APPLICATION FOR ADDITIONAL BENEFIT COVER

ACTIVE SUPER

Use this form if you are a member of the Retirement Scheme and wish to apply for additional benefit cover.

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

Before completing this form, please ensure you read the Retirement Scheme 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

2. GUIDANCE FOR ANSWERING THE QUESTIONS IN THIS FORM

You are responsible for the information provided to the Trustee. 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 Trustee 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 Trustee may ask you whether the information that has been given as part of your application 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.

Medical Examinations

When you apply for cover, you may be required to provide medical reports, evidence and information or submit to medical examination(s) as may be required by the Trustee. If you do not meet these requirements, or pass a medication examination in the opinion of the Trustee, your application may not be approved. If, after approving an application, the Trustee forms the opinion that, in relation to the application, or to a medical examination, an untrue statement was made and that its approval would not have been given had the untrue statement not been made, the Trustee shall revoke the approval.

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.

NOTE

All questions in Section 3 MUST be answered. To apply for Additional Benefit Cover, you must be under the Early Retirement Age.

3. YOUR MEDICAL HISTORY

What is the state of your health at present?

Have any members of your immediate family had diabetes, nervous disorder, heart disease, stroke or cancer? No ☐ Yes ☐

If yes please provide details

Height (in cms) Weight (in kgs)

Has your weight altered in the last three years? No ☐ Yes ☐

If 'Yes' what was the increase or decrease? Increase: kgs Decrease: kgs

Have you ever had any of the following? Please select Yes or No

1. Asthma, chronic bronchitis, chronic cough, tuberculosis or any other lung complaints? No ☐ Yes ☐
2. Back strain, slipped disc or other disease or injury of the spine, neck joints or tendons? No ☐ Yes ☐
3. Gout, rheumatic fever or any form of arthritis? No ☐ Yes ☐
4. Stomach ulcer, liver or other digestive trouble or chronic bowel disorder? No ☐ Yes ☐
5. Epilepsy, blackouts or fits of any kind? No ☐ Yes ☐
6. Kidney or bladder disease including renal colic or stone? No ☐ Yes ☐
7. Diabetes, thyroid or glandular disorder? No ☐ Yes ☐

3. YOUR MEDICAL HISTORY (CONT.)

8. Cancer or tumour of any type?	No ☐	Yes ☐
9. Ear discharge, hearing defect or sinus trouble?	No ☐	Yes ☐
10. Defects in sight or any other eye problems?	No ☐	Yes ☐
11. Bleeding from the lung, stomach, bowel or kidney?	No ☐	Yes ☐
12. Dermatitis, eczema or other skin problems?	No ☐	Yes ☐
13. Sexually transmitted disease?	No ☐	Yes ☐
14. High blood pressure, stroke, pain in the chest or any heart complaint?	No ☐	Yes ☐
15. Muscular dystrophy, muscular weakness or wasting?	No ☐	Yes ☐
16. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	No ☐	Yes ☐

If you answered 'Yes' for any of the questions above, please give full details including type of illness, date of onset, treatment received, date of recovery and name and address of doctor consulted.

If insufficient space please provide additional information on a separate sheet.

Question no.	Details

3. YOUR MEDICAL HISTORY (CONT.)

a) Are you now or have you at any time in the last five years taken any drugs or tablets on a regular basis? No ☐ Yes ☐

If 'Yes' please details, including reasons, names of drugs, dates and dosages.

b) During the last five years have you had any illness, accident or injury, operation, medical examination, test or x-ray, advice or treatment? No ☐ Yes ☐

If 'Yes' please provide full details, including nature of illness or accident, treatment received, recovery (including dates) and name and address of doctor consulted.

c) Have you ever had any other serious illness, accident, injury or operation (excluding details provided in question b)? No ☐ Yes ☐

If 'Yes' please provide details, including name and address of doctor consulted.

d) Have you ever had any mental disorder, breakdown, anxiety, depression or other nervous condition? No ☐ Yes ☐

If 'Yes' please provide details, including name and address of doctor consulted.

e) Have you ever applied for or claimed a payment or payment arising from an accident (eg, Third Party or Workers Compensation) or from any medical cause? No ☐ Yes ☐

If 'Yes' please provide details, including dates, causes and, where payment has been received, amounts.

f) Have you ever been refused, deferred or granted limited benefits for life assurance or superannuation? No ☐ Yes ☐

If 'Yes' please state when, by which company and reason.

g) Do you smoke? No ☐ Yes ☐

If 'Yes' please give types, duration and quantity.

h) Do you drink alcohol? No ☐ Yes ☐

If 'Yes' please state how often, what type, and what quantity.

i) Have you ever been advised to seek treatment as a result of your use of alcohol? No ☐ Yes ☐

Please ensure that all sections of this form are completed and that the declaration is signed by you.

IMPORTANT

Most applications will be assessed on the information provided on this application form. However, if we are unable to make an assessment of your eligibility for the Additional Benefit Cover from this information, you may be required to undergo a medical examination.

IMPORTANT

Once you have Additional Benefit Cover you cannot cancel that cover. You must continue the cover until it ceases under the Retirement Scheme rules or you exit the Scheme.

4. YOUR DECLARATION

I understand that I shall not be covered for the Additional Benefit until Active Super has approved my application and appointed a day from which the cover will commence.

I hereby state that all information in this application has been provided by me or under my direction and is true and correct.

I further understand that any untrue or misleading statement declared by me or any non-disclosure may result in Active Super refusing my application or revoking my Additional Benefit Cover at any time in the future.

I hereby authorise any doctor who has attended or examined me, or whom I have consulted, to disclose, in writing to Active Super, all information concerning me, which may in any manner have been acquired that may be relevant to this application or a claim for Active Super benefits.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by the Trustee 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.

I declare that I have read and understood the important notes in this form and the Product Disclosure Statement (PDS).

I also declare that the information provided is true and correct.

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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