# ANZ SUPER ADVANTAGE
## INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

1 February 2020

Customer Services

Phone 13 38 63

Email customer@onepath.com.au
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### INSTRUCTIONS

OnePath Life Limited ABN 33 009 657 176 (OnePath Life) is the group life insurer to OnePath Custodians, the trustee of the Fund. ANZ Super Advantage is a division of the Fund.

Please complete this form if you wish to apply to for Death only or Death and TPD cover for over $1,000,000 (including any existing cover) or GSC cover or where we specifically requested you to complete this form. Members in an employer plan should note that if GSC is available in the employer plan, you cannot elect a different waiting period from that chosen by your Employer.

By completing this form, you are requesting OnePath Custodians to submit an application to OnePath Life to enable OnePath Life to assess your request for cover. Before proceeding with this application it is important that you have read and understood the ANZ Super Advantage Product Disclosure Statement (PDS). You will be required to complete some or all of the questions in this form. Please follow all instructions carefully.

- Please complete this form and send it to ANZ Super Advantage, OnePath Custodians Pty Limited, GPO Box 4028, Sydney NSW 2001.

### IMPORTANT NOTICE

**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 3 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 3 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.

**OnePath Custodians Pty Limited (OnePath Custodians)** ABN 12 008 508 496, AFSL 238346, RSE L0000673
**OnePath Life Limited (Insurer/OnePath Life)** ABN 33 009 657 176, AFSL 238341
**Retirement Portfolio Service (Fund)** ABN 61 808 189 263, RSE R1000986

# ANZ SUPER ADVANTAGE
## INSURANCE APPLICATION AND FULL PERSONAL HEALTH STATEMENT

### 1. PERSONAL DETAILS

Member number

Employer plan name

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

Surname

Given name(s)

Gender ☐ Male ☐ Female Date of birth D D / M M / Y Y Y Y Age next birthday

Residential address (this cannot be a PO Box)

Suburb/Town State Postcode

Country

Postal address (if different from above)

Suburb/Town State Postcode

Country

Home phone Business phone

Mobile phone

Email

May one of our underwriters contact you by phone if we require more information? ☐ Yes ☐ No

If yes, when is the most convenient time and on what phone number?

Days Time (from/to)

### 2. AMOUNT OF COVER

| Type of cover required – Employer sponsored members | Total amount of cover |
|---|---|
| ☐ Death Only (no maximum benefit limit applies) | $ |
| ☐ Death and Total and Permanent Disablement (TPD) (maximum insurance cover is $3 million) | $ |
| ☐ Group Salary Continuance (monthly benefit). The monthly benefit may be the equivalent of either 50% of 75% of your monthly salary, but cannot exceed $30,000 per month. | $ |

Where your employer has not selected GSC 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

| Type of cover required – ANZ Super Advantage Personal members | Total amount of cover |
|---|---|
| ☐ Death Only (no maximum benefit limit applies)† | $ |
| ☐ Death and TPD (maximum insurance cover is $3 million)† | $ |
| ☐ GSC (monthly benefit). The monthly benefit may be the equivalent of either 50% of 75% of your monthly salary, but cannot exceed $30,000 per month | $ |

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

† Personal members are members who were part of an ANZ Super Advantage employer plan prior to transferring to ANZ Super Advantage Personal.

| Type of cover required – ANZ Super Advantage Spouse members* | Total amount of cover |
|---|---|
| ☐ Death Only (no maximum monthly benefit limit applies) | $ |
| ☐ Death and Total and Permanent Disablement (TPD) (maximum insurance cover is $3 million) | $ |

## 3. RESIDENCE AND TRAVEL DETAILS

a. Are you a permanent resident or citizen of Australia or New Zealand? ☐ Yes ☐ No

b. How long have you lived in Australia?

c. 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

Destinations

d. Purpose of stay? ☐ Holiday ☐ Business ☐ Residing ☐ Other, please specify

## 4. INSURANCE DETAILS

1. Do you have, or have you previously applied for any life, TPD or income protection cover with OnePath Life , through any other superannuation fund or any other company? (Note: this includes insurance through your superannuation fund and insurance your employer may have arranged for you.) ☐ Yes ☐ No

If yes to question 1, 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 (dd/mm/yyyy) | Will this policy be discontinued/ replaced? | Date last fully underwritten (replacement policies only) (dd/mm/yyyy) |
|---|---|---|---|---|---|
| | | $ | / / | ☐ Yes ☐ No | / / |
| | | $ | / / | ☐ Yes ☐ No | / / |
| | | $ | / / | ☐ Yes ☐ No | / / |
| | | $ | / / | ☐ Yes ☐ No | / / |

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, 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. Occupation Industry

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

c. 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. Please note: the examples below are to be used as a guide only. |
|---|---|---|
| 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, painting, carpentry, mechanic, etc.) |

How many hours on average do you work per week?

Annual salary (before tax) $ (only to be completed if applying under ANZ Super Advantage Personal)

## 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 continue completing this section below for the relevant activity.

**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? ☐ Yes ☐ No

If yes, give details

**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

**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.).

If yes, provide frequency and details

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

**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.

## 7. PERSONAL HEALTH STATEMENT

1. What is your current height and weight? Height (cm) Weight (kg)
2. Has your weight varied by more than 10kg during the past 12 months? ☐ Yes ☐ No
   If yes, please provide details
3. During the past 12 months have you smoked tobacco or any other substance? ☐ Yes ☐ No
   If yes, please state type and quantity per day
4. During the last three months have you used nicotine replacement treatment or anti-smoking medication? ☐ Yes ☐ No
   If yes, please state type used and duration of use
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, state type 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 smoking or to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No
   If yes, please provide full details

## 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, cystic fibrosis, familial adenomatous polyposis of the bowel, polycystic 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) been diagnosed with any of the following conditions: diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? ☐ 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 21):

| Relation | Condition/disorder | Age diagnosed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 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 bold above, please complete the relevant questionnaire on pages 13 to 21.**

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, bowel trouble or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, liver 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)? ☐ 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 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. In the past 5 years have you:
   - had sex without using a condom with a person you know or suspect to be either HIV positive or who uses non prescribed drugs intravenously
   - had sex without using a condom with a sex worker or as a sex worker ☐ Yes ☐ No
   - had anal intercourse without using a condom (except with someone whom you have been in a monogamous relationship for five years or more)? ☐ Yes ☐ No

If you answered yes to question 35 a private and confidential questionnaire will be sent to you.

**36. 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 DD MM YYYY ☐ 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 9–34 or 36, please complete the table on the following page. If there is not enough space here, please provide details on page 21.

Question no. ☐ Disability, illness, injury or conditions

Investigation type(s) and results

Date started DD MM YYYY Date ceased DD MM YYYY

Treatment and type

Date provided DD MM YYYY Date ceased DD MM YYYY

Time off work Have you fully recovered? ☐ Yes ☐ No

Name of institution or health professional

Address of institution or health professional

Suburb/Town State Postcode

Question no. ☐ Disability, illness, injury or conditions

Investigation type(s) and results

Date started DD MM YYYY Date ceased DD MM YYYY

Treatment and type

Date provided DD MM YYYY Date ceased DD MM YYYY

Time off work Have you fully recovered? ☐ Yes ☐ No

Name of institution or health professional

Address of institution or health professional

Suburb/Town State Postcode

Question no. Disability, illness, injury or conditions

Investigation type(s) and results

Date started D D M M Y Y Y Y Date ceased D D M M Y Y Y Y

Treatment and type

Date provided D D M M Y Y Y Y Date ceased D D M M Y Y Y Y

Time off work Have you fully recovered? ☐ Yes ☐ No

Name of institution or health professional

Address of institution or health professional

Suburb/Town State Postcode

Question no. Disability, illness, injury or conditions

Investigation type(s) and results

Date started D D M M Y Y Y Y Date ceased D D M M Y Y Y Y

Treatment and type

Date provided D D M M Y Y Y Y Date ceased D D M M Y Y Y Y

Time off work Have you fully recovered? ☐ Yes ☐ No

Name of institution or health professional

Address of institution or health professional

Suburb/Town State Postcode

## 10. USUAL DOCTOR OR MEDICAL CENTRE DETAILS

1. a) Full name of usual doctor/medical centre

   Phone

   b) Full address of usual doctor/medical centre

   Number and street

   Suburb/Town State Postcode

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

2. 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 (dd/mm/yyyy) | Reason for check up or consultation | Outcome including degree of recovery, medication, treatment, etc. |
|---|---|---|---|
| | / / | | |
| | / / | | |
| | / / | | |
| | / / | | |

## 11. DECLARATION BY THE LIFE INSURED

I declare that:

- 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 my employer (or former employer) or the Trustee of my superannuation fund has 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 section 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 have read the Privacy Statement in this form, and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in 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 ANZ, OnePath Custodians and OnePath Life 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 Product Disclosure Statement(s) (PDS) and information on for the type (s) of cover for which I am applying.
- I acknowledge that insurance cover will not commence until I am notified of acceptance in writing.
- 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 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 acknowledge that OnePath Life is no longer a related body corporate of OnePath Custodians.
- I understand that I may cancel my existing cover at any time.

Name of life insured/applicant

Signature of life insured/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, 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.

**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 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 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 D D / M M / Y Y Y Y

## 13. ADVISER TO COMPLETE

**First adviser**

Name

Phone | Fax

Agency number | Adviser reference number

**Second adviser**

Name

Phone | Fax

Agency number | Adviser reference number

Do you expect that this Insurance will replace all or part of an existing insurance, or one discontinued within the past two months? ☐ Yes ☐ No

If yes, previous insurer

Reminder: For quick processing, please ensure all applicable questions are fully answered.

**Adviser comments**

## 14. PRIVACY STATEMENT

Your personal information will be handled by OnePath Custodians, as issuer of this product, ANZ, as alliance partner of IOOF Holdings Limited ABN 49 100 103 722 (IOOF), who wholly owns OnePath Custodians 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 an alliance partner of IOOF, ANZ will collect your personal information when you deal with it, its agents, or its related bodies corporate, issuers and distributors of this product, or suppliers acting on ANZ's behalf. ANZ may use your personal information for the purposes of carrying out business functions, undertaking analytics activities and as otherwise set out in ANZ's privacy policy available at anz.com/privacy

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 of this product, 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.

## 15. 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 had any time off work due to this condition? ☐ Yes ☐ No
   If yes, please provide the dates and duration
5. 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
6. 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
7. How has your doctor described your asthma? ☐ Mild ☐ Moderate ☐ Severe
8. Have you ever used any medication, including steroids? ☐ Yes ☐ No
   If yes, please provide details:

| Type | Date commenced (dd/mm/yyyy) | Frequency (e.g. daily, weekly, etc.) | Dosage | Date ceased (if applicable) (dd/mm/yyyy) | Reason for cessation |
|---|---|---|---|---|---|
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |

9. 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 of hospital
   Address
   Suburb/Town | State | Postcode
10. Have you ever had lung function tests performed? ☐ Yes ☐ No
    If yes, please provide details:

| Date (dd/mm/yyyy) | Test results |
|---|---|
| / / | |
| / / | |

**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 (dd/mm/yyyy) | Frequency (e.g. daily, weekly, etc.) | Dosage | Date ceased (if applicable) (dd/mm/yyyy) | Reason for cessation |
|---|---|---|---|---|---|
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |

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

   If yes, please provide details:

| Test performed | Date (dd/mm/yyyy) | Results |
|---|---|---|
| | / / | |
| | / / | |

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. When is 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 ___ Cholesterol ___ HDL Cholesterol ___ LDL Cholesterol ___
3. Did you undergo any tests or investigations? ☐ Yes ☐ No

   If yes, please provide details.

| Test performed | Date (dd/mm/yyyy) | Results |
|---|---|---|
| | / / | |
| | / / | |

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

   If yes, please provide details.

| Type | Date commenced (dd/mm/yyyy) | Frequency (e.g. daily, weekly, etc.) | Dosage | Date ceased (dd/mm/yyyy) | Reason for cessation |
|---|---|---|---|---|---|
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |
| | / / | | | / / | |

   b) 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 were your cholesterol readings at that time? Cholesterol ___ Cholesterol ___ HDL Cholesterol ___ LDL Cholesterol ___
8. How has your doctor described your cholesterol control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

   If other, please provide details

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

3. 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

4. How often do you monitor your sugar levels?

   ☐ One or two times daily ☐ Three or more times daily ☐ Other

   If other, please provide details

5. 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 (dd/mm/yyyy) | Treatment |
|---|---|---|
| | / / | |
| | / / | |

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

   If yes, please provide details:

| Date (dd/mm/yyyy) | Test Results |
|---|---|
| / / | |
| / / | |

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

If yes, please provide details:

| Date (dd/mm/yyyy) | Test Results |
|---|---|
| / / | |
| / / | |

7. 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 diagnosed (dd/mm/yyyy) | Date condition ceased (if applicable) (dd/mm/yyyy) |
|---|---|---|---|
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |

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

   If yes, please provide date(s) of last symptoms:

5. 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:

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

   If yes, please provide details:

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

   If yes, please provide the dates and duration:

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

If yes, please provide details:

| Treatment (e.g. tranquilisers, sedatives, ECT, counselling, etc.) | Date commenced (dd/mm/yyyy) | Date ceased (if applicable) (dd/mm/yyyy) | Reason ceased |
|---|---|---|---|
| | / / | / / | |
| | / / | / / | |
| | / / | / / | |
| | / / | / / | |

9. Do you feel that this condition 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:

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

If yes, please provide details:

Name

Address

Suburb/Town State Postcode

Date of consultation D D M M Y Y Y Y

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

If yes, please provide details:

Name

Address

Suburb/Town State Postcode

Date of consultation D D M M Y Y Y Y

Doctors consulted

**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 (dd/mm/yyyy) |
|---|---|---|
| | | / / |
| | | / / |

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 (dd/mm/yyyy) | Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immoblisation etc.) |
|---|---|---|---|
| | | / / | |
| | | / / | |
| | | / / | |
| | | / / | |

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 (dd/mm/yyyy) | Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture, etc.) |
|---|---|---|---|
| | | / / | |
| | | / / | |
| | | / / | |

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 (dd/mm/yyyy) | Type (e.g. basal cell carcinoma, melanoma, cyst, mole, etc.) | Pathology results (e.g. malignant, benign, unknown, etc.) |
|---|---|---|---|
| | / / | | |
| | / / | | |
| | / / | | |

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

   If yes, please provide details for each: 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 (dd/mm/yyyy) | Results |
| --- | --- | --- |
| | / / | |
| | / / | |

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 consultation D D / M M / Y Y Y Y

## 16. ADDITIONAL INFORMATION/COMMENTS

**OnePath Custodians Pty Limited (OnePath Custodians)** ABN 12 008 508 496, AFSL 238346, RSE L0000673
**OnePath Life Limited (Insurer/OnePath Life)** ABN 33 009 657 176, AFSL 238341
**Retirement Portfolio Service (Fund)** ABN 61 808 189 263, RSE R1000986 A2611/0220