June 2024

ZURICH

Group Risk

Personal Statement for ANZ Staff Super members

Personal Statement to be completed by ANZ Staff Super members who wish to obtain or increase Salary Continuance cover

IMPORTANT NOTICE

Zurich is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by Zurich
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by Zurich.

Zurich requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to seal it in an envelope and send it to:

ANZ Staff Super, GPO Box 2139, Melbourne VIC 3001

Duty to take reasonable care not to make a misrepresentation

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer. To meet this duty, you must also take reasonable care not to make such a misrepresentation.

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

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

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

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the fund trustee may pass on to us personal information you provide to them. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you should:

- think carefully about each question before answering. 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. Please don't assume we will ask others such as your doctor;
- review your application carefully. If someone else helped prepare your application, please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you would now answer our questions differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we'll let you know whether it has any impact on the cover.

Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

If you need help

It's important that you understand this information and the questions we ask. Ask us for help if you have difficulty answering our questions or understanding the application process.

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 for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

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

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

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was;
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent;
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

Type of Plan

Group Salary Continuous

Policy number	6095152
Name of Fund	ANZ Staff Super

Type of cover	**Amount of required benefit/cover#**
○ Group Salary Continuance (monthly benefit)	$

Details of Group Salary Continuance Cover

Waiting Period	○ 90 days
Benefit Period	○ 2 year

#Benefit amount
Choose a monthly benefit payment of up to 75% of your salary (subject to a maximum benefit of $30,000 per month). The benefit period is up to two years if you're temporarily unable to work due to illness or accident. A three month waiting period applies before payments commence. Other conditions may apply.

Eligibility for cover

You will be eligible to apply for Salary Continuance Insurance if you:

- are aged less than 60 years;
- work more than 20 hours per week on a permanent basis; and
- are an Australian citizen or permanent resident, living in Australia

Salary Continuance Insurance is not automatically available to members. Your application will need to be accepted by the Insurer.

1. Personal details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Doctor ◯ Other

Surname Given name(s)

Date of birth (dd/mm/yyyy) / / ◯ Male ◯ Female

Residential address (this cannot be a PO Box)

Street

Suburb State Postcode

Country

Home phone Work phone Mobile phone

Email

May one of our underwriting staff or Zurich authorised service providers contact you by phone if we require more information?

◯ Yes

◯ No

If **yes**, when is the most convenient day(s) and time and on which phone number?

Days Time: From To

Phone ◯ Home ◯ Work ◯ Mobile

2. Residence and travel details

1. Are you currently residing in Australia?

◯ Yes

◯ No

If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian or New Zealand citizen or do you hold a visa that entitles you to reside permanently in Australia?

◯ Yes

◯ No

If **yes**, please proceed to question 3

If **no**, please advise what type of visa you hold

3. Do you have any intention of travelling outside Australia within the next two years?

◯ Yes

◯ No

If **yes**, please complete the following:

Date of departure (dd/mm/yyyy) / / Duration of stay

Destination(s) (country/cities)

Purpose of stay ◯ Holiday ◯ Business ◯ Residing ◯ Other

Please specify if **other**

3. Insurance details

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including Zurich (other than this application), including benefits under superannuation or insurance benefits by your employer?

◯ Yes

◯ No

If you have answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	**Type of cover**	**Amount insured**	**Date commenced** (dd/mm/yyyy)	**Will this policy be discontinued/ replaced?**	**Date last fully underwritten** (replacement policies only) (dd/mm/yyyy)
		$	/ /	◯ Yes ◯ No	/ /
		$	/ /	◯ Yes ◯ No	/ /
		$	/ /	◯ Yes ◯ No	/ /
		$	/ /	◯ Yes ◯ No	/ /
		$	/ /	◯ Yes ◯ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions?

◯ Yes

◯ No

If **yes**, please provide name of company, alteration, date and reason (if known)

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans' Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation?

◯ Yes

◯ No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc

4. Occupation details

1. What is your usual occupation?

2. Do you possess any trade or tertiary qualifications relevant to your occupation?

◯ Yes

◯ No

If **yes**, please provide details

3. In which industry do you work?

4. Which of the following best describes you employment situation?

- ◯ Employed by family company/trust
- ◯ Employed by my own company
- ◯ Partnership
- ◯ Casual
- ◯ Sole Trader
- ◯ Employed by an independent employer
- ◯ Employed under terms of a contract

5. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary/administration (e.g. filing, computer work, answering telephone, reception duties, etc)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5 kg, etc)		
Manual work – heavy (e.g. bricklaying, lifting over 5 kg, painting, carpentry, mechanic, etc)		
Hazardous activity (e.g. working from heights, working underground, handling dangerous substances/explosives/chemicals, handling needles, sharps or biohazardous materials, etc)		

6. How many hours (on average) do you work per week in your principal occupation (include hours worked at home)?

7. a. What is your current annual income earned through personal exertion, before tax, and including superannuation contributions, but after deduction of business expenses? $

b. What is the percentage of your superannuation contribution? %

8. Do you have more than one occupation?

- ◯ Yes
- ◯ No

If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s)

9. Are you familiar with all applicable safe-work procedures relating to your occupation?

- ◯ Yes
- ◯ No

If **no**, please indicate the reason you gave this response

If **yes**, do you practice these at all times when performing your work? ◯ Yes ◯ No

If **no**, please provide details of when safe-work procedures are not practiced in your occupation

5. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work?

◯ Yes

◯ No

2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc?

◯ Yes

◯ No

3. aviation/flying, other than as a fare-paying passenger?

◯ Yes

◯ No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity

Motorcycle/motor racing

Do you have a Motorcycling Australia (MA), FIM international or similar licence ◯ Yes ◯ No

Vehicle type Races p.a.

Engine size Max. speed (km/h) Class ◯ Recreational ◯ Amateur ◯ Professional

Scuba/skin diving

Average depth (m) Maximum depth (m) Dives per annum

Do you use explosives? ◯ Yes ◯ No Do you dive in caves or potholes? ◯ Yes ◯ No

If **yes**, give details

Football/Soccer/Aussie Rules, etc

Code played and grade

Games p.a. ◯ Recreational ◯ Amateur ◯ Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc? ◯ Yes ◯ No

If **yes**, provide amount and details

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ◯ Yes ◯ No

If **yes**, state type and period held

Do you intend to change the scope of your present licence? ◯ Yes ◯ No

Have you ever had an accident or been charged with violating CASA regulations? ◯ Yes ◯ No

Do you always use authorised landing areas? ◯ Yes ◯ No

Please complete the table below

No. of hours flown	**Past 12 months**		**Future annual average**	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? ◯ Yes ◯ No

If **yes**, please provide frequency and details.

Other sports or pastimes

Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc)

a. Activity

On what basis do you partake in this activity ◯ Recreational ◯ Amateur ◯ Professional

b. Activity

On what basis do you partake in this activity ◯ Recreational ◯ Amateur ◯ Professional

c. Activity

On what basis do you partake in this activity ◯ Recreational ◯ Amateur ◯ Professional

6. Personal statement

1. What is your current height and weight? Height (cm) Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? ◯ Yes ◯ No

If **yes**, please provide details.

3. Have you smoked tobacco, e-cigarettes (vaping) or any other substance in the last 12 months, or have you used any nicotine-replacement product within the last 3 months? ◯ Yes ◯ No

If **yes**, please state type and quantity per day

4. Non-smokers – have you ever smoked regularly in the past? ◯ Yes ◯ No

If **yes**, please state **type, quantity** per day and date ceased

5. Do you consume alcohol? ◯ Yes ◯ No

If **yes**, please state how many standard drinks you consume **per** day (a standard drink is 125ml wine, 250ml beer or 30ml spirits)

6. Have you ever been advised to stop or reduce your alcohol intake due to a medical condition? ◯ Yes ◯ No

If **yes**, please provide full details

If you are required to a have a full medical examination, go to Section 9 on page 13

7. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so)

1. **Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder?**

◯ Yes

◯ No

2. **Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)?**

◯ Yes

◯ No

If you answered **yes** to either question 1 or 2, please complete the following table

Relation	Condition/Disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood-related family members – living or deceased (mother, father, brothers, sisters).

8. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable

		No	Yes
1	**Asthma?**	◯	◯
2	**High blood pressure?**	◯	◯
3	**High cholesterol?**	◯	◯
4	**Diabetes?**	◯	◯
5	**Stress, anxiety, depression or any other mental health condition?**	◯	◯
6	**Back or neck pain, sciatica or any disorder of the spine or neck?**	◯	◯
7	**Arthritis, shoulder or knee pain or any other disorder of the joints?**	◯	◯
8	**Cyst, mole or skin lesion?**	◯	◯

If you answered yes to any of the conditions in bold above, please complete the relevant questionnaire on pages 16 to 26

9	Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition?	◯	◯
10	Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder?	◯	◯
11	Thyroid or glandular trouble?	◯	◯
12	Ulcers or recurring indigestion?	◯	◯
13	Epilepsy, fits or dizziness, fainting of any kind or persistent headaches?	◯	◯
14	Alzheimer's disease or dementia?	◯	◯
15	Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis?	◯	◯
16	Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?	◯	◯

		No	Yes
17	Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)?	○	○
18	Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)?	○	○
19	Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders?	○	○
20	Any abnormality affecting eyesight, hearing or speech?	○	○
21	Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment)?	○	○
22	Anaemia, haemophilia or any other disease of the blood?	○	○
23	Bowel, liver or gall bladder disease or hepatitis?	○	○
24	Coughing of blood or passing of blood from the bowel or in the urine?	○	○
25	Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason?	○	○
26	Due to injury or illness have you ever been off work for more than seven consecutive days **(if not already mentioned)**?	○	○
27	Do you now have any symptoms of ill health or disability?	○	○
28	Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future (e.g. X-ray, ECG, blood test, etc)?	○	○
29	Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis?	○	○
30	Have you **ever** used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence?	○	○
31	Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?	○	○
32	Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS-related condition?	○	○
33	Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis?	○	○
34	**a.** Is the combined total of your existing insurance(s) detailed in Section 3 question 1, and any new insurance you are applying for with Zurich, more than any one of the following; $500,000 Death; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? If you answered Yes to question 34(a) please proceed to 34(B), otherwise continue to question 35	○	○
	b. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (Please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you).	○	○

FEMALES ONLY

35	**a.** Have you ever had any complications with pregnancy or childbirth?	○	○
	b. Are you now pregnant? If yes, please advise due date (dd/mm/yyyy) / /	○	○
	c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	○	○
	d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium?	○	○

If you answered **yes** to any questions from 9–35, please complete the following table. If there is not enough space here, please provide details on page 26

	Question no:		Question no:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)	/ /		/ /	
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First / /	Last / /	First / /	Last / /
Has further treatment, referral or investigation(s) been recommended?	◯ Yes ◯ No		◯ Yes ◯ No	
Time off work				
Have you completely recovered?	◯ Yes ◯ No		◯ Yes ◯ No	
Date of last symptoms (dd/mm/yyyy)	/ /		/ /	
Name and address of medical facility and attending doctor				

	Question no:		Question no:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)	/ /		/ /	
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First / /	Last / /	First / /	Last / /
Has further treatment, referral or investigation(s) been recommended?	◯ Yes ◯ No		◯ Yes ◯ No	
Time off work				
Have you completely recovered?	◯ Yes ◯ No		◯ Yes ◯ No	
Date of last symptoms (dd/mm/yyyy)	/ /		/ /	
Name and address of medical facility and attending doctor				

	Question no:		Question no:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)	/ /		/ /	
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First / /	Last / /	First / /	Last / /
Has further treatment, referral or investigation(s) been recommended?	◯ Yes ◯ No		◯ Yes ◯ No	
Time off work				
Have you completely recovered?	◯ Yes ◯ No		◯ Yes ◯ No	
Date of last symptoms (dd/mm/yyyy)	/ /		/ /	
Name and address of medical facility and attending doctor				

9. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre

Doctor/Medical centre

Phone

No. and street

Suburb State Postcode

2. How many years have you been attending this doctor/medical centre? Years Months

a. When was your last visit to this doctor/medical centre?

b. Reason for check-up or consultation?

c. Outcome including medication, treatment etc

d. Degree of recovery? %

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned?

◯ Yes

◯ No

If **yes**, please provide details

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc
	/ /		
	/ /		
	/ /		
	/ /		

10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
- I have read the Privacy Statement at Section 12 of this form (below). (Zurich's Privacy Policy details how we manage personal information. It is available at zurich.com.au/important-information/privacy)
- I acknowledge and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statement on this form (see Section 12).
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to Zurich in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Product Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by Zurich.

Life insured/applicant – signature

✗ Date / /

11. Consent for accessing 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, Zurich, 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.

Please read each Authority carefully and the explanatory notes below.

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 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 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 Zurich, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Zurich 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.
- Zurich 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 Zurich 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 (dd/mm/yyyy)

/ /

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 Zurich, or to third parties they engage, only if Zurich 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:

- Zurich 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 Zurich 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 (dd/mm/yyyy)

/ /

12. Privacy Statement

In this section, 'we', 'us' and 'our' refers to Zurich Australia Limited. 'You' and 'your' refers to policyowners and life insureds.

We are bound by the *Privacy Act 1988* (Cth). Before providing us with any personal or sensitive information, read this outline to understand what we'll do with your information. If you're not the only person providing information, then the other people providing information need to know this too.

We collect and use personal information to manage your insurance. We collect, use, process, and store personal information and, in some cases, sensitive information about you for several purposes. Purposes include complying with our legal obligations, assessing your application for insurance, managing the insurance, improving customer service or products, managing claims and dealing with potential misrepresentation. If you don't agree to provide us with the information, we may not be able to process your application, manage your cover or assess your claims. Other than from you, we may also collect information from government offices and third parties to assess an application or a claim.

By providing us or your intermediary with your information, you consent to our use of this information which includes us sharing your information with other parties where relevant for the purposes. Other parties can include the policy owner, your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our banking gateway providers and credit card transaction processors, and our business partners. It also includes other organisations in an alliance with us to co-issue, distribute, improve, manage and administer our products and services (including health services), carry out business functions and undertake analytic activities. We may also use or disclose your information as authorised or required by law within Australia or overseas.

These are the relevant Australian laws that may apply:

- *Australian Securities and Investment Commissions Act 2001*
- *Corporations Act 2001*
- *Insurance Contracts Act 1984*
- *Life Insurance Act 1995*
- *Superannuation Industry (Supervision) Act 1993*
- *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*
- *Anti-Money Laundering and Counter-Terrorism Financing Rules Instrument 2007 (No. 1)*
- *Income Tax Assessment Act 1936*
- *Income Tax Assessment Act 1997*
- *Taxation Administration Act 1953*
- *Superannuation Guarantee (Administration) Act 1992*
- *Small Superannuation Accounts Act 1995*
- *Superannuation (Unclaimed Money and Lost Members) Act 1999*
- *Superannuation (Resolution of Complaints) Act 1993*
- *Superannuation (Government Co-contribution for Low Income Earners) Act 2003*
- *Family Law Act 1975* (Part VIIIB).

We must also comply with updates to these laws and any associated regulations. In addition to these, other acts may require or authorise us to collect your personal information.

We may use personal information (but not sensitive information) collected about you to tell you about other products and services we offer, including health services and reward programs. If you don't want your personal information to be used in this way, please contact us on 1800 199 414.

If you want to know more

We can provide:

- a list of service providers and business partners that we typically may share your information with
- a list of countries in which recipients of your information are likely to be located
- details of how you can access or correct the information we hold about you
- information about how to make a complaint.

For further information about our Privacy Policy please refer to the Privacy link on our homepage – zurich.com.au, contact us by phone on 1800 199 414 or email us at privacy.officer@zurich.com.au.

Our data commitment

We understand that data security is an important concern. You can rest assured that we'll:

- keep your data safe
- never sell personal data
- not share personal data without being transparent about it
- put data to work so we can better protect you.

13. Supplementary questionnaires

ASTHMA QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 1 in Section 8

1. When did you have your first episode of asthma? Date (dd/mm/yyyy) / /

2. When was your most recent episode of asthma? Date (dd/mm/yyyy) / /

3. Approximately how many episodes have occurred in the last 12 months?

4. Have you ever suffered from nocturnal asthma attacks?

◯ Yes

◯ No

If **yes**, please provide the frequency of these attacks and approximate date of last attack

5. Have you had any time off work due to this condition?

◯ Yes

◯ No

If **yes**, please provide the dates and duration

6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)?

◯ Yes

◯ No

If **yes**, please provide details

7. Have you sought medical treatment or advice for asthma?

◯ Yes

◯ No

If **yes**, please provide details

Name of doctor/health professional

Address

Suburb State Postcode

Date of last consultation (dd/mm/yyyy) / /

8. How has your doctor described your asthma? ◯ Mild ◯ Moderate ◯ Severe

9. Have you ever used any medication, including steroids?

◯ Yes

◯ No

If **yes**, please provide details

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

10. Have you ever been hospitalised due to asthma?

◯ Yes

◯ No

If **yes**, please provide details

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Name of hospital

Address

Suburb State Postcode

11. Have you ever had lung function tests performed?

◯ Yes

◯ No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	
/ /	

BLOOD PRESSURE QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 2 in Section 8

1. When was your high blood pressure first diagnosed? Date (dd/mm/yyyy) / /

2. What was your blood pressure reading at that time? Systolic Diastolic

3. Have you ever been treated by medication?

◯ Yes

◯ No

If **yes**, please provide details

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations?

◯ Yes

◯ No

If **yes**, please provide details

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor?

◯ Yes

◯ No

If **yes**, please provide details

Name

Address

Suburb State Postcode

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last blood pressure check? Date (dd/mm/yyyy) / /

7. What was your blood pressure reading at that time? Systolic Diastolic

8. How has your doctor described your blood pressure control? ◯ Excellent ◯ Good ◯ Poor ◯ Other

If **other**, please provide details

9. What is the date of your next blood pressure check-up? Date (dd/mm/yyyy) / /

CHOLESTEROL QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 3 in Section 8

1. When was your high cholesterol first diagnosed? Date (dd/mm/yyyy) / /

2. What were your cholesterol readings at that time? Cholesterol Triglycerides

HDL Cholesterol LDL Cholesterol

3. Did you undergo any tests or investigations?

◯ Yes

◯ No

If **yes**, please provide details

Tests performed	**Date (dd/mm/yyyy)**	**Results**
	/ /	
	/ /	

4a. Have you ever used any medication?

◯ Yes

◯ No

If **yes**, please provide details

Type	**Date commenced (dd/mm/yyyy)**	**Frequency (e.g. daily, weekly)**	**Dosage**	**Date ceased (if applicable) (dd/mm/yyyy)**	**Reason for cessation**
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)?

◯ Yes
◯ No

If **yes**, please provide date of when treatment changed and the reason(s) for change

5. Is the treating doctor different to your usual doctor?

◯ Yes
◯ No

If **yes**, please provide details

Name

Address

Suburb State Postcode

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last cholesterol check? Date (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol Triglycerides

HDL Cholesterol LDL Cholesterol

8. How has your doctor described your cholesterol control? ◯ Excellent ◯ Good ◯ Poor ◯ Other

If **other**, please provide details

9. What is the date of your next cholesterol check-up? Date (dd/mm/yyyy) / /

DIABETES QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 4 in Section 8

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed? Date (dd/mm/yyyy) / /

3. How is your diabetes controlled?

◯ Insulin – go to question 3
◯ Diet only – go to question 4
◯ Oral – list medications below and then go to question 4

4. How many times a day do you administer insulin?

◯ I'm on an insulin pump
◯ One or two times daily
◯ Three or more times daily

5. How often do you monitor your sugar levels?

◯ One or two times daily
◯ Three or more times daily
◯ Other

If **other**, please provide details

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine?

◯ Yes

◯ No

If **yes**, please provide details

Condition	Date (dd/mm/yyyy)	Treatment
	/ /	
	/ /	

7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months?

◯ Yes

◯ No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months?

◯ Yes

◯ No

If **no**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

8. Is the treating doctor different to your usual doctor?

◯ Yes

◯ No

If **yes**, please provide details

Name

Address

Suburb State Postcode

Date of last consultation (dd/mm/yyyy) / /

MENTAL HEALTH QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 5 in Section 8.

1. Please tick the conditions you have had (or currently have), or received treatment for:

◯ Anxiety including generalised anxiety, panic or phobia disorder

◯ Eating disorder including anorexia nervosa or bulimia

◯ Depression including major depression or dysthymia

◯ Manic depressive illness or bipolar disorder

◯ Alcohol or other substance abuse or addiction

◯ Post traumatic stress

◯ Schizophrenia or any other psychotic disorder

◯ Stress, sleeplessness or chronic tiredness

◯ Other

If **other**, please describe

2. Please complete the table below for all described conditions

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms?

◯ Yes

◯ No

If **yes**, please provide details including dates

4. Are you currently symptom free? ◯ Yes ◯ No

5. Date of last symptoms Date (dd/mm/yyyy) / /

6. Have you ever attempted suicide or self harm?

◯ Yes

◯ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital

7. Are you aware of the cause or reason for your condition(s)?

◯ Yes

◯ No

If **yes**, please provide details

8. Have you ever had any time off work due to your condition(s)?

◯ Yes

◯ No

If **yes**, please provide the dates and duration

9. Are you currently or have you ever been on treatment, including medication?

◯ Yes

◯ No

If **yes**, please provide details

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life?

◯ Yes

◯ No

If **yes**, please provide details

11. Have you been referred for consultation with a psychiatrist or psychologist?

◯ Yes

◯ No

If **yes**, please provide details

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

12. Have you been admitted to hospital or any other care facility?

◯ Yes

◯ No

If **yes**, please provide details

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

Doctor(s) consulted

BACK/NECK QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 6 in Section 8

1. When did your back/neck condition first occur? Date (dd/mm/yyyy) / /

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc)

5. Was an X-ray, CT scan or any other type of investigation performed?

◯ Yes

◯ No

If **yes**, please provide details

Tests	Date of tests (dd/mm/yyyy)	Results
	/ /	
	/ /	

6. Have you had recurrent or multiple episodes of the back/neck condition?

◯ Yes

◯ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration

7. Please provide details of all people you have consulted for this condition in the table below

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition?

◯ Yes

◯ No

If **yes**, please provide the dates and duration

9. Are your work duties or activities limited/affected by the condition?

◯ Yes

◯ No

If **yes**, please provide details

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind?

◯ Yes

◯ No

If **yes**, please provide details

11. Overall do you feel that your back/neck condition is? ◯ Resolved ◯ Improving ◯ Stable ◯ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yyyy) / /

ARTHRITIS/JOINT QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 7 in Section 8

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition

	Left	Right		Left	Right
Ankle	◯	◯	Wrist	◯	◯
Elbow	◯	◯	Hip	◯	◯
Shoulder	◯	◯	Other	◯	◯
Knee	◯	◯			

If **other**, state which joint

2. When did this condition first occur? Date (dd/mm/yyyy) / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known

5. Have you had recurrent or multiple episodes of the condition?

◯ Yes

◯ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration

6. Please provide details of all people you have consulted for this condition in the table below

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition?

◯ Yes

◯ No

If **yes**, please provide the dates and duration

8. Do you have any residual pain, limitation of movement or restriction of any kind?

◯ Yes

◯ No

If **yes**, please provide details

9. Are your work duties or activities limited/affected by the condition?

◯ Yes

◯ No

If **yes**, please provide details

10. Are you still undergoing treatment?

◯ Yes

◯ No

If **yes**, please provide details

11. Overall do you feel that your condition is ◯ Resolved ◯ Improving ◯ Stable ◯ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yyyy) / /

CYST/MOLE/SKIN LESION QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 8 in Section 8

1. Please provide details in the table below

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ◯ Yes ◯ No

If **yes**, please provide details for each Date (dd/mm/yyyy) / /

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable

3. Have you been or are you required to attend any further treatment or regular follow-up since the original removal?

◯ Yes

◯ No

If **yes**, please provide details and advise how often follow-up is required

4. Have you had any other tests, investigations or treatments not mentioned above?

◯ Yes

◯ No

If **yes**, please provide details

Tests/Treatments/ Investigations	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor?

◯ Yes

◯ No

If **yes**, please provide details

Name

Address

Suburb State Postcode

Date of last consultation (dd/mm/yyyy) / /

Additional information/comments

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