

# SHORT PERSONAL STATEMENT



FORM A Join the Club Your Industry Super Fund

*This request will be invalid if not signed and dated.*

Please return this completed form to: Payroll or Club Plus Administration, Locked Bag 5007, Parramatta NSW 2124.

Complete this form if you are applying for additional Death & TPD insurance cover of up to \$800,000.

If you wish to apply for more than \$800,000 worth of cover, or answer "Yes" to any of the questions in the "Personal Health Details" section below, please do not continue completing this form. In this case please complete and return a Full Personal Statement, available at [www.clubplussuper.com.au](http://www.clubplussuper.com.au), or by calling Club Plus on 1800 680 627.

Please carefully read the information in the PDS before completing this Short Personal Statement (Form A).

## YOUR DETAILS

CLUB PLUS MEMBERSHIP NUMBER	DATE OF BIRTH (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>
MR/MRS/MS/MISS	SURNAME
<input type="text"/>	<input type="text"/>
GIVEN NAMES	
<input type="text"/>	
<input type="text"/> UNITS	Please refer to page 19 of the Member Booklet for the scale of cover per unit.

## PERSONAL HEALTH DETAILS

- 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
- Are you claiming or have you ever claimed a benefit from any source, eg. TPD benefit from any superannuation fund, worker's compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?  NO  YES
- Are you at the date of this application, due to injury, accident or illness:
  - off work?  NO  YES
  - restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even though your actual employment can be on a full-time, part-time or casual basis?  NO  YES
- Have you lost the sight of an eye or the total and permanent loss of the use of a limb ('limb' includes whole hand or whole foot)?  NO  YES
- Please provide the following details:
 

HEIGHT (CM)		FT/INS
<input type="text"/>	or	<input type="text"/>
WEIGHT (KG)		ST/LBS
<input type="text"/>	or	<input type="text"/>
- Excluding the contraceptive pill and inhaled asthma medication, have you been advised to take, or been given prescribed medication by a medical practitioner that has intended to be used for three months or longer within the last year (including but not limited to blood pressure, diabetes, oral steroids for asthma or depression medication)?  NO  YES
- Have you been unable to work because of sickness or injury for more than two consecutive weeks in the last three years?  NO  YES
- Have you undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any illness or injury that would affect your longterm health and require ongoing medical supervision. This includes, but is not limited to:
  - cancer or diabetes
  - high blood pressure, cholesterol or any heart complaint
  - alcohol or drug abuse
  - stroke, paralysis, neurological disorder or multiple sclerosis NO  YES
- Have you been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis B and C?  NO  YES

YOU MUST COMPLETE THE REVERSE SIDE OF THIS FORM

# SHORT PERSONAL STATEMENT

## PERSONAL HEALTH DETAILS (CONT.)

10. Have you received any medical advice, or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery, for any of the following:
- a) Any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last twelve months and/or any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints?  NO  YES
  - b) Depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder)?  NO  YES
  - c) Chest pain, asthma, bronchitis or any other lung complaint requiring hospitalisation within the last five years?  NO  YES
  - d) Disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel, or liver?  NO  YES
  - e) Epilepsy?  NO  YES

## 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.

## DECLARATION

This section must be completed in all circumstances.

I have read the Duty of disclosure in Section C of this Personal Statement and I am aware of the consequences of nondisclosure.

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.

### 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.

### Full Name

SURNAME

GIVEN NAMES

SIGNATURE OF LIFE TO BE INSURED

DATE (DD/MM/YYYY)

[This is a two page extract from the Product Disclosure Statement \(PDS\).](#)  
[Click here to download the complete PDS](#)