

Application for insurance cover form and Personal health statement



VALID FROM 1 NOVEMBER 2009

Please complete this form in **BLACK PEN** and **CAPITAL LETTERS**.

Your Member No.

YOU SHOULD USE THIS FORM IF YOU ARE:

An Employer-Sponsored member and:

- for **Death and Total and Permanent Disablement** cover, you would like to apply for:
 - Standard Default Cover (because you were ineligible to receive Standard Default cover or Employer-Selected Default Cover automatically) and would like to apply for **more cover** than that offered under Standard Default Cover OR
 - additional cover (e.g. member selected cover).

Complete Sections 1-4, 6 and 8. (If you answer YES to any question in Section 6, you will also need to complete Section 7.)

- In relation to **Pay Protector**, you would like to:
 - apply for cover (where your employer has opted out of this cover or you were not eligible for automatic cover)
 - apply to amend existing cover
 - nominate a salary
 - nominate a waiting period
 - apply to have the Pre-existing Condition exclusion removed from your cover.

Complete Sections 1-3, 5 and 8. If you are applying for cover, or to reduce your waiting period or remove the Pre-existing Condition exclusion, you will also need to complete Section 6. (If you answer YES to any question in Section 6, you will also need to complete Section 7 as well.)

A Personal Account member and:

- for **Death and Total and Permanent Disablement** cover, you would like to apply:
 - to remove the Pre-existing Conditions exclusion from your Restricted Standard Default Cover OR
 - for Restricted Standard Default Cover (because you were ineligible to receive it automatically) and would like to apply for more cover than that offered under the Restricted Standard Default Cover OR
 - for additional cover (e.g. Member-selected cover).

Complete Sections 1-4, 6 and 8. (If you answer YES to any question in Section 6, you will also need to complete Section 7.)

- In relation to **Pay Protector** you would like to:
 - apply for cover (ineligible for automatic acceptance)
 - nominate a salary*
 - nominate a waiting period*
 - apply to have the Pre-existing Condition exclusion removed from your cover.

* Complete these sections even if you are eligible for automatic cover.

Complete Sections 1-3, 5 and 8. If you are applying to remove the Pre-existing Condition exclusion, you will also need to complete Section 6. (If you answer YES to any question in Section 6, you will also need to complete Section 7 as well.)

DO NOT USE THIS FORM IF YOU ARE APPLYING:

- within 60 days of joining Media Super, to increase by one unit your Standard Default Cover, Limited Standard Default Cover or Restricted Default Cover (as applicable). To do this, complete the **Application for default insurance form** attached to this PDS.
- for Standard Default Cover, Limited Standard Default Cover or Restricted Default Cover (as applicable), or you would like to re-instate Standard Default Cover, Limited Standard Default Cover Restricted Standard Default Cover after you have previously elected to cancel your insurance cover. In these cases, please complete the **Application for default insurance cover form** attached to this PDS.

Applying for your Media Super insurance

1. HOW TO APPLY

To apply for insurance cover or additional cover, you need to complete this application.* **Some members will be automatically accepted for default insurance cover.**

The Insurer may ask you to provide more information to assist their assessment. You may also be asked to attend medical examinations or have other medical tests where necessary. If you are asked to have tests or an examination as part of your application for insurance, the Insurer will pay for any medical expenses incurred.

* Death cover is not available for members who are 70 years of age or more.
TPD cover is not available for members who are 65 years of age or more.
Pay Protector cover is not available for members who are 65 years of age or more. Those members should NOT complete this application.

2. COMMENCING COVER

Your insurance cover or increase in cover will commence when (and if) the Insurer accepts your application. You will be notified in writing. Interim accident cover applies during the processing period under the conditions set in the **Insurance** section of the Member Booklet (Product Disclosure Statement) dated 1 November 2009.

3. COOLING-OFF PERIOD

You have 14 days from the date on which you are advised that you have been accepted for Death and TPD, Death only and Pay Protector insurance to review the terms and conditions set out in the Member Booklet to ensure that they meet your needs. Alternatively, you may request a copy of the policy.

If you are not satisfied that the insurance meets your needs, you may cancel the cover or any increase in Death and TPD, Death only and Pay Protector insurance, in writing, by post or email to Media Super within this cooling-off period. In this circumstance, the insurance is treated as if it had never existed, and any premiums paid will be refunded to your Media Super account.

4. FURTHER INFORMATION

If you require any further information about insurance, contact Media Super on **1800 640 886** or go to our website at **www.mediasuper.com.au**.

Application for insurance cover form (cont.)

Section 1: Personal details

You must complete this section.

The information requested in this section is required to match your insurance application to your super account.

Mr/Mrs/Ms/Miss/Dr	Gender	Date of birth (DD/MM/YYYY)
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/> / <input type="text"/> / <input type="text"/>
Surname		
<input type="text"/>		
Given names		
<input type="text"/>		
Address		
<input type="text"/>		
		State
		Postcode
Telephone (home)		Telephone (work)
(<input type="text"/>) <input type="text"/>		(<input type="text"/>) <input type="text"/>
Mobile		
<input type="text"/>		
Email address		
<input type="text"/>		

Section 2: Additional personal details required

The information requested in this section is required by the Insurer of Media Super.

It is used for the purpose of determining the level of risk and therefore the level of insurance cover allowable to each individual.

Are you applying for:

- Cover as an **Employer-sponsored member**
- Cover as a **Personal-account member**

Note: If you are not sure which type of membership applies to you, phone us on **1800 640 886**.

Your employer's name

Date commenced with employer

 / /

I authorise an ING underwriting service representative to contact me by phone if further information is required.

I can be contacted at the following times:

- Monday Tuesday Wednesday Thursday Friday Any business day

Between . and .

Please tick your preferred contact method:

- Home phone Work phone Mobile Email

Section 3: Occupation / Duties

Please complete this section with details of your current occupation. An occupational factor may be applied to your premium if your Death and TPD cover is Formula-based cover or Fixed-dollar cover. Your premium may be increased or decreased depending on which occupational factor applies to you.

Are you solely engaged in a professional, managerial, marketing, accounting, administrative or clerical occupation? YES NO

If YES, please specify your occupation:

- Management Clerical Marketing Administration Accounting

Other occupation where the main duties are performed in a sitting posture, with little exercise (write your job title and main duties below)

Section 3: Occupation /Duties (continued)

- Do you work in an office environment at least 80% of the time in your occupation? YES NO
- Are you actively working and able to perform your usual duties and not undergoing any rehabilitation program? YES NO
- Are you engaged in any other occupation? YES NO

If YES, please specify the occupation and duties:

Section 4: Your insurance – Death and TPD or Death only

Use this section to indicate the amount of Death and TPD or Death only cover you require up to the maximum amount of cover, which is \$2 million for Total and Permanent Disablement and \$5 million for Death.

EMPLOYER-SPONSORED MEMBERS

As an **Employer-sponsored member**, you may qualify for automatic acceptance up to the Automatic Acceptance Level (AAL). For details, see the **Insurance** section of the Member Booklet. If you are not sure if you qualify for automatic acceptance, phone us on **1800 640 886** for assistance. You only need to complete this section to apply for additional Death only or Death and TPD cover.

I wish to apply for Member-selected cover (either Unit-based or Fixed-dollar cover) YES NO

Please select the type of cover that you require.

Please note that you can only elect to have the same type of cover (Death only cover or Death and TPD cover). Any approved cover will replace any existing cover.

When selecting Unit-based cover, ensure that your nominated units are greater than the minimum number of default units for your age (see the **Insurance** section of the Member Booklet).

I wish to apply for the following cover:

Death only

Nominate the total number of units that you require (\$0.28 per week each) **OR**

Nominate a Fixed-dollar cover amount \$

Death and TPD

Nominate the total number of units that you require (\$0.44 per week each) **OR**

Nominate a Fixed-dollar cover amount \$

Note: any existing Unit-based cover will be cancelled if Fixed-dollar cover is approved.

PERSONAL-ACCOUNT MEMBERS

Personal-account members may qualify for automatic acceptance up to the Automatic Acceptance Level (AAL) for Restricted Standard Default cover as detailed in the **Insurance** section of the Member Booklet. If you are not sure if you qualify for automatic acceptance, phone us on **1800 640 886** for assistance. If you wish to increase your cover further, you can apply for Member-selected cover. You can apply for either Unit-based cover or Fixed-dollar cover.

I wish to apply for unrestricted Standard Default cover

I wish to apply for Member-selected cover (either Unit-based or Fixed-dollar cover)

Death only

Nominate the total number of units that you require (\$0.28 per week each) **OR**

Nominate a Fixed-dollar cover amount \$

Death and TPD

Nominate the total number of units that you require (\$0.44 per week each) **OR**

Nominate a Fixed-dollar cover amount \$

Application for insurance cover form (cont.)

Section 5: Your insurance – Pay Protector

EMPLOYER-SPONSORED MEMBERS

Eligible **Employer-sponsored members** are automatically provided with Pay Protector insurance up to a maximum benefit of \$20,000 per month, subject to the employer not opting out of this cover on their behalf.

If you would like to apply:

- for in excess of \$20,000 per month or nominate a salary in excess of \$20,000 per month;
- to have the Pre-existing Condition exclusion removed from your cover; or
- to reduce the default waiting period (see your Welcome Letter); OR

If you did not automatically receive cover:

you must complete Sections 6 and 8 of this form. (If you answer YES to any question in Section 6, you will also need to complete Section 7.)

Apply for cover or apply to amend existing cover

I wish to apply for cover

I wish to amend existing cover

Nominate a salary

I wish to nominate a salary or update my salary.

Current gross annual salary \$

Number of working hours a week hours

Mode of employment Full-time Part-time Other (please specify)

I would like to nominate a salary \$

Nominate a waiting period

I wish to elect the following waiting period:

30 days 60 days 90 days

Pre-existing condition exclusion

I wish to apply to remove the pre-existing condition exclusion from my cover.

PERSONAL-ACCOUNT MEMBERS

Personal-account members must nominate a salary and waiting period at the time of joining Media Super to receive automatic Pay Protector cover up to the maximum benefit of \$10,000 per month.

If you are not eligible for automatic cover, or would like to apply for cover in excess of \$10,000 per month and/or have the Pre-existing Condition exclusion removed from your cover, you must complete Sections 6 and 8 of this form. (If you answer YES to any question in Section 6, you will also need to complete Section 7.)

Complete one of the following:

I am ineligible for automatic cover; OR

I am eligible for automatic cover

Please select a waiting period. The longer the waiting period, the more time must elapse after a claim before a benefit begins to be paid. Longer waiting periods attract lower premiums.

30 days 60 days 90 days

Current gross annual salary \$

Number of working hours a week hours

Mode of employment Full-time Part-time Other (please specify)

Choose one of the following:

I would like to apply for Pay Protector cover based on my current salary

I would like to nominate a salary \$

Pre-existing Condition exclusion

I wish to apply to remove the Pre-existing Condition exclusion from my cover.

Section 6: Personal Health Statement

PART A

The Insurer will process most applications using the information in Section 6. In some cases, the Insurer may require additional details, such as financial information, medical reports, blood test results, or may require you to complete a medical examination.

Your cover will commence when your application is approved by the Insurer.

Please complete all questions in Part A.

1. What is your height?
 cm; OR feet and inches
2. What is your weight?
 kg; OR stone and pounds
 Has your weight varied by more than 10kg (22 pounds) during the past 12 months? YES NO
 If YES, please provide details below:

Please tick 'YES' or 'NO' boxes for each of the following questions:
 YES NO

At any time in your life have you ever suffered from, experienced symptoms, or been diagnosed with any of the following?

3. Heart trouble, heart murmur, high blood pressure, high cholesterol, chest pain, rheumatic fever, palpitations, stroke or vascular disorder?
4. To the best of your knowledge, has the virus which causes AIDS (Acquired Immune Deficiency Syndrome) ever infected you or are you carrying antibodies of the virus?
5. Disease related to kidney, bladder, prostate, bowel, stomach or liver (including Hepatitis B and C)?
6. Mental illness, depression, anxiety, chronic fatigue, nervous condition, stress or post traumatic stress disorder?
7. Diabetes, thyroid or glandular trouble?
8. Asthma, lung conditions and breathing disorder?
9. Back, neck, shoulder, or knee pain; strain, sciatica, whiplash, or any disorder of the spine or neck, or any disorder of the joints, muscles, ligaments, cartilage or limbs (including broken bones)?
10. Disorder of the eyes, ears or skin (excluding prescriptions for glasses or contact lenses)?
11. Disease of the brain, nervous system, stroke or epilepsy?
12. Cancer, leukaemia, tumour of any kind or blood disorder?
13. Are you currently off work, or unable to perform all your usual duties on a permanent full-time basis, or are you receiving any form of medical treatment?
14. To the best of your knowledge, have you taken more than a total of seven days off your work over the past 12 months due to illness or injury (other than cold or flu)?
15. (a) During the last twelve months have you smoked tobacco or any other substance?
 If YES, please state the type and quantity per day:
- (b) Have you been advised by a medical practitioner to give up or reduce the amount of smoking on specific medical grounds, or have you been informed that you have a medical condition as a result of your smoking?

16. (a) Do you consume alcohol?
 If YES, please state the type and quantity per week:
 Beer Wine Spirits
 Others Qty per week
- (b) Have you been advised by a medical practitioner to give up or reduce the amount of alcohol consumed on specific medical grounds, or have you been informed that you have a medical condition as a result of your alcohol consumption?
 If YES, please provide details

PART B

Please complete ONLY if you answered 'YES' to any questions in Part A AND/OR you are applying for more than \$500,000 of Death and TPD cover OR more than \$4,000 of monthly Pay Protector cover. Otherwise, please proceed to Section 8: Declaration.

Please complete all questions in Part B.

Please tick 'YES' or 'NO' boxes for each of the following questions:
 YES NO

1. Have any of your near relatives (i.e. your father, mother, brothers or sisters) been diagnosed prior to age 60 with hereditary disorders such as diabetes, cancer, heart disease, mental disorder, haemophilia or Huntington's chorea?
 If you answered 'YES' to this question, please advise the relationship, condition and age of the diagnosed:
2. Do you engage in, or intend to engage in (other than as a fare-paying passenger) any hazardous activities such as flying, motor racing, parachuting, hang gliding or diving?
 If 'YES', please provide details of the activity and the frequency with which you participate in this activity, including maximum speed/height/depth:

 I participate in this activity times per year.
3. Have you ever had an application for life, disability, accident or sickness insurance declined, postponed, modified or accepted on special terms (eg. exclusions or loadings)?
 If 'YES', please provide details below:
4. Have you ever made a claim, or are any claims pending or intended for any type of accident or sickness, lump-sum total and permanent disablement, workers' compensation or personal injury insurance?
 If 'YES', please provide details:

Continued ►

Application for insurance cover form (cont.)

Section 6: Personal Health Statement (continued)

Please tick 'YES' or 'NO' boxes for each of the following questions:

YES NO

5. Do you currently have or are you currently applying for Death, Total and Permanent Disablement (TPD) or Income Protection (Pay Protector) Insurance with any other superannuation fund or Insurer?

If 'YES', please provide details below:

6. Have you ever had any of the following or, to the best of your knowledge, do you currently have any of the following:
- (a) Ill health or disability?
- (b) Asthma, sleep apnoea, bronchitis, persistent cough or any other chest or lung trouble or allergy?
- (c) Ulcers, bowel trouble or recurring indigestions?
- (d) Epilepsy, fits or dizziness of any kind or persistent headaches?
- (e) Stress, anxiety, depression, mental or nervous disorder, Alzheimer's disease or dementia?
- (f) Kidney or bladder problem, renal cholic or stone nephritis, pyelitis, cystitis?
- (g) Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI or any regional pain syndrome, or Chronic Fatigue Syndrome (Myalgic Encephalomyelitis)?
- (h) Cancer, tumour, cyst, growth of any kind, or breast lumps (even if you have not seen a doctor)?
- (i) Varicose veins, hernia or skin trouble?
- (j) Any abnormality affecting eyesight, hearing, speech or physical mobility?
- (k) Anaemia, haemophilia or any other disease of the blood?
- (l) Bowel, liver or gall bladder disease, or hepatitis?
- (m) Any other disease or condition or relevant symptom lasting more than four weeks, or of an ongoing nature?
- (n) Coughing of blood or passing of blood from the bowel or in the urine?
- (o) Are you currently receiving or considering receiving medical attention, or taking prescribed drugs (other than for contraceptive purposes)?
- (p) Have you ever had any tests for HIV (Human Immunodeficiency Virus) other than as a direct requirement of your employment, residency, pregnancy, being a blood donor, or an application?
- (q) Have you ever worked as, or engaged in, sexual activity with a prostitute; or engaged in anal sexual activities?
- (r) Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?

7. Question 7 is for females only.

- (a) Are you currently pregnant?

If 'YES', please provide due date:

 / /

- (b) Have you had any complications with pregnancy or childbirth?

If 'YES', please provide details:

- (c) Have you ever had an abnormal pap smear, breast ultrasound or mammogram?

If 'YES', please provide details:

8. (a) Usual doctor or medical centre details:

Full name of usual doctor/medical centre

Telephone number

 ()

Address of doctor

Reasons for last consultation:

Date of your last consultation

 / /

Outcome:

- (b) If you have been attending your usual doctor for less than 12 months, please advise name, number and address of the doctor who has details of your medical history:

Full name of doctor/medical centre

Telephone number

 ()

Address of doctor

Reasons for last consultation:

Date of your last consultation

 / /

Outcome:

- (c) If you have more than one usual doctor, please provide details of additional doctors below:

Full name of doctor/medical centre

Telephone number

 ()

Continued ►

Section 6: Personal Health Statement (continued)

Address of doctor

Reasons for last consultation:

Date of your last consultation

 / /

Outcome:

Full name and address of doctor or hospital consulted:

Does your usual doctor have details of this condition? YES NO

Other information:

2. Which question in Part B did you answer 'YES' to?

Please advise if illness, injury or test:

Main symptoms/causes:

Date commenced: / /

Time off work:

DETAILS OF PERSONAL HEALTH QUESTIONS

Please complete this section if you answered 'YES' to any questions from 1 to 7 in Part B. If not, please proceed to Section 8: Declaration.

Note: If you answered 'YES' to more than two questions, please photocopy this page, complete this section, and attach the pages to this application.

1. Which question in Part B did you answer 'YES' to?

Please advise if illness, injury or test:

Main symptoms/causes:

Date commenced: / /

Time off work:

Please tick 'YES' or 'NO' boxes for each of the following questions:

YES NO

Has the condition recurred? YES NO

If 'YES', state date range:

From: / /

To: / /

Have you fully recovered? YES NO

If 'YES', give date: / /

If 'NO', please provide degree of recovery %

Full details of treatment:

Date of last symptom: / /

Further treatment recommended: YES NO

If 'YES', please give details:

Please tick 'YES' or 'NO' boxes for each of the following questions:

YES NO

Has the condition recurred? YES NO

If 'YES', state date range:

From: / /

To: / /

Have you fully recovered? YES NO

If 'YES', give date: / /

If 'NO', please provide degree of recovery %

Full details of treatment:

Date of last symptom: / /

Further treatment recommended: YES NO

If 'YES', please give details:

Full name and address of doctor or hospital consulted:

Does your usual doctor have details of this condition? YES NO

Other information:

Section 7: Disclosure of information – Doctor’s authority

Please sign and date this authorisation.

For the purpose of assessing my eligibility for insurance, I authorise my current medical practitioner, and any other medical practitioner or health professional I have consulted or may consult in the future or that ING Life appoints to examine me, to disclose information about my health and related matters to ING. A photocopy of this authorisation will be valid as the original.

Applicant’s signature

X

Date (DD/MM/YYYY)

/ /

Section 8: Declaration

Please sign and date this form and return it to the address shown below.

I declare that I:

- Have read and carefully considered the questions in the Personal Health Statement above, and all answers provided are true and correct.
- Have read the conditions and directions for completion attached to this form, and agree to be bound by them.
- Have read and understand the Duty of Disclosure and Non-Disclosure sections below, and I have not withheld any information that may affect the Insurer’s decision as to whether to accept my **Application for insurance cover** form. I understand that the Duty of Disclosure continues after I have completed this statement until my application has been accepted by the insurer in writing.
- Am currently gainfully employed and able to attend work and perform my normal duties, without restriction due to injury or illness.

- Have read and understood the Media Super Privacy Policy and the ING Privacy Statement in the Member Booklet (Product Disclosure Statement) issued 1 November 2009, as well as the privacy-related statements made in this Application, and consent to my personal information being collected and used in accordance with these.
- Have read the Member Booklet (Product Disclosure Statement).

FURTHERMORE:

- I acknowledge that if I do not complete this Application correctly or I do not sign and date this form, my application will not be considered by the Insurer.

Applicant’s signature

X

Date (DD/MM/YYYY)

/ /

Important notice

Media Super has taken out a contract of insurance with an Insurer to provide the insurance benefits in the Fund. On becoming a member, you are bound by the terms and conditions of this contract of insurance.

DUTY OF DISCLOSURE

Before you enter into a contract of life insurance, you have a duty under the *Insurance Contracts Act 1984* to disclose to the Insurer any matter that you know, or could reasonably be expected to know, is relevant to the Insurer’s decision as to whether to accept the risk of insurance and, if so, on what terms. You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate a contract of life insurance. Your duty 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;
- 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 entered into the contract on any terms if the failure had not occurred, the Insurer may void the contract within three years of entering into it. If your Non-Disclosure is fraudulent, the Insurer may void the contract at any time. An Insurer who is entitled to void a contract of life insurance may, within three years of entering into it, elect not to void it but to reduce the sum for which you have been insured in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant information to the Insurer.

WE MAY NEED ADDITIONAL INFORMATION

The Insurer will consider most members’ applications on the basis of their answers to the questions included on the Application. However, the Insurer may require some people to provide additional information, undergo a medical examination and/or have a blood test as part of their assessment. Generally, this requirement may only apply to people in an older age group or those applying for a high level of cover. Media Super will advise you if the Insurer requires additional information to assess your application.