VOLUNTARY INSURANCE COVER
ACTIVE SUPER ACCUMULATION SCHEME

ACTIVE SUPER

For peace of mind when life doesn't go to plan.
Use this form to apply for or increase your Voluntary insurance cover.

You are making this application for voluntary insurance issued by our insurer, TAL Life Limited (ABN 70 050 109 450, AFSL 237848). You must complete all sections for your application to be considered for assessment by the insurer.

Please use a black pen and CAPITAL letters or type directly into this form online, print it and send it to us. Use a (✓) to mark boxes.

Before completing this form, please ensure you read the relevant Product Disclosure Statement (PDS) available at activesuper.com.au/PDS

1. YOUR DETAILS

Member no. ☐☐☐☐☐☐☐☐☐

Date of birth (DD MM YY) ☐☐☐☐☐☐ Title (e.g. Ms) _____

Given name(s) _____

Family name _____

Email _____

Phone (home) _____ Phone (work) _____

Phone (mobile) _____

Postal address

No./Street _____

Suburb/Town _____

State/Territory ☐☐☐ Postcode ☐☐☐☐

Residential address ☐ **select if same as postal address above**

No./Street _____

Suburb/Town _____

State/Territory ☐☐☐ Postcode ☐☐☐☐

These amounts must be multiples of $1,000 with a minimum of $50,000 for new applications for cover. There is no maximum for Death cover, however there is a maximum of $3,000,000 for Total and Permanent.

Salary Continuance Cover is available in multiples of $100 with a minimum cover of $1,000 per month. The highest cover you can apply for is $25,000 per month with a waiting period of either 30, 60 or 90 days. This monthly benefit must not exceed 75% plus a Superannuation Contribution Benefit of 10% of your declared earned income.

IMPORTANT

Accident cover applies for a maximum of 90 days after we receive this form. It is therefore important that you forward this application to us promptly.

2. INSURANCE LEVEL

I wish to apply for (or increase my level of voluntary insurance cover to):

☐ Death cover in the amount of: $

☐ Death and Total and Permanent Disablement cover in the amount of: $

☐ Salary Continuance Cover:

Short term (two-year benefit period) in the monthly amount of: $

Long term (to age 65 benefit period) in the monthly amount of: $

Monthly income benefit waiting period ☐ 30 days ☐ 60 days ☐ 90 days

3. OCCUPATION DETAILS

3.1 ☐ Self employed ☐ Employee ☐ Full time

☐ Part time ☐ hrs/wk ☐ weeks/year

3.2 Your occupation Industry

3.3 Duties performed

3.4 Annual salary $

(includes items such as your super contributions, but excludes bonuses/commission)

4. THE DUTY TO TAKE REASONABLE CARE

When you apply for insurance, 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 us or 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.

5. GROUP MEDICAL REQUIREMENTS

Death and Total Permanent Disablement levels of cover and initial requirements for members under 45 years of age.

Level of cover	Initial requirements
Up to $2,500,000	• Member's Personal Statement (refer to question 7)
$2,500,001 to $3,000,000	• Member's Personal Statement (refer to question 7) • Blood Tests (upon receipt of your application, you will be notified if these are required) • Fast Check Medical (upon receipt of your application, you will be notified if these are required)
Over $3,000,000	• Personal Medical Attendant's Report from your Doctor • Please contact us for requirements

Death and Total Permanent Disablement levels of cover and initial requirements for members aged 45 years and over.

Level of cover	Initial requirements
Up to $1,500,000	• Member's Personal Statement (as above)
$1,500,001 to $2,000,000	• Member's Personal Statement (as above) • Blood Tests (as above) • Fast Check Medical (as above)
$2,000,001 to $3,000,000	• Member's Personal Statement (as above) • Blood Tests (as above) • Fast Check Medical (as above)
Over $3,000,000	• Personal Medical Attendant's Report from your Doctor • Please contact us for requirements

Salary Continuance monthly benefit levels and initial requirements for members aged under 45.

Monthly benefit	Initial requirements
Up to $12,000	• Member's Personal Statement (as above)
$12,001 to $15,000	• Member's Personal Statement (as above) • Blood Tests (as above)
$15,001 to $20,000	• Member's Personal Statement (as above) • Fast Check Medical (as above) • Blood Tests (as above)
$20,001 to $25,000	• Please contact us for requirements

Salary Continuance monthly benefit levels and initial requirements for members aged 45 and over.

Monthly benefit	Initial requirements
Up to $12,000	• Member's Personal Statement (as above)
$12,001 to $15,000	• Member's Personal Statement (as above) • Personal Medical Attendant's Report from your Doctor • Blood Tests (as above)
$15,001 to $20,000	• Member's Personal Statement (as above) • Fast Check Medical (as above) • Blood Tests (as above) • Personal Medical Attendant's Report from your Doctor
$20,001 to $25,000	• Personal Medical Attendant's Report from your Doctor • Please contact us for requirements

6. HABITS AND ACTIVITIES

6.1 Do you drink alcohol? ☐ No ☐ Yes

If 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.):

6.2 Have you smoked in the past 12 months? ☐ No ☐ Yes

If Yes, state form and daily quantity:

6.3 In the last 5 years have you smoked any substance other than tobacco? ☐ No ☐ Yes

If Yes, state substances smoked, frequency of use, date first smoked and date last smoked

6.4 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

If 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).

6.5 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

If Yes, please provide details below (where, when, duration and reason):

6.6 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? ☐ No ☐ Yes

If No to 6.6, please advise type of visa and expiry date, plans for applying for permanent residency and nationality/current citizenship:

7. PERSONAL STATEMENT

7.1 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".

7.2 Name and address of your usual doctor

Doctor's full name

No./Street

Suburb/Town

State/Territory Postcode

Country Phone

7.3 Details of last medical consultation with your usual doctor

Date (DD MM YY)

Reason

Outcome/results

7.4 If you have attended that doctor for less than 12 months, please state the name and address of your previous doctor

Doctor's full name

No./Street

Suburb/Town

State/Territory Postcode

Country Phone

7.5

a. Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquillisers? ☐ No ☐ Yes

b. Have you EVER had an ECG, ultrasound, X-ray, transfusion, mammogram or any other investigation? ☐ No ☐ Yes

c. Have you EVER had any blood tests which revealed an abnormality e.g. raised blood sugar, liver function, kidney function results or anaemia, etc? ☐ No ☐ Yes

d. Do you contemplate seeking any medical examination, advice, treatment or surgery for any other current health condition in the future? ☐ No ☐ Yes

Please provide full details for all Section 7.5 'Yes' answers:

Question	Dates (from/to)	Name and address of doctor, hospital or clinic	Condition, medications, treatment and time off work	Recovery %

Please provide details for all 'Yes' answers in the general medical questionnaire at section 8.

7.6 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

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

l. 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

m. 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

n. 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

o. 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

Please provide details of your family medical history.

7.7 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 (e.g. breast cancer, heart attack, Type 2 diabetes)	Age when diagnosed	Age at death (if applicable)

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Please provide full details for all 'Yes' answers in Section 7.6 , Q's a-o. Please continue on a separate sheet if required.

8. GENERAL MEDICAL QUESTIONNAIRE

	Question ☐ Specific condition	Question ☐ Specific condition	Question ☐ Specific condition	Question ☐ Specific condition
a. Date symptoms first started and description of symptoms?				
b. What was the condition and which part and side of the body was affected?				
c. What was the medical diagnosis including results of x-rays and investigations?				
d. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
e. What was the severity (mild/ moderate/severe) and duration of attacks or symptoms?				
f. How long were you unable to work or perform your normal duties/ activities?				
g. If a hospital visit was required, please provide date and duration of your stay.				
h. What advice/ treatment did you receive?				
i. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
j. Date treatment/ medication ended.				
k. When did you last suffer from any symptoms				
l. Degree of recovery (%)				

IMPORTANT

Superannuation legislation requires us to cancel your insurance if your account becomes inactive (i.e. has not received contributions for 16 months or more).

You must mark the box on the right if you wish to keep your insurance if your account becomes inactive.

PLEASE NOTE

Basic insurance cover is provided automatically to members who are at least 25 years and have a super balance of at least $6,000. You can reduce or cancel your Basic insurance cover at any time. If you are aged 15 or over, you can also opt in to receive Basic insurance cover before you become eligible by logging in to Member Online, via the Active Super mobile app or completing the Opt in to insurance cover form. You can apply for for additional voluntary insurance cover over and above the basic cover, by completing this form. Please read the PDS and Insurance in your super fact sheet for more information.

9. YOUR DECLARATION

To keep your Voluntary insurance cover:

☐ I am aged 15 or over and elect to keep my Voluntary insurance cover even if my account becomes inactive in the event of not receiving any contributions or rollovers for 16 months or more.

- I acknowledge that I have read the Duty to take Reasonable Care under Section 4 of this form and I am aware about the consequences of non-disclosure.
- I have read and checked any answers not completed in my handwriting or typed online and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or Personal Statement which relate to me are true and correct.
- I understand that insurance cover under this application, if accepted by the insurer, will be provided even if my account balance is less than $6,000 and/or I am under 25 years of age.
- I consent to my personal information (including health and sensitive information) being collected, used or disclosed by the Trustee and the Insurer or its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information the Insurer collects on this form or future forms in relation to this insurance.

I hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written or typed online by me or by any person on my behalf. I also declare that I have read and understood the Product Disclosure Statement and the Voluntary insurance fact sheet, including the terms and conditions of Voluntary insurance cover, such as the types of cover, when cover commences, when cover ceases and how cover may be cancelled.

Name

Signed

Date (DD MM YY)

SEND YOUR COMPLETED FORM BACK TO US AT:

Mail Active Super, PO Box N835, Grosvenor Place NSW 1220

Email admin@activesuper.com.au

Privacy Collection Statement

The information provided on this form is collected by LGSS Pty Limited (ABN 68 078 003 497) as Trustee for Local Government Super (ABN 28 901 371 321) ('Active Super') for the purposes of administering accounts and providing services to you associated with fund membership. If you do not provide the requested information, Active Super may not be able to perform these services. Your personal information may be shared with our administrator, other superannuation trustees and other service providers, in order to be able to provide our services to you. We may provide information to government, regulatory or other bodies if required by law. For further information about how we manage and protect personal information, please refer to our privacy policy available at activesuper.com.au/privacy-policy or by calling us on 1300 547 873. It sets out how we use the information we hold about you, how you can access and correct the information, how you may complain about a breach of privacy and our process for resolving privacy related enquiries and complaints.

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