



# Personal Statement Member's Declaration

## Insured's duty of disclosure

A person who enters into a life insurance contract in respect of your life has a duty, before entering into the contract, to tell us anything that he or she knows, or could reasonably be expected to know, which may affect our decision to provide the insurance and on what terms.

The person entering into the contract has this duty until we agree to provide the insurance. The person entering into the contract has the same duty before he or she extends, varies or reinstates the contract.

The person entering into the contract does not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

For contracts of insurance entered into, renewed, extended, varied or reinstated from 28 December 2015, if you do not tell us something that you know, or could reasonably be expected to know, which may affect our decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to tell us something that he or she must tell us.

## If the person entering the contract does not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate contracts of life insurance. If they do, we may apply the following rights separately to each type of cover.

If the person entering into the contract does not tell us anything he or she is required to, and we would not have provided the insurance if he or she had told us, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if he or she had told us everything he or she should have. However, if the contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if he or she had told us everything he or she should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

## Personal Information

By completing this form you consent to any personal information, including any information that may be of a sensitive nature AIA Australia may collect about you (including from your responses in this Personal Statement), being handled in the manner outlined in AIA Australia's privacy policy. A copy of AIA Australia's privacy policy can be obtained by visiting [aia.com.au](http://aia.com.au).

## A. Life Insured (Life insured to complete this section in full.)

1. Name

Title	Surname	Given Name

2. Date of Birth (dd/mm/yy)    3. Gender at Birth  Male  Female

4. Residential Address

No.	Street	
Suburb	State	Postcode

5. Mailing Address (if different to above)

Suburb	State	Postcode

We may need to contact you to clarify information you have provided in the application. If so we will contact you during business hours. Please nominate a preferred local contact time:  8am – 11am  11am – 2pm  2pm – 5pm

6. Contact Details

Phone (home)	Phone (work)	Mobile
E-mail		

7. Country of Birth

8. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia (as approved by the Department of Home Affairs)? ..... Yes  No

If 'No', are you applying for, or intending to apply for, Permanent Residency in Australia? ..... Yes  No

Please advise what type of visa you hold and expiry date.

## B. Type of Insurance

(Please tick)	(Please tick)	Amount	\$	(Please tick)	Amount	\$
<input type="checkbox"/> New	<input type="checkbox"/> Death Only			<input type="checkbox"/> Death & TPD		
<input type="checkbox"/> Increase	<input type="checkbox"/> TPD Only			<input type="checkbox"/> Income Protection		

### Income Protection only:

Benefit Period	<input type="checkbox"/> 2 years (to age 65 if earlier)	<input type="checkbox"/> To Age 65	<input type="checkbox"/> Other – please specify <input type="text"/> years/other	
Waiting Period	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> Other – please specify <input type="text"/> days

## C. Personal History (Life insured to complete this section in full.)

1. (a) Do you have, or are you applying for life, disability or trauma insurance on your life (including any pending applications held with any insurer)? If 'Yes', please complete policy details below..... Yes  No

Policy Number	Commencing Date	Policy Owner	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

- (b) Have you **ever** been declined, deferred or accepted on special terms for life, disability or trauma insurance? ..... Yes  No
- (c) Have you **ever** claimed benefits from any source (excluding unemployment), e.g. Accident, Sickness, Workers Compensation, Social Security, Disability Income Insurance or Pension? If 'Yes' please give the name of the company, date, amount and reason for each claim below. .... Yes  No

If you answered 'Yes' to 1(b) or 1(c) please provide details.

.....

.....

.....

.....

.....

.....

2. (a) Have you smoked tobacco or any other substance during the last twelve months? ..... Yes  No   
If 'Yes', please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

.....

- (b) How many standard drinks do you consume per week on average?   
One standard drink = one nip (30ml) spirits, 100ml wine, 10oz/285ml beer

- (c) Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? ..... Yes  No   
If 'Yes', please provide details.

.....

.....

3. (a) What is your height?  cm (b) What is your weight?  kg

4. Do you intend to travel or reside overseas? If 'Yes', please state: ..... Yes  No

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure
				/ /
				/ /

5. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football and oztag), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike riding/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? ..... Yes  No   
If 'Yes', please fill in **Section G** (Aviation or Activities/Pursuits Questionnaire).

### Family History

6. Have any of your immediate family (father, mother, brother, sister) prior to the age of 60 (living or dead), ever suffered from heart disease, breast cancer, ovarian cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, mental disorder, stroke, Huntington's chorea or any hereditary disease? You are only required to disclose family history information pertaining to first degree blood related family members. If 'Yes', please provide details in the table below. .... Yes  No

	Condition/Illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

## C. Personal History (Life insured to complete this section in full.)

### Sexual Health

7. (a) In the last 5 years, have you been tested for any of the following condition/s?

**HS** = Health screening as part of an executive health assessment or a requirement of an application (e.g. migration, insurance, blood donation etc.)

**SHS** = Sexual health screening (as recommended by your doctor or a medical practitioner)

(i) Human Immunodeficiency Virus (HIV) infection..... Yes  No

If you answered 'Yes', please provide the reason: **HS**  **SHS**  **Other**  Are you awaiting the result? ... Yes  No

If you answered 'Other', please provide further details.

(ii) Sexually Transmitted Infections (STIs)..... Yes  No

If you answered 'Yes', please provide the reason: **HS**  **SHS**  **Other**  Are you awaiting the result? ... Yes  No

If you answered 'Other', please provide further details.

(b) In the last 5 years, have you had sexual intercourse **without** a condom with the following persons?

(i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection..... Yes  No   
*(This may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you.)*

(ii) Someone who injects non-prescribed drugs ..... Yes  No

(iii) Someone who is a sex worker..... Yes  No

(iv) Someone who is infected with Human Immunodeficiency Virus (HIV) infection ..... Yes  No

(v) Someone who is infected with Hepatitis B ..... Yes  No   
*(You may answer 'No' if you are vaccinated and have immunity for Hepatitis B.)*

(vi) Someone who is infected with Hepatitis C ..... Yes  No

(c) In the last 5 years, have you been diagnosed with or experienced symptoms of Sexually Transmitted Infection/s (STIs) (examples, chlamydia, gonorrhoea, syphilis)? ..... Yes  No

**D. Medical and Health History** (Life insured to complete this section in full and complete relevant questionnaire.)

- Have you **ever** suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?
  - High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. .... Yes  No   
If 'Yes', please complete Section H – **High Blood Pressure/High Cholesterol Questionnaire**.
  - Asthma, chronic lung disease, sleep apnoea or other respiratory disorder. .... Yes  No   
If 'Yes', please complete Section I – **Asthma Questionnaire**.
  - Indigestion, gastric or duodenal ulcer or any bowel disorder..... Yes  No   
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.
  - Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder..... Yes  No   
If 'Yes', please complete Section K – **Mental Health Questionnaire**.
  - Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis. .... Yes  No   
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.
  - Arthritis, repetitive strain injury (RSI), fibromyalgia..... Yes  No   
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.
  - Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles. .... Yes  No   
If 'Yes', please complete Section L – **Spinal/Joints Disorder Questionnaire**.
  - Psoriasis or eczema, skin disorder, defect in hearing or sight. .... Yes  No   
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.
  - Diabetes, abnormal blood sugar, gout or thyroid disorder. .... Yes  No   
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections H to L).

- Cancer, cyst, lump, tumour or growth of any kind. .... Yes  No
- Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone. .... Yes  No
- Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia. .... Yes  No
- Hepatitis B or C or are a Hepatitis B or C carrier, Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus. .... Yes  No

**Females only**

- Are you pregnant? If 'Yes', please provide estimated date child is due. .... /..... /..... Yes  No   
Have you ever had or been advised to have treatment for:
  - Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? .... Yes  No
  - An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?..... Yes  No
  - Abnormal vaginal bleeding within the last 12 months or endometriosis? .... Yes  No

- Have you ever suffered symptoms of or had any other illness, disease or disorder? .... Yes  No
- In the last 5 years have you:
  - Had any medical examinations, consultations, X-rays, pathology tests or procedures? .... Yes  No
  - Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? .... Yes  No
- Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? .... Yes  No
- Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? .. Yes  No

For each 'Yes' answer in questions 1j-1q, 2, 3, 4 and 5 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %*	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

## E. Doctor's Details (Life insured to complete this section in full.)

1. (a) Details of your personal doctor.

**IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.**

Name:		
Address:		Postcode
Phone (    )	Fax (    )	Email <small>(if known)</small>

(b) What was the date of your last consultation? (Give approximate date if exact date unknown.)

(c) How long have you been attending the surgery/practice?

## F. Present Occupation (Life insured to complete this section in full)

1. (a) What is your usual occupation?

(b) Do you perform any manual work? If 'Yes', please describe duties and percentage of time spent in each..... Yes  No

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary		
Light manual		
Heavy manual		

2. What is your annual income?

3. Employer:

Hours currently working per week

Zero     1-14 hours     15-60 hours     >60 hours

**Questionnaires** (Life insured to complete – may be photocopied for additional activities/pursuits.)

**G. Aviation Questionnaire**

1. Please state the number of hours flown where applicable:

(a) **Private flying**

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rotary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (eg. Ultralight, Microlight)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(b) **Commercial flying** (excluding large mainstream carriers, eg. Qantas)

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rotary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (eg. Ultralight, Microlight)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(c) **Agricultural flying**

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rotary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (eg. Ultralight, Microlight)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Are your flying activities:  
 Recreational, or  Required for your occupation?  
 Please provide details.

3. (a) Name of aircrafts flown.

(b) Make and model of the aircrafts.

(c) **If pilot only.**  
 (i) Age of the aircrafts flown.

(ii) Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced?  Yes  No

4. Do you fly or intend to fly outside Australia?  Yes  No  
 If 'Yes', please provide details.

5. Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? If 'Yes', please provide details.  Yes  No

6. Have you ever been involved in any aviation accidents? If 'Yes', please provide details.  Yes  No

**G. Activities/Pursuits Questionnaire**

1. Please describe the activity or pursuit.

2. Please advise the number of times you engage in the activity per year.

3. How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4. What qualifications, certificates, licences, associations and club memberships do you hold?

5. How long have you been involved in this activity?

6. Where do you engage in this activity and in what locations?

7. Do you ever engage in this activity alone, or are you always with a group?

8. Do you compete in this activity?  Yes  No  
 If 'Yes', please advise the level of competition and names of events.

9. Do you receive any payments for your involvement in this activity?  Yes  No  
 If 'Yes', please advise details.

10. Please advise the maximum heights, speeds, depths the activity includes.

11. Are any of the above likely to change over the next 2 years?  Yes  No  
 If 'Yes', please provide full details.

12. Are you involved in any record attempts?  Yes  No  
 If 'Yes', please provide details.

13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details.

14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15. Have you ever been involved in any accident/mishap whilst participating in this activity?  Yes  No  
 If 'Yes', please provide details.

**H. High Blood Pressure/High Cholesterol Questionnaire**

1. When was high blood pressure/ high cholesterol first diagnosed?

2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

Readings	Results	Date diagnosed
Blood Pressure		
Total Cholesterol		
HDL		
LDL		
Triglycerides		

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage

4. Are you still on treatment?  Yes  No  
If 'No', when was treatment discontinued and why?

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Results

6. Regarding the monitoring of your condition:

(a) Name of medical attendant:

(b) How often do you attend for follow-up?

(c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.

(d) Have you suffered from any of the following conditions:

(i) Eye disorder (other than short/long sightedness)  Yes  No

(ii) Symptoms or disorder relating to heart or circulatory system  Yes  No

(iii) Kidney disorder or protein in urine  Yes  No

(iv) Dizziness, fainting episodes or stroke  Yes  No

If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigations	Results

(e) How long has your blood pressure/cholesterol been well controlled?  
 < 6 months  6 months to 12 months  > 12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application.

8. Please attach copies of any reports or results (eg. xray, pathology, ultrasound, etc) you may have.

**I. Asthma Questionnaire**

1. Date asthma first diagnosed.  /  /

2. How often do you experience symptoms? eg. wheezing, breathlessness, chest tightness.  
 Daily  Weekly  Monthly  Other

3. When was your most recent episode of asthma?  /  /

4. Are you aware of any causes that trigger your symptoms? eg. allergy, exercise.

5. Have you ever been off work due to asthma?  Yes  No  
If 'Yes', please advise when, and for how long.

6. Name of medications.

(a) Dosage

(b) Frequency

(c) When was the last time you received medication?

(d) What additional treatment do you use to control an attack?

7. Have you ever required steroid therapy (by tablet or syrup)?  Yes  No  
If 'Yes', please provide details.

8. Have you ever been in hospital or received emergency treatment for asthma?  Yes  No  
If 'Yes', please state when, for how long and where?

9. Have you ever undergone a lung function test?  Yes  No  
If 'Yes', please advise dates and highest and lowest readings, if known.

10. Have you ever consulted a specialist for this condition?  Yes  No  
If 'Yes', please advise name and address of doctor of last consultation.

11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

**J. Multi-Purpose Questionnaire**

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?   
 (b) Please state which side.  Left  Right  Not applicable
3. The cause.
4. (a) Date symptoms commenced.  /  /   
 (b) How long have you been free of symptoms?   
 (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition?  Yes  No  
 If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities?  Yes  No  
 If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition?  Yes  No  
 If 'Yes', advise names of medication(s), dosage(s) and frequency.  
  
 Are you still taking this medication?  Yes  No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)?  Yes  No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)?  Yes  No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition?  Yes  No
11. Have you seen a doctor or other therapist for anything related to this condition.  Yes  No  
 If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

**If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.**

12. Has further treatment been recommended for this condition?  Yes  No  
 If 'Yes', please provide details.
13. Does your usual doctor have details of this condition?  Yes  No  
 If 'No', provide name and address of doctor who has full details.

**J. Multi-Purpose Questionnaire**

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?   
 (b) Please state which side.  Left  Right  Not applicable
3. The cause.
4. (a) Date symptoms commenced.  /  /   
 (b) How long have you been free of symptoms?   
 (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition?  Yes  No  
 If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities?  Yes  No  
 If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition?  Yes  No  
 If 'Yes', advise names of medication(s), dosage(s) and frequency.  
  
 Are you still taking this medication?  Yes  No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)?  Yes  No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)?  Yes  No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition?  Yes  No
11. Have you seen a doctor or other therapist for anything related to this condition.  Yes  No  
 If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

**If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.**

12. Has further treatment been recommended for this condition?  Yes  No  
 If 'Yes', please provide details.
13. Does your usual doctor have details of this condition?  Yes  No  
 If 'No', provide name and address of doctor who has full details.



**K. Mental Health Questionnaire**

1. Please indicate the condition(s) you have had or received treatment for.

- Anxiety including generalised anxiety, panic or phobic disorder
- Eating disorder including anorexia nervosa, bulimia
- Depression including major depression or mild depression
- Manic depressive illness, bi-polar disorder
- Alcohol or other substance abuse or addiction
- Post traumatic stress
- Schizophrenic or any other psychotic disorder
- Stress, sleeplessness, chronic fatigue
- Other (please specify)

2. Describe your symptoms including the date started and how long they lasted.

Symptoms	Date from	Date to

3. (a) Has any reason for your condition been identified or are there any factors which trigger your condition?

(b) Have you ever had suicidal thoughts or attempted suicide? If 'Yes', please provide details.  Yes  No

4. (a) Date symptoms commenced.  /  /

(b) Date of last symptoms.  /  /

(c) Have you had any recurrences of this condition?  Yes  No

If 'Yes', how many times?  When?  /  /

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased

(b) Are you currently receiving treatment?  Yes  No

(c) If 'Yes', please provide details.

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition?  Yes  No  
If 'Yes', when and how long?

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition?  Yes  No  
If 'Yes', please provide details.

**L. Spinal/Joints Disorder Questionnaire**

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. left knee, right hip, shoulders, elbows etc).

2. Please state the precise diagnosis.

3. When did symptoms first occur?

4. (a) What was the cause?

(b) Please describe your symptoms.

(c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs?  Yes  No

(d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms?  Yes  No

(a) If 'No', date of last experienced symptoms.  /  /

(b) If 'Yes', how frequently have symptoms occurred since commencing treatment?

Daily  Weekly  Monthly  Yearly

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

(b) Are you still receiving treatment?  Yes  No

(i) If 'No', when did you cease treatment?  /  /

(ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

(c) Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition?  Yes  No  
If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor.

8. Have you had an operation for this condition or is an operation being considered?  Yes  No  
If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long?  Yes  No

(b) Are your occupation duties restricted in any way?  Yes  No  
If 'Yes', please provide details.

(c) Is it necessary to avoid lifting or to restrict your daily activities in any way?  Yes  No  
If 'Yes', please provide details.

## M. Declaration

- I declare that the information I provided in this Personal Statement (whether written in my hand or not) is true and correct and that no information material to the insurance has been withheld.
- I agree that any personal statements made (including this one) together with any relevant supporting documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I also understand that my duty to disclose continues after I have completed the insurance application until AIA Australia has accepted the risk. I understand AIA Australia may cancel the cover from inception or provide cover on amended terms if I do not comply with my duty of disclosure.
- I consent to AIA Australia collecting sensitive information, i.e. health information about me, for the purpose of the performance of this contract.
- I agree that cover will not commence until the premium is paid and AIA Australia has accepted the risk.
- I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at [www.aia.com.au](http://www.aia.com.au) as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.

I confirm the Declarations are true and accurate.

Signature

X

Date

/ /

## N. Privacy

Your privacy is important to us. The AIA Australia Privacy Policy sets out how your personal information (including sensitive information) is collected, used, handled and disclosed by us, and other important information. AIA Australia's current Privacy Policy is available at [www.aia.com.au](http://www.aia.com.au) or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect personal and sensitive information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your personal and sensitive information from, and provide to, third parties in Australia and overseas, such as your financial adviser, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your personal and sensitive information under various laws including insurance, taxation, financial services and other laws set out in the AIA Australia Privacy Policy; and
- disclose personal and sensitive information to third parties which may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy and you acknowledge that by providing your consent as set out in this form, Australian Privacy Principle 8.1 will not apply to the disclosure, we will not be accountable for those overseas parties under the Privacy Act and you may not be able to seek redress under the Privacy Act for breaches of the Privacy Act by those overseas parties.

If you do not provide the required personal and sensitive information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your personal information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's privacy policy.

# O. Authority to Release Health Information

## Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, (**AIA Australia**), collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

### Authority 1

**Authority 1 explanatory notes** – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

.....  
**Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice**

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **AIA Australia**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **AIA Australia** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature:

Date:

### Authority 2

**Authority 2 explanatory notes** – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

.....  
**Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances**

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **AIA Australia**, or to third parties they engage, only if **AIA Australia** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature:

Date:

.....  
 I/We authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me/us with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my/our health and medical history.