

Full Personal Statement (Form B)



Complete this form if you are applying for Death only, Death and TPD or Income Protection cover for:

- more than \$6,000 per month for Income Protection cover;
- more than \$800,000 for Death only or Death and TPD cover;
- or if you answer 'Yes' to any questions in Form A.

A – Your details

Membership number	Surname	Given name/s	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Salary	Occupation		
<input type="text"/>	<input type="text"/>		

Please carefully read the information in the PDS before completing this Full Personal Statement.

B – Insurance history details

1 Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

No

Yes Please provide details below

Fund or insurance company name	Date commenced	Terms offered and reason
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

2 Are you claiming or have you ever claimed a benefit from any source, eg. TPD benefit from any superannuation fund, workers compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?

No

Yes Please provide details below

Benefit type/source/reason for claim	Claim date	Claim amount	Date claim finalised
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

C – Residency, activities and pastimes

1 Are you a permanent Australian resident? Tick (✓) yes or no
No Yes

2 Do you currently engage in, or intend to engage in, any of the following sports or hazardous activities:

- Flying (other than as a fare paying passenger on a commercial airline)? No Yes
- Underwater diving? No Yes
- Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing? No Yes
- Football of any code (including touch football or tag)? No Yes
- Any other sport or hazardous activities, eg. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports or recreations involving heights? No Yes

What are the activity/ies you engage in?

C – Residency, activities and pastimes continued

Tick (✓) the appropriate box

At what level do you participate? Recreational only (noncompetition)
Recreational with competition
Semi-professional/professional

Number of times you participate on average in this activity/ies per annum (eg. hours flown, number of drives, events etc.)

Do you receive income from participating in this activity/ies? **Tick (✓) yes or no**
No Yes

D – Personal health details

1 What is your height and current weight?
Height cm or ft/ins **Weight** kg or st/lbs

2 Have you smoked tobacco, or any other substance, at any time during the last twelve months?
 No
 Yes **Please indicate type (eg. cigarettes, cigars, etc.) and average amount smoked below**

Substance smoked	Per day	Per week	Per year
<input style="width: 100%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>

3 Do you drink alcohol?
 No
 Yes **Please provide the average number of drinks consumed**

Per day	Per week	Per year
<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>

E – Family history

1 Have any of your immediate family (parents, brothers, sisters) suffered from, or been diagnosed with, any of the following:

a Heart problems, stroke, high blood pressure, diabetes?
 No
 Yes **Please complete the table in Qc below**
 Unknown

b Cancer?
 (please specify type)

c Any other inherited or hereditary disease (e.g. huntington's disease, polycystic kidney, muscular dystrophy, familial polyposis, etc.)?
 (please specify type)

Family member	Condition	Approximate age of onset	Age at death (if applicable)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

F - Doctor details

1 What is the name and address of the last doctor or medical centre you visited?

Full name of doctor

Phone number

Facsimile number

Address

State Postcode

2 a What was the date of your last consultation?

b Reason for last consultation?

c What was the result/outcome from your last consultation? (please tick (✓) the appropriate box)

Referral to specialist/health professional

Tests conducted – results pending

Not fully recovered yet

Ongoing treatment (eg. ventolin inhaler)

Routine tests conducted – results all clear/normal

All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication)

3 Is the doctor/medical centre mentioned above your usual doctor/medical centre?

No

Yes

G – Lifestyle declaration

To the best of your knowledge, is there any possibility that you have ever been infected with, or have you ever tested positive for, AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis, or are you in a high-risk category (eg. injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or, engaged the services of a prostitute)?

No

Yes **Please provide details below**

Please note: If you answered 'Yes' to the declaration above, you will be asked to complete a specific lifestyle questionnaire.

H – Medical history

Have you ever had, or sought advice or treatment, experienced symptoms, or suffered from any of the following:

1	Asthma, bronchitis or any other lung complaint?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2	Cysts, moles, sunspots or skin lesions?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
3	Diabetes or abnormal blood sugar?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
4	Back, neck, shoulder, knee, elbow complaints , sciatica, disc or spine complaints, or injury of the joints, bones or muscles?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5	Depression or mental disorder (including but not limited to stress, anxiety, panic attacks, behavioural or nervous disorder)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
6	Chest pains, heart complaint, heart murmur, high blood pressure, raised cholesterol, palpitations or rheumatic fever?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
7	Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
8	Cancer, tumour or melanoma?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
9	Thyroid, glandular or pancreatic disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
10	Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
11	Any disorder of the gall bladder or liver (including hepatitis B, C or raised liver function)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
12	Varicose veins, haemorrhoids or hernia?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
13	Disorder of the kidney, bladder or prostate, blood in urine or kidney stones?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
14	Epilepsy, fits of any kind, fainting episodes, or recurring headaches or migraines?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
15	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
16	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
17	Eczema, dermatitis, psoriasis, or any other skin disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
18	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
19	Any impairment of sight (other than corrected by glasses or lenses) or blurred vision?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
20	Any impairment of hearing, including tinnitus, or speech?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
21	Any sexually transmitted diseases?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
22	Any other illness, injury, disease or disorder not mentioned above?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
23	Other than those conditions mentioned above, are you taking any regular prescribed medication (excluding contraceptives)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
24	Within the last three years, have you had: <ul style="list-style-type: none"> • Any blood tests which revealed an abnormality? • Any tests such as ECG, X-ray (excluding broken bones or joint strains), genetic test or ultrasound (other than for pregnancy)? 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
25	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
26	(Females only) Are you currently pregnant?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
	• If yes: due date for birth of baby?	/ /	
27	Have you ever had any complications with pregnancy or childbirth (eg. diabetes, ectopic pregnancy)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
	• If yes: please provide details below	<input style="width: 100%; height: 20px;" type="text"/>	

Please note: If you have answered 'Yes' to question 1 to 5 above, we will ask you to complete a **Specific questionnaire** on the related condition.
If you answered 'Yes' to question 6 to 25 above, please provide full details in **Section I – General health questionnaire** on pages 5 and 6.

I - General health questionnaire

If you have answered 'Yes' to any part of questions 6 to 25 in Section H, please complete the table below. Please ensure you write the question number in the brackets above each column.

	Question ()	Question ()	Question ()	
1	Name of condition	1.	2.	3.
2	Date symptoms first started	/ /	/ /	/ /
3	Date symptoms ceased	/ /	/ /	/ /
4	Are these symptoms ongoing	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
5	How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, yearly, one off, other (please specify)			
6	Severity of condition Please choose from one of the following: mild, moderate, severe, never had symptoms, symptoms ceased			
7	Did you take medication or have you had any other treatment (eg. physiotherapy or an operation) for this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', name the treatment/condition			
8	Are you still on treatment, including medication?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
9	Have you ever been off work due to this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', provide details. If there is insufficient space please attach an additional sheet			
10	If 'Yes', also state the total time off work in days, months and years	days months years	days month years	days months years
11	Have you had any residual, ongoing effects or restrictions as a result of this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', please provide details and dates			
		/ /	/ /	/ /

J – Duty of disclosure

Your Duty Of Disclosure

Before you enter into, or become insured, under a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your insurance. Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

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

An insurer who is entitled to avoid your cover may, within three years of issuing it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

K – Declaration

This section must be completed in all circumstances.

I have read the Duty of disclosure in this Personal Statement and I am aware of the consequences of non-disclosure.

I understand that the Duty of disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers);
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me;
- any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

I declare that:

- the answers to all the questions and the declarations on this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance.

I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.

I have read and understood the Privacy Section of the PDS. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.

A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Full name

Signature of life to be insured

Date