

Insurance application

PERSONAL STATEMENT AND MEMBER DECLARATION

Member Services Centre 13 43 72 Facsimile 1800 300 067 gesb.com.au
PO Box J 755, Perth WA 6842 Level 4 Central Park, 152 St Georges Terrace, Perth

Did you know you can apply for most insurance cover via Member Online at gesb.com.au at any time? If you visit Member Online and click on 'Your insurance', there may be no need to complete this form.

This form allows you to apply for the following insurance:

- Death
- Total and Permanent Disablement (TPD) and
- Salary Continuance Insurance (SCI)

It also allows you to apply to decrease your waiting period for SCI.

To transfer cover from another fund, use the 'Individual insurance transfer declaration'.

MORE INFORMATION

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 underwritten 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 and misrepresentation

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 avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract at any time. An Insurer who is entitled to avoid a contract of insurance may, within three years of entering into 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 contribution that would have been payable if you had disclosed all relevant matters to the Insurer.

Privacy

By completion of this form you consent to any personal information, including information that may be of a sensitive nature we or AIA Australia may collect about you in the normal course of our and AIA Australia's business, being used as outlined in our and AIA Australia's respective Privacy Policies. These policies are designed to protect your interests and are consistent with the requirements of the Privacy Act. A copy of AIA Australia's privacy policy can be obtained from www.aia.com.au. GESB has a Privacy Statement to ensure that it handles private information about individuals responsibly. GESB's Privacy Statement is available at gesb.com.au or can be obtained by contacting your Member Services Centre on 13 43 72.

SECTION 1 YOUR DETAILS

GESB member number

Applying for insurance cover in:

GESB Super **OR**

West State Super

Mr Mrs Miss Ms Other

Surname (family name) please print

Given names

Date of birth / / Male Female

Current age

Residential address

Postcode

Postal address (if different from residential)

Postcode

Email address

Telephone – home

 ()

Telephone – work

 ()

Telephone – mobile

AIA Code
APPLS



SECTION 1 YOUR DETAILS CONTINUED

Employer

Occupation

Industry

Daily duties, including the % time spent performing each duty (ie. manual duties):

What is your current employment status?

appropriate box)

Permanent full-time

Permanent part-time

Casual

Other (specify)

Note: Casual employees include sessional workers. Board members are considered permanent employees for insurance purposes.

Do you intend changing occupations, altering your duties or hours worked within the next 12 months?

Yes No

If YES, state below:

How many full-time equivalent hours do you work each week? (ie What is your FTE%? 1 day per week = 0.2 FTE)

SECTION 2 TYPE OF INSURANCE

appropriate box)

New insurance cover **OR** Increase my existing insurance cover

I would like the total value of my insurance cover to be increased to:

appropriate box)

Death

\$ Total cover

in increments of \$10,000, up to a maximum of \$10 million. The nominated amount will be rounded down to the nearest \$10,000 if not in \$10,000 increments.

Total and Permanent Disablement (TPD)

\$ Total cover

in increments of \$10,000, up to a maximum of \$3 million. The nominated amount will be rounded down to the nearest \$10,000 if not in \$10,000 increments.

Salary Continuance Insurance (SCI)

\$ Total cover

in increments of \$200 per month. The nominated amount will be rounded down to the nearest \$200 if not in \$200 increments.

The maximum SCI cover you can apply for is the lesser of 85% of your income (75% of income plus up to 10% superannuation contribution) and \$30,000 per month. If you are classified as being in the Hazardous Category, your cover will be limited to the lesser of \$3000 per month or 85% of your income (75% of income and up to a 10% superannuation contribution).

SALARY CONTINUANCE INSURANCE ONLY:

Waiting period one)

30 days

60 days

90 days

120 days

180 days

Annual salary \$ (excluding super)

It is important to understand that the level of cover you apply for will be a fixed amount until you change it. However any TPD cover will automatically reduce annually to nil from your 61st birthday until age 65.

SECTION 3 PERSONAL HISTORY

1. State your:

Height cm Weight kg

	(✓)	
	Yes	No
2. Are you a permanent resident of Australia?		
3. Have you smoked any tobacco or any other substance in the last 12 months? If YES, state forms and quantities:		
4. Do you intend to work, live or travel overseas? If YES, state the destination, duration, frequency and purpose of travel:		
5. Have you ever engaged or are you likely to engage in aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (eg motor racing, football, martial arts, scuba diving)? If YES, provide details:		
At the date of this application:		
6. Are you absent from work or unable to carry out all the duties of your current or usual occupation on a full-time basis?		
7. Have you ever had back or neck pain for seven or more consecutive days, or have you ever had mental/nervous/stress disorders, cancer, blindness or deafness?		
8. In the last three years, have you had any medical advice or treatment, taken prescribed (excluding for colds or flu) or illicit drugs or been hospitalised for any injury or sickness?		
9. Are you under any treatment by diet, medication, sedative or drugs?		
10. Has any company ever declined, deferred, applied special or modified conditions or cancelled any proposal to insure you for a life or disablement policy?		
If you answered YES to any of the above questions (6–10), give full details:		

SECTION 4 MEDICAL DETAILS
Part A – Medical details

	✓	
	Yes	No
1. Have you ever suffered from, or received treatment for, or had symptoms of:		
A. High blood pressure or blood disorder (eg leukaemia, anaemia or haemophilia)?		
B. Heart, vein or circulatory disorder, including chest pain, heart attack, stroke, heart murmur, raised cholesterol or rheumatic fever?		
C. Mental or nervous disorder (eg stress, depression, insomnia), fainting, epilepsy, fits of any kind, paralysis, multiple sclerosis, migraines, brain disorder, psychiatric treatment/counselling or neurological disorder?		
D. Gout, arthritis, rheumatism, skeletal injury, spine/neck disorder, cartilage or ligament injury, bone fracture or hernia?		
E. Back or neck pain, whiplash, sciatica or any muscle or joint disorder?		
F. Asthma, bronchitis, tuberculosis, pleurisy or other respiratory disorder?		
G. Stomach, intestinal or rectal disorder, ulcer, bleeding from bowel, gall bladder?		
H. Diabetes, thyroid or prostate disorder?		
I. Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?		
J. Impairment/disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?		
K. Hepatitis B or C or have you ever been told you are a Hepatitis B or C carrier?		
L. Dermatitis, psoriasis or any skin disorder?		
M. Liver, kidney or bladder disease, including renal colic or stone, blood in urine or reproductive organ disorder?		
N. Sexually transmitted diseases?		
O. Drug or alcohol dependence?		
P. Any other medical condition not mentioned above?		
Q. Females only		
i) Female organ disorder (including abnormal:– pap smear, breast ultrasound or mammogram)?		
ii) Are you currently pregnant?		
If YES, date of expected delivery: <input style="width: 100px; height: 20px; border: 1px solid black;" type="text" value=" / /"/>		

Part B – Further medical background

	Yes	No
1. Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?		
2. During the last five (5) years have you:		
A. Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?		
B. Been in hospital, clinic or nursing home?		
C. Been advised to have an operation?		
D. Had any tests, including blood tests, ECG, X-rays or genetic tests?		
E. Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquilisers?		

If you answered YES to ANY of the questions in Parts A or B, complete Part C onwards.
Otherwise, complete Part D onwards.

SECTION 4 MEDICAL DETAILS (CONTINUED)

Part E – Other details

1. Do you drink alcohol?

Yes No If YES, what type of alcohol?

How much (daily intake)?

2. Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)?

Yes No

If YES, provide the policy details in the schedule below:

Start date	Insurer	Type of cover	Amount of cover	To be replaced* 'Yes' or 'No'
/ /				
/ /				
/ /				
/ /				

*For policies to be replaced, attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

Part F – Family history

1. Have any of your parents, brothers or sisters (living or deceased), had huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder?

Yes No

If YES, provide details in the schedule below:

Relation	Condition/illness	Age at onset (approximately)	Age at death (if applicable)

2. Have any of your parents, brothers or sisters (living or deceased), been diagnosed prior to age 65 with any of the following conditions: diabetes, heart disease, mental illness, haemophilia, hemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (specify type), stroke or kidney disease?

Yes No

If YES, provide details in the schedule below:

Relation	Condition/illness (For cancer specify type)	Age at onset (approximately)	Age at death (if applicable)

SECTION 5 AIDS DECLARATION

I hereby declare that:

- I am not suffering from Acquired Immune Deficiency Syndrome (AIDS) and I am not infected with the HIV virus and I am not carrying antibodies to the HIV virus;
- Since 1980, I have not used intravenous drugs, I have not engaged in male to male anal sexual activity and I have not worked as or had sexual intercourse with a prostitute; and
- I have not had sexual intercourse with someone I know or suspect to be HIV positive.

I am ABLE to declare that ALL the above statements are true.

I am UNABLE to declare that ALL the above statements are true.*

* If unable, a Confidential Supplementary Personal Statement is required, contact your Member Services Centre on 13 43 72 for a copy.

Before signing, one of the above boxes must be ticked.

Signature of Life Insured

Date

 / /

SECTION 6 INCOME DETAILS

Complete only if Salary Continuance Insurance is required.

- 1. A.** State your monthly income from your current occupation (net of business expenses but before tax):
DO NOT INCLUDE INVESTMENTS AND SUPERANNUATION.

Employed

Your income is the total value or remuneration paid by your employer including salary, fees, regular commission, regular bonuses, regular overtime and fringe benefits but excluding mandated superannuation contributions.

Current year \$ per month

Previous year \$ per month

Self-employed

If you are self-employed, a working director or partner in a partnership, your income is the income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses. Note the benefit may be averaged in some circumstances based on the last two years' income.

- B.** How long have you been at your current occupation?

years months

- C.** How much of the above income will continue if you are disabled?

\$

i) For how long? years months

ii) State source of income (eg sick leave, director's fees, income protection insurance, profit share from the business):

- 2.** If you become disabled, would you receive income from **other** sources?

Yes No

If YES:

A. How much? \$ per month

B. For how long? years months

C. State source of income:

- 3.** Do you also perform another occupation?

Yes No

If YES, describe the daily duties of this occupation (including manual work):

- 4.** Do you receive any unearned income (eg from investments such as a rental property or dividends)?

Yes No

If YES, how much? \$ per month

- 5.** What was your previous occupation?

- 6.** Are you self-employed or employed by your own company?

Yes No

If NO: Please go to question 8.

If YES:

A. Date your business started / /

B. How long have you been self-employed?

years months

C. What percentage of your work is:

i) Freelance? %

ii) Contract? %

D. How many people do you employ?

- 7.** Has your business or practice had a net operating loss in the last 2 years?

Yes No

If YES, provide copies of Profit and Loss Statements for the last 2 years.

- 8.** Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?

Yes No

If YES, when? / /

Date of discharge: / /

- 9.** Do you work at home?

Yes No

If YES, state percentage of time: %

- 10.** Do you earn commission or bonuses?

Yes No

If YES, state percentage of total income: %

SECTION 7 DECLARATION

- I have read the 'Insurance and your super' brochure and the section 'Important information' which contains information on your duty of disclosure, non-disclosure and misrepresentation and privacy. I understand it serves as general information only and does not contain financial advice.
- I declare that the statements in this form are true and correct (whether written in my hand or not) and that I have not withheld information with regard to the insurance cover I am applying for.
- I agree that any personal statements made together with other relevant documents shall form the basis of the proposed contract of insurance with AIA Australia Limited, the Insurer.
- I declare that I have read the Privacy Statement set out in this application and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.
- I consent to the Insurer collecting sensitive information, that is, health information about me for the purposes of the performance of this contract.
- I agree that cover will not commence until the premium is paid and the proposal is accepted by the Insurer.
- I have read the Duty of Disclosure notice and understand what is meant by that notice.
- I also understand that my duty to disclose continues after I have completed this application until the Insurer has accepted the risk.
- I understand that the Insurer does not currently send any direct marketing materials.
- I understand my cover will be a fixed amount until I change it, however my TPD cover will automatically reduce annually to nil from my 61st birthday until age 65.

Signature of Life Insured

Date

X

/ /

Check that all parts of this form have been completed and that your member number is included on any attachments, then return to:

GESB

PO Box J 755

Perth WA 6842

We will send you a confirmation notice outlining your new insurance details and any relevant premiums.

MEDICAL AUTHORITY

I,

authorise any Doctor/Hospital/Clinic to disclose to AIA Australia Limited full details of my health and medical history.

Signature of Life Insured

Date

X

/ /

Full name of Life Insured