



# Insurance Application

## Personal Statement and Member Declaration

PO Box J 755, Perth WA 6842  
Level 4 Central Park, 152 St Georges Tce, Perth WA 6000  
Member Services Centre 13 GESB (4372)  
Facsimile 1800 300 067  
Website gesb.com.au

THIS FORM ALLOWS YOU TO APPLY FOR THE FOLLOWING INSURANCE:

- DEATH;
- TOTAL AND PERMANENT DISABLEMENT (TPD); AND
- SALARY CONTINUANCE INSURANCE (SCI).

### YOUR DUTY OF DISCLOSURE

Before you enter into 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 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 a contract of insurance.

### 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 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.

### Section 1 – Your details

Please provide your GESB Member Number and personal details.

GESB Member Number

WIN No. Office Use Only

Applying for insurance cover in:

GESB Super

West State Super

Mr  Mrs  Miss  Ms  Other

Surname (Family Name) please print

Given Names

Date of Birth  /  /  Male  Female

Age Next Birthday

Residential Address

Postcode

Postal Address (If different from residential)

Postcode

Email Address

Telephone – Home

Telephone – Work

Telephone – Mobile

AIG Code  
APPLS



Note: GESB has a Privacy Statement to ensure that it handles private information about individuals responsibly. Our Privacy Statement is available on our website or can be obtained by contacting your Member Services Centre.

FOR OFFICE USE ONLY

Government Employees  
Superannuation Board  
ABN 43 418 292 917

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?

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, please 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

Please  one

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

**I would like the value of my insurance cover to be increased to:** (please )

Death

\$

in increments of \$10,000, up to a maximum of \$5 million.

Total and Permanent Disablement (TPD)

\$

in increments of \$10,000, up to a maximum of \$2 million. The value of your TPD cover can not exceed the value of your Death cover.

Salary Continuance Insurance (SCI)

\$

in increments of \$200 per month.

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 \$20,000 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 (Please  one)

30 days

60 days

90 days

120 days

180 days

Annual Salary \$  (excluding super)

### Section 3 - Personal history

(Please ✓ where applicable)

1. Please state your:

Height  cm      Weight  kg

(please ✓)

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, please state forms and quantities:

4. Do you intend to work, live or travel overseas?

If YES, please 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, please 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 illness?

9. Are you under any treatment by diet, medication, sedative, 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), please give full details:

## Section 4 - Medical details

### PART A – MEDICAL DETAILS

1. Have you ever suffered from, or received treatment for, or had symptoms of:

(please ✓)

YES NO

- 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:  /  /

### 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, please complete Part C onwards.  
Otherwise, complete Part D onwards.

**Section 4 - Medical details (continued)**

**PART C – ANSWERS IN DETAIL**

If you answered YES to ANY question in Parts A or B, please provide details in the schedule below.  
If there is insufficient space, please provide a signed and dated supplementary statement.

QUESTION REFERENCE (PART A OR B)	TESTS, OR NATURE OF CONDITION OR COMPLAINT	START – END DATE DD/MM/YY – DD/MM/YY	TIME OFF WORK	DEGREE OF RECOVERY %	FULL DETAILS OF TREATMENT & RESULTS (INCLUDE TYPE OF OPERATIONS)	FULL NAME & ADDRESS OF DOCTOR OR HOSPITAL (IF ANY)

**PART D – PERSONAL DOCTOR'S DETAILS (PLEASE PROVIDE CURRENT DETAILS)**

If no personal doctor, please state name/address of last clinic or medical centre attended.

Name

Date of last consultation  /  /  How long have you been a patient?  years  months

Address

Telephone (  )  Facsimile (  )

Email Address (if known) (  )  ABN (if known) (  )

Please state the reasons and results of your last consultation:

## 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, please 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, please 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, please 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 (please specify type), stroke or kidney disease?

Yes

No

If YES, please provide details in the schedule below:

RELATION	CONDITION/ILLNESS (FOR CANCER SPECIFY TYPE)	AGE AT ONSET (APPROXIMATELY)	AGE AT DEATH (IF APPLICABLE)

## Section 5 - Income details

Complete only if Salary Continuance Insurance is required.

1. A. Please 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. Please 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, please provide copies of Profit & 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, please state percentage of time:  %

10. Do you earn commission or bonuses?

Yes  No

If YES, please state percentage of total income:  %

## Section 6 - 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, please contact our Member Services Centre on 13 GESB (4372) for a copy.

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

**Signature of Life Insured**

X

Date

/ /

## Section 7 - Declaration

- I have read the relevant Product Information Booklet (PIB). I understand the PIB 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 American International Assurance Company (Australia) Limited trading as AIG Life.
- 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 AIG Life 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 AIG Life.
- 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 AIG Life has accepted the risk.
- I understand that AIG Life does not currently send any direct marketing materials.

**Signature of Life Insured**

X

Date

/ /

## AIG Life Privacy Statement

American International Assurance Company (Australia) Limited ABN 79 004 837 861 AFS Licence No 230043 (AIA) trading as AIG Life is required under the National Privacy Principles of the Privacy Amendment (Private Sector) Act 2000 to provide you with the following information.

### PURPOSE OF COLLECTION

AIA collects personal and sensitive information about you to process your claim(s) and, if appropriate, to pay benefits under the policy. If you do not provide us with all or part of the personal and sensitive information we request from you, or if that information is not accurate and true, we may not be able to process your claim or pay you a benefit.

### ACCESS TO YOUR INFORMATION

You are entitled at any time to request access to your personal information held by AIA. All requests to access your personal information should be made in writing to the Compliance Manager, Level 3, 549 St Kilda Road, Melbourne VIC 3004.

You can ask us to update your personal information at any time if it is inaccurate, incomplete or out of date.

In some circumstances, AIA may not permit access to your personal information. Circumstances where access may be denied include where access would be unlawful or denying access is authorised by law.

In these cases, AIA will provide you with written reasons for denial of access or a refusal to correct personal information.

### DISCLOSURE OF INFORMATION

AIA may disclose your personal information to:

- Another member of the AIG group of companies (whether in Australia or otherwise);
- Your adviser;
- AIA contractors and third party service providers (eg medical practitioners, reinsurers, investigators and accountants);
- Your employer;
- Financial institutions you nominate;
- Government authorities to which we are required by law to disclose information (eg Australian Taxation Office).

We will only disclose your personal information to these parties for the purpose for which it was collected as stated above.

In some circumstances, AIA is entitled or required to disclose your personal information to third parties without your authorisation, such as law enforcement agencies or government authorities to protect our interests or to report illegal activities.

### ANY QUESTIONS OR CONCERNS

If you have any questions or concerns about your personal information please write to the Compliance Manager, Level 3, 549 St Kilda Road, Melbourne VIC 3004.

AIA has established an internal dispute resolution process for handling customer complaints about AIA's compliance with the National Privacy Principles. This dispute resolution mechanism is designed to be fair and timely to all parties and is free of charge.

If you have a complaint about AIA's compliance with the National Privacy Principles, you should submit it in writing to the Compliance Manager. You will receive a letter from AIA within 5 working days, which documents AIA's complaints handling process. Your complaint will be referred to AIA's Internal Dispute Resolution Committee who shall endeavour to resolve your complaint within 45 days of receipt.

Should your complaint not be resolved to your satisfaction by AIA's internal dispute resolution process, you may take your complaint to the Privacy Commissioner. The Privacy Commissioner's contact details are: Office of the Federal Privacy Commissioner, GPO Box 5218, Sydney NSW 2001 or call the Privacy Hotline on 1300 363 992.

### YOUR ACKNOWLEDGEMENT AND CONSENT

Your signature below indicates your consent to such use and disclosures of your personal information as outlined above.

Your signature below indicates that you understand that AIG Life does not currently send any direct marketing materials.

#### Signature of Life Insured

Date

Print name:

**Please 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

## Medical Authority

I,

authorise any Doctor/Hospital/Clinic to disclose to AIG Life full details of my health and medical history.

#### Signature of Life Insured

Date

Full Name of Life Insured