SMSF Master Insurance Plan

Full Personal Statement

Policy Ref No. *(Office use only)*

Australian Group Insurances

SMSF Provider Code:

Member No: *(Office use only)*

Duty of Disclosure Notice

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.

Life Insured *(please provide your current details)*

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname

Given Name(s)

Date of Birth DD / MM / YYYY

Gender ☐ F ☐ M

Daytime contact no.

Email address

Postal address

State Postcode

Country

Occupation

Industry

Daily Duties (Including % time spent performing each duty, i.e. manual duties)

Employment status ☐ Full time ☐ Part time ☐ Casual ☐ Contractor

How many hours per week do you work?

Gross Annual Income $

Self Managed Superannuation Fund Details

Name of your Self Managed Superannuation Fund

ABN

Trustee Type ☐ Corporate ☐ Individual (Life Insured is Trustee)

Name of Corporate Trustee *(if applicable)*

Trustee's Postal Address

Suburb State Postcode

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Send your completed form to AGI at smsf@agigroup.com.au

The SMSF Master Insurance Plan is distributed and administered by
Australian Group Insurances Pty Ltd (AGI) ABN 97 140 572 434 AFSL 379565
Product Issuer: AIA Australia Limited ABN 79 004 837 861 AFSL 230043

Type of Insurance

Is this a new application for insurance or an application to increase your existing insurance cover with the SMSF Master Insurance Plan? ☐ New ☐ Increase

Cover	Sum Insured	Policy to be held
Death	$	Within SMSF
Total & Permanent Disablement (TPD)		
TPD cover	$	Within SMSF
TPD own occupation definition	$	As a non-superannuation policy
Income Protection (IP) – as a non-superannuation policy		
Income Protection cover (per month) (minimum $1,000, maximum $30,000)	$	(limited to 75% of your monthly Income)
Superannuation contribution benefit	%	What % of your cover represents the super contribution component?

☐ **IP Plus Options** provides ancillary benefits, including Accommodation Benefit, Family Care Benefit, Home Care Benefit, Nursing Care Benefit, Overseas Assistance Benefit, Specific Injury Benefit and Trauma Benefit.

Benefit Period ☐ 2 years (to age 65 if earlier) ☐ 5 years (to age 65 if earlier) ☐ To Age 65

Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days

Personal History

1) Please state your: Height? ☐ cm and Weight? ☐ kg

	Yes	No
2) Are you a permanent resident of Australia?	☐	☐
3) Have you smoked any tobacco or any other substance in the last 12 months?	☐	☐
If YES, please state forms and quantities		
4) Do you drink alcohol?	☐	☐
If YES, what type of alcohol? ☐ How much (daily intake)? ☐		
5) Do you intend to work, live or travel overseas?	☐	☐
If YES, please state the destination, duration, frequency and purpose of travel		
6) Have you ever engaged or are you ever likely to engage in aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (e.g. motor racing, football – all codes, martial arts, scuba diving)?	☐	☐
If YES, please provide details		

At the date of this application:	Yes	No
7) Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full time basis, due to an injury or sickness (even if you are not currently working on a full time basis or unemployed)?	☐	☐
8) Have you ever had back or neck pain for 7 or more consecutive days, or have you ever had mental/nervous/stress disorders, cancer, blindness or deafness?	☐	☐
9) In the last 3 years, have you had any medical advice or treatment, taken prescribed (excluding for colds or flu) or illicit drugs or been hospitalised for any injury or sickness?	☐	☐
10) Are you under any treatment by diet, medication, sedative, drugs?	☐	☐
11) Has any company ever declined, deferred, applied special or modified conditions or cancelled any proposal to insure you for life or disablement policy?	☐	☐

If you answered YES to any of the above questions (7–11), please give full details.

. . . continued ☞

Medical History

SECTION A – Medical Details

		Yes	No
1)	Have you ever had or received treatment for or had symptoms of:		
a)	High blood pressure or blood disorder e.g. leukaemia, anaemia or haemophilia?	☐	☐
b)	Heart, vein or circulatory disorder, including chest pain, heart attack, stroke, heart murmur, raised cholesterol or rheumatic fever?	☐	☐
c)	Mental or nervous disorder (e.g. stress, depression, insomnia), fainting, epilepsy, fits of any kind, paralysis, multiple sclerosis, migraines, brain disorder, psychiatric treatment/counselling or neurological disorder?	☐	☐
d)	Gout, arthritis, rheumatism, skeletal injury, spine/neck disorder, cartilage or ligament injury, bone fracture or hernia?	☐	☐
e)	Back or neck pain, whiplash, sciatica or any muscle or joint disorder?	☐	☐
f)	Asthma, bronchitis, tuberculosis, pleurisy or other respiratory disorder?	☐	☐
g)	Stomach, intestinal or rectal disorder, ulcer, bleeding from bowel, gall bladder?	☐	☐
h)	Diabetes, thyroid or prostate disorder?	☐	☐
i)	Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?	☐	☐
j)	Impairment/disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?	☐	☐
k)	Hepatitis B or C or have you ever been told you are a Hepatitis B or C carrier?	☐	☐
l)	Dermatitis, psoriasis or any skin disorder?	☐	☐
m)	Liver, kidney or bladder disease, including renal colic or stone, blood in urine or reproductive organ disorder?	☐	☐
n)	Sexually transmitted diseases?	☐	☐
o)	Drug or alcohol dependence?	☐	☐
p)	Any other medical condition not mentioned above?	☐	☐
q)	**Females only** i) Female organ disorder (including abnormal:- pap smear, breast ultrasound or mammogram)?	☐	☐
	ii) Are you currently pregnant?	☐	☐
	If YES, date of expected delivery D D / M M / Y Y		

SECTION B – Further Medical Background

		Yes	No
1)	Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?	☐	☐
2)	During the last five years have you:		
a)	Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?	☐	☐
b)	Been in hospital, clinic or nursing home?	☐	☐
c)	Been advised to have an operation?	☐	☐
d)	Had any tests, including blood tests, ECG, x-rays or genetic tests?	☐	☐
e)	Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquilisers?	☐	☐

If you answered YES to ANY of the questions in Sections A or B, please complete all Sections below. Otherwise, complete Section D onwards.

SECTION C – Answers in Detail

1) If you answered YES to ANY question in sections A or B, please provide details in the schedule below. If there is insufficient space, please provide a signed and dated supplementary statement.

Question Reference (Section A or B)	Tests, or nature of condition or complaint	Commencement Date	Duration	Time off work	Degree of Recovery (%)	Full details of treatment and results (include type of operations)	Full name and address of doctor or hospital (if any)

. . . *continued* ☞

SECTION D – Personal Doctor's Details (please provide current details)

If no personal doctor, please state name/address of last clinic or medical centre attended.

Name | Date of last consultation D D / M M / Y Y | How long have you been a patient? yrs/mths

Address | State | Postcode

Telephone | Facsimile

Email (if known) | ABN (if known)

Please state the reasons and results of your last consultation.

SECTION E – Other Details

	Yes	No
1) Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)? If YES, please provide the policy details in the schedule below.	☐	☐

Commencement Date	Insurer	Type of Cover	Amount of Cover	*To be Replaced 'Y' or 'N'

*For policies to be replaced, please attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

SECTION F – Family History

	Yes	No
1) Have any of your parents, brothers or sisters (living or deceased) had Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder? If YES, please provide details in the schedule below.	☐	☐

Relation	Condition/Illness	Age at Onset (approximately)	Age at Death (if applicable)

	Yes	No
2) Have any of your parents, brothers or sisters (living or deceased) been diagnosed prior to age 65 with any of the following conditions: Diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? If YES, please provide details in the schedule below.	☐	☐

Relation	Condition/Illness For Cancer – Specify Type	Age at Onset (approximately)	Age at Death (if applicable)

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Further Income Details (Complete only if Income Protection is required)

1) a) Please state your monthly Income from your current occupation (net of business expenses but before tax)?
DO NOT INCLUDE INVESTMENTS AND MANDATORY SUPERANNUATION.

- **SELF EMPLOYED**
  Means the Income generated from the business due to your personal exertion or activities for the last 12 months less your share of necessarily incurred business expenses for the last 12 months. Income does not include unearned income such as dividends, interest, rental income or proceeds from the sale of assets but does include ongoing regular bonuses, regular management fees and regular commissions. Bonuses and commissions will be calculated based on the average of the last three years bonuses and commissions.
- **EMPLOYED**
  Means your pre-tax Income paid to you by an employer including salary, fees, regular bonuses, regular commissions, regular overtime, fringe benefits and salary sacrificed superannuation contributions but excluding mandatory superannuation contributions and unearned income (e.g. investment or interest income). Bonuses, overtime earnings and commissions will be calculated based on the average of the last three years received by you from an employer.

Principal Occupation: Current Year $ _____ per month Previous Year $ _____ per month

b) How long have you been at your current occupation? _____ years _____ months

c) How much of the above Income will continue if you are disabled? $ _____

i) For how long? _____ years/months

ii) State source of Income (e.g. sick leave, director's fees, Income Protection insurance, profit share from the business)

_____

2) If you become disabled, would you receive Income from **other** sources? ☐ Yes ☐ No

If YES:

a) How much? $ _____ per month

b) For how long? _____ years/months

c) State source of Income _____

3) Do you also perform another occupation? ☐ Yes ☐ No If YES, describe the daily duties of this occupation (including manual work)

_____

4) Do you receive any unearned Income? ☐ Yes ☐ No If YES, how much? $ _____ per month
(e.g. from investments such as rental property or dividends)?

5) What was your previous occupation? _____

6) Are you self-employed or employed by your own company? ☐ Yes ☐ No

If YES:

a) Date your business started DD / MM / YY

b) How long have you been self-employed? _____ years/months

c) What percentage of your work is: i) Freelance? _____ % ii) Contract? _____ %

d) How many people do you employ? _____

7) Has your business or practice had a net operating loss in the last 2 years? ☐ Yes ☐ No
If YES, please provide copies of Profit & Loss Statements for the last 2 years.

8) Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? ☐ Yes ☐ No

If YES, when DD / MM / YY Date of discharge DD / MM / YY

9) Do you work at home? ☐ Yes ☐ No If YES, state percentage of the time _____ %

10) Do you earn commission or bonuses? ☐ Yes ☐ No If YES, state percentage of total Income _____ %

AIDS Declaration

I hereby declare that:

- I am not suffering from Acquired Immune Deficiency Syndrome (AIDS) and I am not infected with the HIV virus and I am not carrying antibodies to the HIV virus;
- I have not used intravenous drugs, I have not engaged in male to male anal sexual activity and I have not worked as or had sexual intercourse with a paid sex worker; and
- I have not had sexual intercourse with someone I know or suspect to be HIV positive.

☐ I am ABLE to declare that ALL the above statements are true.

☐ I am UNABLE to declare that ALL the above statements are true.*

*If unable, a Confidential Supplementary Personal Statement is required.

Before signing, one of the above boxes must be ticked.

Signature of Life Insured ✗ _____ Date DD / MM / YY

Privacy

Personal and sensitive information provided will be handled in the manner described in the AIA Australia and AGI Privacy Policies as updated from time to time, accessible by visiting **www.aia.com.au** and **www.agigroup.com.au** respectively.

AIA Australia and AGI handles and collects personal and sensitive information for purposes which include the administration of your policy or claim, the provision of products and services, our business operations and other purposes set out in the respective Privacy Policies.

By providing information to us or your adviser (and the licensed dealer or broker they represent), the trustee or administrator of a superannuation fund, or other representative or intermediary, or by continuing your relationship and otherwise interacting with us, you confirm that you have been notified of the matters and consent to the collection, use, disclosure and handling of personal and sensitive information as described in the Privacy Policies as updated from time to time on the websites listed above.

We rely on the accuracy of the personal information provided. If any of your personal information reflected in this form or any of the attachments are incorrect, out of date or incomplete, please call us on 1800 333 610 and we can take reasonable steps to correct the personal information. Where you provide personal and sensitive information about someone else, you must have their consent to provide their information to us in the manner described in both AIA Australia's and AGI Privacy Policies.

Declaration and Agreement

I, the trustee or the corporate trustee of the above named superannuation fund, request AIA Australia to issue the insurance cover under the Policy described in this form.

I agree to be bound by the terms and conditions of the policy document and the trust deed governing the superannuation fund.

I confirm that I have the power under the trust deed and/or constitution of the company governing the superannuation fund to effect cover under the Policy described on this form.

I agree that no benefit will be paid under this Policy in any circumstances if I make the application on behalf of another person.

I am a Permanent Resident of Australia and want to be covered under this Policy of insurance.

I have read and understood the SMSF Master Insurance Plan Product Disclosure Statement (PDS) in conjunction with this application and agree to be bound by its terms.

I have read and understood my Duty of Disclosure and I declare that all the information provided is true and correct and complete and I have not withheld or omitted any information relevant to this application for insurance. I also understand that my duty to disclose continues after I have completed this application until AIA Australia has accepted the risk.

I have read and understood the Privacy Policies of AIA Australia and AGI and consent to the collection, use and disclosure of personal and sensitive information in accordance with the Privacy Policies as updated from time to time, including exchange with third parties located in Australia and overseas.

I understand that after I receive the first Policy Insurance Certificate from AGI, I have a 28-day cooling off period in which I may cancel the insurance by notifying AGI in writing and returning the Policy Insurance Certificate and I will receive a full premium refund (unless a claim has been or could be made under the Policy).

I have read and considered the PDS in making my decision to apply for this insurance. I have not received any personal advice from AGI in relation to my application for insurance or whether the insurance is right for my personal objectives, financial situation or needs.

I understand that cover will not commence until my application is accepted by AIA Australia.

I consent to AIA Australia and AGI communicating electronically with me about my cover under the Policy as described in the current PDS. In providing this consent, I nominate and authorise AIA Australia and AGI to act on instructions it has received electronically. This consent and authority will apply to all communications permitted to take place electronically by law (including any applicable industry Code or Code of Conduct) including but not limited to (a) statements of my cover under the Policy; (b) notices and other documents received by me about my cover under the Policy; (c) variations to the contract relating to my cover under the Policy; and (d) notices from me to AIA Australia or AGI. Any such communication is to be made to the nominated address in my personal capacity, and with respect to any communication to the Trustee of the superannuation fund that are permitted to be communicated electronically.

Signature of Life Insured as Individual Trustee or as Director for Corporate Trustee ✗

Date DD / MM / YY

Medical Authority

I, Full Name of Life Insured

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to AIA Australia Limited, full details of my health and medical history.

Signature of Life Insured ✗

Date DD / MM / YY