates the contract.

The Trustee does not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is of common knowledge; or
- the Insurer knows or should know as an Insurer; or
- the Insurer waives your duty to tell the Insurer about.

You must disclose relevant information

You must tell the Insurer anything you know, or could reasonably be expected to know, that may affect the Insurer's decision to provide the insurance and on what terms. If you do not do so, this may be treated as a failure by the Trustee to tell the Insurer something that the Trustee must tell the Insurer.

If you provide relevant information to the Trustee rather than the Insurer, The Trustee will provide the information you give the Trustee to the Insurer. The Trustee will do this so that you comply with your obligation to provide relevant information to the Insurer.

If the Trustee does not tell the Insurer something

In exercising the following rights, the Insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, the Insurer may apply the following rights separately to each type of cover.

If the Trustee does not tell the Insurer anything the Trustee is required to, and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if the Trustee had told the Insurer, the Insurer may avoid the contract within three years of entering into it.

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

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

If the failure to tell the Insurer is fraudulent, the Insurer may refuse to pay a claim and treat the contract as if it never existed.

1. PERSONAL DETAILS

| | | | | | | | |
|--------------------------------|-----------------------------|------------------------------|-----------------------------|-------------------------------|-------------------------------|---------------------------------|----------------------|
| Member number(s) | <input type="text"/> | | | | | | |
| Name of employer | <input type="text"/> | | | | | | |
| Title | <input type="checkbox"/> Mr | <input type="checkbox"/> Mrs | <input type="checkbox"/> Ms | <input type="checkbox"/> Miss | <input type="checkbox"/> Dr | <input type="checkbox"/> Other | <input type="text"/> |
| Surname | <input type="text"/> | | | | | | |
| First name | <input type="text"/> | | | | | | |
| Date of birth | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Male | <input type="checkbox"/> Female | |
| Residential address | <input type="text"/> | | | | | | |
| Suburb/Town | <input type="text"/> | | | State | <input type="text"/> | | |
| Country | <input type="text"/> | | | | | | |
| Postage address (if different) | <input type="text"/> | | | | | | |
| Suburb/Town | <input type="text"/> | | | State | <input type="text"/> | | |
| Country | <input type="text"/> | | | | | | |
| Home phone | <input type="text"/> | | | Work phone | <input type="text"/> | | |
| Mobile phone | <input type="text"/> | | | Fax | <input type="text"/> | | |
| Email | <input type="text"/> | | | | | | |

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I authorise one of OnePath Life'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

- | Type of cover required | Total amount of cover |
|--|-------------------------|
| <input type="checkbox"/> Death Only (no maximum benefit limit applies) | \$ <input type="text"/> |
| <input type="checkbox"/> Death and Total and Permanent Disablement (TPD) (maximum insurance cover is \$3 million) | \$ <input type="text"/> |
| <input type="checkbox"/> Total and Permanent Disablement (if you already have Death cover) (maximum insurance cover is \$3 million. 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 Duration of stay

Destination(s) (country/cities)

Purpose of stay Holiday Business Residing Other, please specify

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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 OnePath Life (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 underwritten (replacement policies only) |
|-----------------|---------------|----------------|----------------|--|--|
| | | \$ | DD / MM / YYYY | <input type="checkbox"/> Yes <input type="checkbox"/> No | DD / MM / YYYY |
| | | \$ | DD / MM / YYYY | <input type="checkbox"/> Yes <input type="checkbox"/> No | DD / MM / YYYY |
| | | \$ | DD / MM / YYYY | <input type="checkbox"/> Yes <input type="checkbox"/> No | DD / MM / YYYY |

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? 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.) | | |

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):

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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 23.

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 have a full medical examination, go to Section 10 on page 9.

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 24)

| 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).

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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 13 to 23.

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

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29. A. Is the combined total of your existing insurance(s) detailed in section 3 Question 1, and any new insurance you are applying for with OnePath Life, 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 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 24.

| |
|--|
| Question number |
| Disability, illness, injury or condition |
| Investigation type(s) and result(s) |
| Date of first symptoms <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> Frequency of symptoms |
| Type of treatment |
| Date treatment provided and ceased: From: <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> to <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> |
| Has further treatment, referral or investigation(s) been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Time off work |
| Have you completely recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last symptoms <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="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 <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> Frequency of symptoms |
| Type of treatment |
| Date treatment provided and ceased: From: <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> to <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> |
| Has further treatment, referral or investigation(s) been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Time off work |
| Have you completely recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last symptoms <input type="text" value="D D"/> <input type="text" value="M M"/> <input type="text" value="Y Y Y Y"/> |

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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 Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: to

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

Time off work

Have you completely recovered? Yes No Date of last symptoms

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 Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: to

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

Time off work

Have you completely recovered? Yes No Date of last symptoms

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 Frequency of symptoms

Type of treatment

Date treatment provided and ceased: From: to

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

Time off work

Have you completely recovered? Yes No Date of last symptoms

Name and address of medical facility and attending doctor

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Question number _____

Disability, illness, injury or condition _____

Investigation type(s) and result(s) _____

Date of first symptoms Frequency of symptoms _____

Type of treatment _____

Date treatment provided and ceased: From: to

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

Time off work _____

Have you completely recovered? Yes No Date of last symptoms

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. |
|---|---|-------------------------------------|---|
| | <input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| | <input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| | <input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| | <input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |

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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 OnePath Life 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 understand the Trustee's Duty of Disclosure sections above, and I have not withheld any information that may affect the Insurer's decision as to whether to accept my application. I understand that the Trustee's Duty of Disclosure continues after I have completed this form until my application has been accepted by the Insurer and confirmation is issued in writing.
- 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 12), 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 OnePath Life's Privacy Policy which is available at onepath.com.au/insurance/privacy-policy. 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 OnePath Life 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 OnePath Life.
- 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 OnePath Life 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 OnePath Life is no longer 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 OnePath Life 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 health condition exclusion(s).
- I acknowledge that any information received by OnePath Life 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

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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, OnePath Life Limited ABN 33 009 657 176 (OnePath Life), 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 of Disclosure 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.

ANZ SMART CHOICE SUPER INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

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 OnePath Life, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form OnePath Life 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.
- OnePath Life 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 OnePath Life 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

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 OnePath Life, or to third parties they engage, only if OnePath Life 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:

- OnePath Life 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 OnePath Life 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

ANZ SMART CHOICE SUPER INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

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 One Path Life, 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 OnePath Life 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 (**OnePath**), 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 IOOF Group, distributors of this product (such as ANZ), or suppliers acting on OnePath's behalf.

OnePath 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.

OnePath may disclose your personal information to related bodies corporate, relevant group life insurers, such as OnePath Life, 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 OnePath's Privacy Policy.

OnePath may also use and disclose your personal information to send you information on its products and services from time to time. OnePath may also disclose your personal information to its related companies, relevant group life insurers, such as OnePath Life 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 OnePath using and disclosing your information for this purpose at any time by calling Customer Services on 133 665.

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

OnePath'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) OnePath 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 OnePath (as issuer of this product), OnePath Life (as general 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.

OnePath Life Privacy Statement

OnePath Life Limited ABN 33 009 657 176, AFSL 238341 (OnePath Life), 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 OnePath Life's behalf. OnePath Life 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.

OnePath Life 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 OnePath Life's Privacy Policy.

OnePath Life may also use and disclose your personal information to send you information on its products and services from time to time. OnePath Life 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 OnePath Life 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, OnePath Life may also send your personal information overseas, as set out in OnePath Life's Privacy Policy.

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

ANZ SMART CHOICE SUPER INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

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?

2. When was your most recent episode of asthma?

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.

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

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 |
|------|---|--------------------------------------|--------|---|----------------------|
| | <input type="text" value="DD/MM/YYYY"/> | | | <input type="text" value="DD/MM/YYYY"/> | |
| | <input type="text" value="DD/MM/YYYY"/> | | | <input type="text" value="DD/MM/YYYY"/> | |
| | <input type="text" value="DD/MM/YYYY"/> | | | <input type="text" value="DD/MM/YYYY"/> | |
| | <input type="text" value="DD/MM/YYYY"/> | | | <input type="text" value="DD/MM/YYYY"/> | |

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

If **yes**, please provide details:

Date from

Date to

Name and address of hospital

ANZ SMART CHOICE SUPER INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

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?

2. What was your blood pressure reading at that time?

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

6. What was the date of your last blood pressure check?

7. What was your blood pressure reading at that time?

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?

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Cholesterol questionnaire

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

1. When was your high cholesterol first diagnosed?

2. What were your cholesterol readings at that time?

| | | | |
|----------------------|-----------------|----------------------|-----------------|
| <input type="text"/> | Cholesterol | <input type="text"/> | Triglycerides |
| <input type="text"/> | HDL Cholesterol | <input type="text"/> | LDL Cholesterol |

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

If **yes**, please provide details.

| Test performed | Date | Results |
|----------------------|--|----------------------|
| <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> |
| <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> |

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 |
|----------------------|--|--------------------------------------|----------------------|--|----------------------|
| <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> | <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> |
| <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> | <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> |
| <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> | <input type="text"/> | <input type="text" value="D D / M M / Y Y Y Y"/> | <input type="text"/> |

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:

Date of last consultation

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

7. What was your cholesterol readings at that time?

| | | | |
|----------------------|-----------------|----------------------|-----------------|
| <input type="text"/> | Cholesterol | <input type="text"/> | Triglycerides |
| <input type="text"/> | HDL Cholesterol | <input type="text"/> | 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?

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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?

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

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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

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:

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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:

Date of last consultation

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

If **yes**, please provide details:

Date of last consultation

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:

Date of last consultation

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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?

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?

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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 | <input type="checkbox"/> | <input type="checkbox"/> | Knee | <input type="checkbox"/> | <input type="checkbox"/> |
| Elbow | <input type="checkbox"/> | <input type="checkbox"/> | Wrist | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | Hip | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | If other, state which joint | <input type="text"/> | |

2. When did this condition first occur?

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?

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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

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

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15. PASTIMES

Motorcycle/motor racing

| | |
|--------------|--|
| Vehicle type | Races p.a. |
| Engine size | Max. speed (km/h) |
| Class | <input type="checkbox"/> Recreational <input type="checkbox"/> Amateur <input type="checkbox"/> 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. | <input type="checkbox"/> Recreational <input type="checkbox"/> Amateur <input type="checkbox"/> 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

