TAL

Member's Personal Statement

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1. YOUR DUTY TO TAKE REASONABLE CARE

When you apply for insurance with TAL (the Insurer), you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Under the *Insurance Contracts Act 1984 (Cth)* there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it would have been in if the duty had been met. For example, the Insurer may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including:

- whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances.
- what the Insurer would have done if the duty had been met – for example, whether it would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

Guidance for answering the questions in this form

You are responsible for the information provided to the Insurer. When answering questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Please note that there may be circumstances where the Insurer later investigates whether the information given to it was true. For example, it may do this when a claim is made.

Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances As any changes might require further assessment or investigation, it could save time if you let the Insurer know about any changes when they happen.

If you need help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know if you're having difficulty due to a disability, understanding English or for any other reason – we're here to help and can provide additional support.

2. PERSONAL DETAILS

Please print your answers clearly

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Given name(s)

Last name

Date of birth DD / MM / YYYY

Gender ☐ Male ☐ Female

Street address

Suburb State Postcode

TAL may contact you directly to clarify or gather information in relation to this application.

Please advise your preferred method of contact:

☐ Telephone

☐ Email

Please ensure the email address provided is your personal address as we may send information of a sensitive and personal nature to it.

3. COVER REQUESTED

BENEFIT TYPE	EXISTING SUM INSURED	ADDITIONAL SUM INSURED	NEW TOTAL SUM INSURED
Death	$	$	$
Total & Permanent Disablement (TPD)	$	$	$

Income Protection (IP)

Existing monthly benefit $

Additional monthly benefit $

New total monthly benefit $

Income level (% of your salary) ☐ 75% ☐ Other (enter value)

Waiting period (days) ☐ 30 ☐ 60 ☐ 90 ☐ Other (enter value)

Benefit period period ☐ 2 yr ☐ 5yr ☐ to age 65 ☐

Other (enter value)

4. YOUR OCCUPATION AND INCOME DETAILS

1. Please select your employment status and complete details

☐ Self-employed ☐ Employee full-time ☐ Employee part-time

   a) Hours worked per week

   b) Weeks worked per year

2. Occupation name

3. Industry

4. Duties performed including % of time in each

5. Annual income before tax $

5. YOUR INSURANCE AND CLAIM HISTORY

1. Apart from this application, do you have or are you applying for any other Life, Total and Permanent Disablement (TPD) or Income Protection (IP) insurance? (Please include cover held or applied and/or applied for through TAL or under superannuation.)

   ☐ No ☐ Yes

2. Are you claiming or have you ever claimed a benefit from any source e.g. Total and Permanent Disablement benefit from any superannuation fund, workers' compensation, disability pension, Veterans' Affairs or any other insurance cover providing accident or illness benefits?

   ☐ No ☐ Yes

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

   ☐ No ☐ Yes

If yes to 1, 2 or 3, please provide full details below.

NAME OF COMPANY	COVER TYPE	SUM INSURED/ MONTHLY BENEFIT	DATE OF APPLICATION OR CLAIM	STATE ANY LOADINGS / EXCLUSIONS	REASON FOR DECISION / CLAIM	DURATION OF CLAIM	RECOVERY	IS COVER TO BE REPLACED
		$	DD / MM / YYYY				%	☐ No ☐ Yes
		$	DD / MM / YYYY				%	☐ No ☐ Yes
		$	DD / MM / YYYY				%	☐ No ☐ Yes

6. YOUR HABITS AND ACTIVITIES

1. Do you drink alcohol?

   ☐ No ☐ Yes → State type, number of standard drinks per day and number of days per week when alcohol is consumed. (A standard drink = 1 nip spirits, 1 x 100ml glass of wine, 1 x 10oz/285ml of beer.)

2. Have you smoked in the past 12 months?

   ☐ No ☐ Yes → State form and daily quantity.

3. In the last 5 years have you smoked any substance other than tobacco?

   ☐ No ☐ Yes → State substances smoked, frequency of use, date first smoked and date last smoked.

4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing?

   ☐ No ☐ Yes → State activity/ies performed, frequency of participation, level of participation (e.g. amateur or professional), maximum depth/speed, equipment used and location (if applicable).

5. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months?

   ☐ No ☐ Yes → State where, when, duration and reason.

6. Are you an Australian citizen, a New Zealand citizen residing in Australia, a holder of an Australian permanent visa or a person who resides in Australia on an approved working visa?

   ☐ Yes ☐ No → State type of visa you hold, expiry date, plans for applying for permanent residency and nationality/current citizenship.

7. MEDICAL DETAILS

1. Please state your:

Height [ ] cm

Weight [ ] kg

Should we require further medical information from your health providers we will seek your consent via requesting you to complete a “Consent for accessing health information”.

2. Name and address of your usual doctor or medical centre

Doctor’s last name

Doctor’s given name

Doctor’s address

Suburb State Postcode

3. Details of last medical consultation with your usual doctor or medical centre

Date DD / MM / YYYY

Reason

Outcome/results

4. If you have attended that doctor for less than 12 months, state name and address of previous doctor

Doctor’s last name

Doctor’s given name

Doctor’s address

Suburb State Postcode

8. YOUR FAMILY HISTORY

Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 65: Heart disease (e.g. angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer’s disease, multiple sclerosis, muscular dystrophy, Parkinson’s disease, polycystic kidney disease, Huntington’s disease or any other inherited blood or neurological disorder?

☐ No ☐ Yes → Provide details in the table below.

RELATIONSHIP TO MEMBER	MEDICAL CONDITION (eg breast cancer, heart attack, type 2 diabetes)	AGE WHEN DIAGNOSED	AGE AT DEATH (if applicable)

9. YOUR MEDICAL HISTORY

Please provide details for all 'Yes' answers in the general medical questionnaire at section 10.

1. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?

   a) Chest pain, high blood pressure, raised cholesterol or any heart / circulatory disorder? ☐ No ☐ Yes

   b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? ☐ No ☐ Yes

   c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder? ☐ No ☐ Yes

   d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? ☐ No ☐ Yes

   e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? ☐ No ☐ Yes

   f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? ☐ No ☐ Yes

   g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind? ☐ No ☐ Yes

   h) Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse? ☐ No ☐ Yes

   i) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)? ☐ No ☐ Yes

   j) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? ☐ No ☐ Yes

2. Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? ☐ No ☐ Yes

3. Apart from treating any condition already disclosed, have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives)? ☐ No ☐ Yes

4. Apart from any condition already disclosed, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms? ☐ No ☐ Yes

5. Apart from any condition already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis? ☐ No ☐ Yes

6. Apart from any condition already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years? ☐ No ☐ Yes

10. GENERAL MEDICAL QUESTIONNAIRE

Please provide details for all 'Yes' answers in Section 9, Q's 1a-j and Q's 2-6. Please complete on a separate sheet if you need to provide additional information.

	QUESTION NUMBER ______	QUESTION NUMBER ______	QUESTION NUMBER ______
1. Date symptoms first started and description of symptoms	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
2. What was the condition and which part and side of the body was affected (if applicable)?			
3. What was the medical diagnosis including results of x-rays and investigations?			
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?			
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
6. How long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide date and duration of your stay.	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
8. What advice/treatment did you receive?			
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
10. Date treatment/ medication ceased (if applicable).	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
11. When did you last suffer from any symptoms?			
12. Degree of recovery (%).			

11. PRIVACY

TAL and its related entities are committed to ensuring that your information is handled responsibly in accordance with the Privacy laws, including the Privacy Act 1988 (Cth) and the Australian Privacy Principles. The way in which TAL collects, uses, secures and discloses your information is set out in the TAL Privacy Policy available at **http://www.tal.com.au/Privacy-Policy** or free of charge on request to TAL by telephoning 1800 666 136.

Collection and use of personal information

We collect personal information, including, but not limited to, your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and processing claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay a claim.

We may take steps to verify the information that you provide, for example we may obtain independent medical reports regarding information about your past and current medical conditions, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of your information

We disclose relevant information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you. The types of people and organisations to which we may disclose information includes, but is not limited to the following:

- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Reinsurers, other insurers and their administrators;
- The trustee, or administrator of your superannuation fund; and
- Other organisations to whom we outsource certain functions during the assessment process of your application process, such as obtaining blood tests.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

Useful information regarding privacy rights is available at the website of the Office of the Privacy Commissioner at **www.oaic.gov.au**

12. DECLARATION

- I have read the duty to take reasonable care as set out in this Personal Statement and understand that this applies to any information I provide to TAL in connection with my application for insurance.
- I confirm that the answers I have provided in this Personal Statement (and any other forms, questionnaires and information provided to TAL) are true, accurate and complete to the best of my knowledge.
- I acknowledge that TAL will rely on the answers and information I have provided in my application for insurance. I understand that, notwithstanding any Authorities which may be provided to TAL, TAL will not necessarily seek or obtain any further information in relation to my application.
- I understand that by signing this form, I consent to the collection, use and disclosure of my personal information (including financial and medical reports and tests) in accordance with TAL's and any other relevant privacy policy.

Signature of member ✗

Date DD / MM / YYYY

SUBMITTING THIS FORM

Please return your completed form and any supporting documentation to:

TAL Life Limited
GPO Box 5380
Sydney NSW 2001

CONTACTING TAL

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1800 666 136
+61 (0)2 9465 2065
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