



# Priority Protection for Platform Investors with AIA Vitality

## netwealth Application Form

Version 17 – 16 December 2017

Platform ID:

|   |   |   |   |   |   |   |   |   |
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AIA Adviser No:

|  |  |  |  |  |  |  |  |  |  |
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|--|--|--|--|--|--|--|--|--|--|

(Head Office Use Only)

Please print in capital letters using a black pen.

### Important Information for Adviser

- This application form is to be used for New Policies only and may also be used where the life insured wishes to apply for AIA Vitality.
- If increasing or adding benefits, please use the *netwealth Application for Increases and/or Additions* form available on the AIA Australia Adviser Site.
- Note: ongoing monthly AIA Vitality contributions must be paid by Direct Debit or Credit Card. AIA Vitality contributions cannot be funded by superannuation, SMSF monies or from a platform account.
- AIA Vitality contribution payments will match the frequency of premium payments on the relevant associated insurance policy. All outstanding amounts due in relation to the eligible AIA Australia insurance policy will need to be paid in full prior to the set-up of an AIA Vitality membership.

Please send completed application form and signed quote to: PO Box 6111, Melbourne VIC 3004, or [infohub@aia.com](mailto:infohub@aia.com)

### Important Information

Before you sign this application form, be aware that we or your adviser are obliged to have provided you with a Priority Protection for Platform Investors Product Disclosure Statement (either in electronic or hard copy format) containing a summary of the important information in relation to this product. This information will help you to understand the product and to decide whether it is appropriate for your needs.

### Your duty of disclosure

If you are the Policy Owner, you have a duty to tell us anything that you know, or could reasonably be expected to know, which may affect our decision to insure you and any other Life Insured and on what terms.

You have this duty until we agree to insure you, and also before you extend, vary or reinstate the Policy.

You do not need to tell us anything that:

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

If you are a Life Insured (other than the Policy Owner), any failure by you to tell us this information may be treated as a failure by the Policy Owner to comply with this duty of disclosure.

### If you do not tell us something

If you are the Policy Owner, and you do not tell us anything you are required to, and we would not have insured you if you 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 reduce the amount you have been insured for, based on a statutory formula. (We may only exercise this right within 3 years of entering into the Policy if it provides death cover.)

If we choose not to avoid the Policy or reduce the amount you have been insured for, if your Policy does not provide death cover, we may vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have.

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

We may apply these rights separately to each type of cover that we consider could form a separate policy.

## A1. Life Insured (Life insured to complete this section in full.)

1. netwealth Account Number

|         | Title                | Surname              | Given Name           | Sex                  |
|---------|----------------------|----------------------|----------------------|----------------------|
| 2. Name | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

|                        | No.                  | Street               | Suburb               | State                | Postcode             |
|------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| 3. Residential Address | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

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 – 6pm

|                    | Mobile               | Phone (home)         | Phone (work)         |
|--------------------|----------------------|----------------------|----------------------|
| 4. Contact Details | <input type="text"/> | <input type="text"/> | <input type="text"/> |

A mobile phone number is mandatory.

Email

An email address is mandatory. To ensure confidentiality a unique email address must be entered.

Note: if you are, or are applying to be an AIA Vitality member you cannot enter the same email address as another AIA Vitality member.

|  | Suburb               | State                | Postcode             |
|--|----------------------|----------------------|----------------------|
| 5. Mailing Address (if different to above) | <input type="text"/> | <input type="text"/> | <input type="text"/> |

6. Smoker  Yes  No      7. Date of Birth (dd/mm/yy)

8. Age next birthday

9. Country of Birth

10. Are you an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship) or are you a New Zealand citizen living permanently in Australia? ..... Yes  No

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

(Please submit a copy of your current Passport and Visa with this application. If applying for Permanent Residency, please submit copies of correspondence from the Australian Immigration Department indicating the same.)

Note: To be eligible for AIA Vitality you must be an Australian Resident.

## A2. AIA Vitality Membership Application (Life insured to complete this section in full.)

### AIA Vitality (only available to the Life Insured)

AIA Vitality is a health and wellness program, encouraging you to get healthier and earn great rewards. Premiums relating to eligible life insurance policies that cover you may be discounted in certain circumstances based on your participation in the AIA Vitality program, the terms of which were provided to you with your application and are available on the AIA Vitality Member website.

Do you have an existing AIA Vitality membership? ..... Yes  No

If 'Yes' please provide your AIA Vitality membership number.

If 'No' would you like to apply for AIA Vitality membership?..... Yes  No

Email

*An email address is mandatory. To ensure confidentiality a unique email address must be entered.*

*Note: if you are, or are applying to be an AIA Vitality member you cannot enter the same email address as another AIA Vitality member.*

Note: If you are or are applying to be an AIA Vitality member, your AIA Vitality membership will be associated with an eligible AIA Australia insurance policy. AIA Australia will determine which is the associated policy.

### Information for completion of Payment Authority forms if you are applying for AIA Vitality:

- AIA Vitality contributions cannot be funded by superannuation, SMSF monies or from a platform account. In order to have the AIA Vitality contribution deducted please complete the AIA Vitality Payment Direct Debit Request or AIA Vitality Payment Credit Card Authority form (page 31).
- In all other instances the AIA Australia insurance premium(s) and the AIA Vitality contribution deducted will be deducted from the same bank account/ credit card. The Payment Direct Debit Request or Payment Credit Card Authority form on page 29 of this Application Form must be completed.

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*Remainder of this page has been left intentionally blank.*

## B. Policy Owner(s) – Policy 1 (Non Superannuation) (To be completed by the policy owner/s.)

This Priority Protection for Platform Investors policy is to be owned by (please tick appropriate box):

**The life insured.** No further details are required.

**OR**

**An individual/s other than the life insured.** Please complete the following.  
If there are two or more policy owners, they will own the policy as joint owners.

### Policy owner 1

|                              |   |                                       |              |                          |  |  |  |
|------------------------------|---|---------------------------------------|--------------|--------------------------|--|--|--|
| Name                         | Title                                       | Surname                               | Given Name   | Sex                      |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Mailing Address              |   |                                       |              |                          |  |  |  |
|                              | Suburb                                      | State                                 |              | Postcode                 |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Contact Details              | Mobile (a mobile phone number is mandatory) | Phone (home)                          | Phone (work) |                          |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
|                              | Fax   | Email (an email address is mandatory) |              |                          |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Relationship to Life Insured |   |                                       |              | Date of Birth (dd/mm/yy) |  |  |  |

Are you an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship) or are you a New Zealand citizen living permanently in Australia? ..... Yes  No

### Policy owner 2

|                              |   |                                       |              |                          |  |  |  |
|------------------------------|---|---------------------------------------|--------------|--------------------------|--|--|--|
| Name                         | Title                                       | Surname                               | Given Name   | Sex                      |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Mailing Address              |   |                                       |              |                          |  |  |  |
|                              | Suburb                                      | State                                 |              | Postcode                 |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Contact Details              | Mobile (a mobile phone number is mandatory) | Phone (home)                          | Phone (work) |                          |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
|                              | Fax   | Email (an email address is mandatory) |              |                          |  |  |  |
|                              |   |                                       |              |                          |  |  |  |
| Relationship to Life Insured |   |                                       |              | Date of Birth (dd/mm/yy) |  |  |  |

Are you an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship) or are you a New Zealand citizen living permanently in Australia? ..... Yes  No

**OR**

**Company/Business Partnership.** Please complete the following:

|  |        |         |          |
|--|--------|---------|----------|
| Company/<br>Business<br>Partnership<br>Name/s                      |        | ABN/ACN |          |
| Nominated contact person   |        |         |          |
| Contact  |        |         |          |
| Email for nominated contact person (an email address is mandatory) |        |         |          |
| Mailing Address  |        |         |          |
|  | Suburb | State   | Postcode |
|  |        |         |          |
| Contact Details  | Phone  | Fax     |          |
|  |        |         |          |

**OR**

**Trustee of a Private/Self-Managed Superannuation Fund.** Please complete the relevant parts of Section V.

## C. Policy Details – Policy 1 (Non Superannuation) (To be completed by the policy owner/s.)

All non-superannuation plans you are applying for must have the premiums paid from one of the following (please tick one option only):

- netwealth** Investment Wrap account (Go to 2. Please **do not** complete the Direct Debit or Credit Card Authorities.)  
OR  
 A financial institution other than **netwealth** (Go to 1.)

You can only select the option to have the premiums paid from a financial institution other than **netwealth** if this application includes an application for an additional policy which has premiums paid from either the applicant's **netwealth** Investment Wrap account or their **netwealth** Superannuation Master Fund account.

1. An initial premium payment is required.

Please select an option:  Credit Card  Direct Debit  Cheque (to be made payable to **AIA Australia**)  Money Order  Bank Cheque

Please note: Direct Debit and Credit Card Authorities will not be processed until your application has been assessed and accepted by AIA Australia.

2. Please select your premium frequency.  Monthly  Half-yearly  Yearly

(Ongoing monthly premiums not paid from a **netwealth** account must be paid by Direct Debit or Credit Card.)

Where AIA Vitality is being applied for, the AIA Vitality contribution payments will match the frequency of the premium payments on the relevant associated insurance policy.

Please note: AIA Vitality contributions cannot be funded from a platform account.

3. Are benefit indexation increases required?  Yes  No *Benefit indexation may automatically be applied if you do not select an option.*

4. (a) Reasons for cover:  Personal Cover  Key person Cover  Business Partnership  Loan Protection  Buy/Sell, Share Purchase

- (b) Is a concurrent application for yourself, a Business Partner or Spouse being submitted? If 'Yes' please provide details.....Yes  No

5. If the Retirement Optimiser benefit as described in the Product Disclosure Statement has been applied for, please select the superannuation fund to which the Retirement Optimiser benefit should be paid at time of any claim.

**netwealth** Superannuation Master Fund

OR

the trustee of the Private/Self Managed Superannuation Fund

You will be able to change your nomination at time of claim or earlier.

## D. Nomination of Beneficiaries – Policy 1 (Non Superannuation) (Applicable only to death benefits.)

Proposer to complete if required. Please list your nominated beneficiary(ies) and the proportion of death benefit you would like each to receive.

1. Surname  Given Name  Date of Birth  Relationship to Life Insured  % of benefit

Address  Country of Citizenship

2. Surname  Given Name  Date of Birth  Relationship to Life Insured  % of benefit

Address  Country of Citizenship

3. Surname  Given Name  Date of Birth  Relationship to Life Insured  % of benefit

Address  Country of Citizenship

4. Surname  Given Name  Date of Birth  Relationship to Life Insured  % of benefit

Address  Country of Citizenship

If more than four beneficiaries are to be nominated use a separate Nomination of Beneficiary form available from us or your adviser.  
If the nominated allocations to beneficiaries do not add up to 100%, AIA Australia will adjust each allocation proportionately so that the total allocation equals 100%.

**TOTAL 100%**

# Superannuation Life Cover Plan

(Policy Owner(s)/life insured to complete this section in full only if Superannuation Life Cover Plan is being purchased.)

## E. Policy Owner(s) and policy details – Policy 2 (To be completed by the policy owner(s)/life insured.)

This Priority Protection for Platform Investors policy is to be owned by (please tick appropriate box):

**netwealth Investments Ltd (ABN 85 090 569 109, AFSL No. 230975) as the trustee for the netwealth Superannuation Master Fund.**  
Premiums will be paid from the life insured's **netwealth** Superannuation Master Fund account and the policy owner will be in the name of **netwealth** Investments Ltd as the trustee for the **netwealth** Superannuation Master Fund.

OR

**The trustee of the Private/Self-Managed Superannuation Fund.**  
Premiums will be paid from the life insured's **netwealth** Investment Wrap account and the policy owner will be the trustee of the life insured's SMSF.

1. Please select your premium frequency.  Monthly  Half-yearly  Yearly  
Where AIA Vitality is being applied for, the AIA Vitality contribution payments will match the frequency of the premium payments on the relevant associated insurance policy.  
Please note: AIA Vitality contributions cannot be funded by superannuation, SMSF monies or from a platform account.

2. Are benefit indexation increases required?  Yes  No *Benefit indexation may automatically be applied if you do not select an option.*

3. Is a concurrent application for yourself or a Spouse being submitted? If 'Yes' please provide details. .... Yes  No

Spouse surname

Spouse given name/s

Policy number (if known)

# Superannuation Income Protection Plan

(Policy Owner(s)/life insured to complete this section in full only if Superannuation Income Protection Plan is being purchased.)

## F. Policy Owner(s) and policy details – Policy 2 (To be completed by the policy owner(s)/life insured.)

This Priority Protection for Platform Investors policy is to be owned by (please tick appropriate box):

**netwealth Investments Ltd (ABN 85 090 569 109, AFSL No. 230975) as the trustee for the netwealth Superannuation Master Fund.**  
Premiums will be paid from the life insured's **netwealth** Superannuation Master Fund account and the policy owner will be in the name of **netwealth** Investments Ltd as the trustee for the **netwealth** Superannuation Master Fund.

OR

**The trustee of the Private/Self-Managed Superannuation Fund.**  
Premiums will be paid from the life insured's **netwealth** Investment Wrap account and the policy owner will be the trustee of the life insured's SMSF.

1. Please select your premium frequency.  Monthly  Half-yearly  Yearly  
Where AIA Vitality is being applied for, the AIA Vitality contribution payments will match the frequency of the premium payments on the relevant associated insurance policy.  
Please note: AIA Vitality contributions cannot be funded by superannuation, SMSF monies or from a platform account.

2. Are benefit indexation increases required?  Yes  No *Benefit indexation may automatically be applied if you do not select an option.*

3. Is a concurrent application for a Spouse being submitted? If 'Yes' please provide details. .... Yes  No

If 'Yes' and Section E (3) completed, refer above. .... Yes

Spouse surname

Spouse given name/s

Policy number (if known)

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

NOTE: AIA Australia underwriting does not have access to your AIA Vitality information (including health and medical information) unless you disclose that information as part of your insurance application. You must answer the questions in this section fully even if you already provided any of the information relevant to those questions in connection with AIA Vitality.

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 other 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' |
|---------------|-----------------|--------------|---------|---------------|-----------------|--|---------------------------|
|               |                 |              |         |               |                 |  |                           |
|               |                 |              |         |               |                 |  |                           |
|               |                 |              |         |               |                 |  |                           |

**IMPORTANT NOTES IF YOU ARE REPLACING AN EXISTING POLICY:** If you intend to replace an existing policy with an AIA Australia policy, we require that you must cancel your existing policy upon acceptance. Proof of cancellation of your existing policy will be required prior to payment of any AIA Australia claims. Cover under your AIA Australia policy will only start when the existing policy is cancelled. Failure to cancel your existing policy will render your AIA Australia policy void.

- (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), eg. Accident, Sickness, Workers Compensation, Disability Pension or Income Protection Insurance? If 'Yes' please give the name of the company, date, amount and reason for each claim below. .... Yes  No
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 (Please note 'packet' is not sufficient detail):
- (b) Do you drink alcohol? ..... Yes  No   
If 'Yes', please state how many standard drinks you consume per week on average (one standard drink = 30 ml spirits (one nip), 100ml wine, 10 oz/285 ml beer):
- (c) Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? ..... Yes  No
3. **Females Only:** Are you pregnant? If 'Yes', please provide estimated date child is due. .... / . / . .... Yes  No
4. (a) What is your height?  cm (b) What is your weight?  kg

If you answered 'Yes' to any of the above questions [except 1(a)] please provide details below. If insufficient space please attach a separate sheet of paper.

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), long-distance sailing, hang gliding, scuba diving, motor racing, parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? If 'Yes', please fill in Section O (Aviation or Activities/Pursuits Questionnaire). ..... Yes  No
6. Do you have definite plans to travel or reside overseas? ..... Yes  No

If 'Yes', please state:

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

### Family History

7. (a) Have any of your immediate family (father, mother, brother, sister), prior to the age of 60 (living or dead), ever suffered from:
- Heart disease or stroke? ..... Yes  No
  - Breast cancer, ovarian cancer, prostate cancer or colon (bowel) cancer? ..... Yes  No
  - Polycystic kidney disease or diabetes? ..... Yes  No
  - Mental disorder? ..... Yes  No
  - Huntington's chorea, Alzheimer's disease, Dementia, Motor neurone disease, Multiple sclerosis, Muscular dystrophy or Parkinson's disease? ..... Yes  No
  - Any other hereditary disease? ..... Yes  No

If 'Yes', please provide details in the table below.

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

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

- (b) Are you required to undergo any regular screening as a result of your family history? If 'Yes', please provide details..... Yes  No
- (c) Have you ever had a genetic test where you received (or are currently awaiting) an individual result or are you considering having a genetic test? If 'Yes', please provide details..... Yes  No

## H. Medical and Health History (Life insured to complete this section in full.)

*(If a medical examination is being arranged – complete question 8 on next page only. Note: This does not apply to short medicals.)*

1. 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?
- (a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke..... Yes  No
- (b) Asthma, chronic lung disease, sleep apnoea or other respiratory disorder..... Yes  No
- (c) Indigestion, gastric or duodenal ulcer, hernia/s or any bowel disorder..... Yes  No
- (d) Diabetes, abnormal blood sugar, gout or thyroid disorder..... Yes  No
- (e) Depression, anxiety/stress state, fatigue, panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder..... Yes  No
- (f) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness, tremor or recurrent headaches or any neurological disorder including multiple sclerosis..... Yes  No
- (g) Arthritis, repetitive strain injury (RSI), chronic fatigue syndrome, fibromyalgia..... Yes  No
- (h) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles..... Yes  No
- (i) Psoriasis or eczema, skin disorder or abnormality with hearing, eyesight or speech..... Yes  No

*If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections P to U). Please use Section U, Multi-Purpose Questionnaire, if a specific questionnaire for the condition is not provided.*

- (j) Cancer, cyst, lump, tumour or growth of any kind..... Yes  No
- (k) Liver, pancreas, prostate, kidney or bladder disorder, renal colic or stone..... Yes  No
- (l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia..... Yes  No
- (m) 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

Have you ever had or been advised to have treatment for:

- (n) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound?..... Yes  No
- (o) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?..... Yes  No
- (p) Abnormal vaginal bleeding within the last 12 months or endometriosis?..... Yes  No

*Questions 2 and 3 below are only applicable if TPD cover, Income Protection cover, Business Expenses cover, any optional Waiver of Premium or Forward Underwriting Benefit are being purchased.*

2. Have you ever been involved in an accident that has caused you to be off work or reduce your working capacity for greater than 10 consecutive days?..... Yes  No
3. Have you consulted a chiropractor, osteopath, physiotherapist or acupuncturist?..... Yes  No

*If you have answered 'Yes' to either of the above questions, please also complete the Multi-Purpose Questionnaire (Section U).*

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

## H. Medical and Health History (continued) (Life insured to complete this section in full.)

(If a medical examination is being arranged – complete question 8 below only. Note: This does not apply to short medicals.)

For each 'Yes' answer in questions 1(j) – 1(p), 4, 5, 6 and 7 on the previous page, 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) |
|--------------------|--------------------------|------------------------|---------------|-----------------------|------------------|--|--|
|                    |                          |                        |               |                       |                  |  |  |
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|                    |                          |                        |               |                       |                  |  |  |
|                    |                          |                        |               |                       |                  |  |  |

\* If the degree of recovery is less than 100% please complete the Multi-Purpose Questionnaire (see Section U).

### 8. Lifestyle Statement

- (a) Have you ever injected yourself with any illicit drugs not prescribed by a medical practitioner? ..... Yes  No

(If 'Yes' to question 8(a) above, a 'Drugs Questionnaire' is required.)

- (b) In the past 5 years have you:

(i) Engaged in male to male sexual activity **without** a condom (except in a relationship between you and only one other person where neither of you has had sex **without** a condom with anyone else in the past 5 years) or

(ii) Had sex **without** a condom:

- with someone you know or suspect to be HIV positive or
- with someone who injects non prescribed drugs or
- with a sex worker or as a sex worker?.....

Yes  No

(If 'Yes' to question 8(b) above, a 'Confidential Supplementary Personal Statement' is required.)

## I. 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 (if known) |          |

- (b) What was the date of your last consultation?

- (c) How long have you been attending this surgery or practice?

- (d) If less than 12 months, please provide the name and address of your previous personal doctor or medical centre.

|           |         |                  |          |
|-----------|---------|------------------|----------|
| Name:     |         |                  |          |
| Address:  |         |                  | Postcode |
| Phone ( ) | Fax ( ) | Email (if known) |          |

**Please note: A medical report is not always obtained.**

**Medical reports are obtained, however, on a random basis to check the validity of medical information provided.**



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

1. (a) Please give details of your **current and previous occupations** over the **last five (5) years**, including any period **unemployed, travelling, studying etc.**

|                      | From | To      | Principal/Main Occupation | Industry | Tick which is applicable |               |          |                      |
|----------------------|------|---------|---------------------------|----------|--------------------------|---------------|----------|----------------------|
|                      |      |         |                           |          | Employee of own company  | Self-employed | Employee | Business Partnership |
| Current Occupation   | / /  | Present |                           |          |                          |               |          |                      |
| Previous Occupations | / /  | / /     |                           |          |                          |               |          |                      |
|                      | / /  | / /     |                           |          |                          |               |          |                      |

- (b) What type of products or services do you or your employer sell?

- (c) Do you work from home more than 30% of your time? Yes  No

If 'Yes', give details including:

- (i) percentage of time working at home,  %

- (ii) office arrangement (i.e separate entrance, separate office etc),

- (iii) how often you are required to leave home as part of your duties,

- (iv) where you work at these times.

- (d) (i) What trade, professional, business or tertiary qualifications do you have?

- (ii) Date tertiary qualifications attained.  / /

- (iii) Is your tertiary qualification related to your occupation? Yes  No  N/A

- (e) What are the important income producing duties of your present occupation? Include all manual work performed.

| Duties (type of work and daily duties performed) | % of time |
|--|-----------|
| Sedentary/Admin:                                 | %         |
|  | %         |
|  | %         |
| Manual:  | %         |
|  | %         |
|  | %         |
| Other:   | %         |
|  | %         |
|  | 100 %     |

- (f) State the location where you perform your duties.

| Location (where do you perform your duties) | % of time |
|---|-----------|
|   | %         |
|   | %         |
|   | %         |
|   | %         |
|   | %         |
|   | %         |
|   | %         |
|   | %         |
|   | 100 %     |

- (i) How many hours per week do you work in your principal/main occupation?

- (ii) If more than 50, have you consistently worked these hours over the last 6 months? Yes  No

- (iii) How many weeks per year in your principal/main occupation?

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

(g) Please state your employment structure:

(i) Permanent Yes  No  or

(ii) Temporary (state date the position will cease/terminate)

Please advise if you work:

(iii)  Full time or

(iv)  Part time

Do you work:

(v) on a Casual basis (under a Casual work agreement) Yes  No  or

(vi) as a Contractor (please state expiry date of your contract)

If you have indicated that you work as a Casual or Contractor, please provide further details below including days worked as a casual or if your contract will be renewed.

(h) How much driving do you do as part of your occupation? (Commuting to your primary workplace should not be included.)

0–100 km per week  100–300 km per week  300–500 km per week  Over 500 km per week

(i) What percentage of your working hours is spent driving?

0% – 5%  5% – 10%  10% – 20%  Over 20%

2. What is your annual income? \$

3. (a) Do you have any other occupation? ..... Yes  No

(b) Do you contemplate or expect any change in occupation (including retrenchments/redundancy or changes in your role or duties or working hours)? ..... Yes  No

4. Does your occupation require you to work underground; at heights (above 10 metres); off-shore; or near dangerous materials or substances? If 'Yes', please give details below, eg. locations, depths, heights, frequency etc. .... Yes  No

5. Please confirm the amount of time you spend at each of the following activities as part of your occupation:

| Activity | % of time |
|----------|-----------|
| Sitting  | %         |
| Standing | %         |
| Walking  | %         |
| Bending  | %         |
| Climbing | %         |
| Kneeling | %         |
|          | 100 %     |

If you have indicated that you work as a Casual or Contractor above and/or answered 'Yes' to Question 3 a, 3 b or 4, please provide full details below.

## K. Further Occupational Information (Life insured to complete.)

If you are applying for TPD cover, Income Protection cover, Business Expenses cover, Waiver of Premium benefit and/or Forward Underwriting Benefit, please complete the additional questions below.

1. What is the business/employer name and address?

2. Do you have a percentage ownership in any other entities (eg. trusts, partnerships, companies, associations)? ..... Yes  No   
If 'Yes', please list all entities below.

| Name and address of each entity | State your business involvement in each entity<br>(eg.: Director, Silent Partner, Board Member) | Date Ownership Commenced | Ownership/ Shareholding (%) |
|---------------------------------|---|--------------------------|-----------------------------|
|                                 |   |                          |                             |
|                                 |   |                          |                             |
|                                 |   |                          |                             |
|                                 |   |                          |                             |

3. Are you or any business with which you are associated, contemplating voluntary administration, or ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? ..... Yes  No

If 'Yes', please complete AIA Australia Bankruptcy Questionnaire.

Date of discharge  /  /

If you are self-employed, in a business partnership or employee of own company, please complete the remaining questions.

4. Do you operate as a  sole trader  business partnership  company, or  trust?

5. (a) What percentage of your work is: Freelance?  % Contract?  %

(b) **Please note different requirements apply where Indemnity/Agreed Value or Extended Indemnity benefit types have been selected.**  
In the last 2 years (for Indemnity/Agreed Value) or 3 years (for Extended Indemnity) have there been any periods of 'no work' or 'unemployment' between contracts or freelance work? ..... Yes  No   
If 'Yes', please provide details.

(c) Is your work seasonal? Yes  No

6. (a) When was the business purchased/started?  / /

(b) Please state what percentage of interest/shareholding you have in the business/practice?  %

7. How many people do you employ?

8. Please provide employee details (excluding yourself) in the table below.

| Occupation of all Business Partners/Employees | Family Member Y/N | Daily Duties | Full-time Part-time or Contractor? | Monthly Remuneration | % Interest in Business |
|---|-------------------|--------------|------------------------------------|----------------------|------------------------|
|   |                   |              |                                    |                      |                        |
|   |                   |              |                                    |                      |                        |
|   |                   |              |                                    |                      |                        |
|   |                   |              |                                    |                      |                        |
|   |                   |              |                                    |                      |                        |

9. **Please note different requirements apply where Indemnity/Agreed Value or Extended Indemnity benefit types have been selected.**  
Has your company had a net operating loss in the last 2 years (for Indemnity/Agreed Value) or 3 years (for Extended Indemnity)? ..... Yes  No   
If 'Yes', please provide details of your company's profit and loss statements for all entities.

**L. Income Details** (Life insured to complete if Income Protection Plan is being purchased.)

1. What is your income from your current occupation? (Personal income is income earned by your personal exertion. Do not include investments.)

(a) **Employee**

Your income is the total remuneration paid by your employer including salary, fees, commission, regular bonuses, regular overtime, fringe benefits and superannuation contributions (statutory or voluntary).

**Where the benefit type selected is Extended Indemnity provide information for:**

|                      |                           |                      |                               |                      |                            |                      |
|----------------------|---------------------------|----------------------|-------------------------------|----------------------|----------------------------|----------------------|
|                      | Last financial year 30/6/ | <input type="text"/> | Previous financial year 30/6/ | <input type="text"/> | Third financial year 30/6/ | <input type="text"/> |
| Remuneration package | \$                        | <input type="text"/> | \$                            | <input type="text"/> | \$                         | <input type="text"/> |

(b) **Self Employed (sole trader, business partner, employee of own company)**

Refer to the Priority Protection for Platform Investors Product Disclosure Statement for the definition of Income (Self-employed Persons).

|   |                           |                         |                               |                         |                            |                         |
|---|---------------------------|-------------------------|-------------------------------|-------------------------|----------------------------|-------------------------|
|   | Last financial year 30/6/ | <input type="text"/>    | Previous financial year 30/6/ | <input type="text"/>    | Third financial year 30/6/ | <input type="text"/>    |
| Gross business income/revenue   | \$                        | <input type="text"/>    | \$                            | <input type="text"/>    | \$                         | <input type="text"/>    |
| Total business expenses   | -                         | \$ <input type="text"/> | -                             | \$ <input type="text"/> | -                          | \$ <input type="text"/> |
| Net business profit/loss (before tax)   | =                         | \$ <input type="text"/> | =                             | \$ <input type="text"/> | =                          | \$ <input type="text"/> |
| % Share of net business income  |                           | <input type="text"/> %  |                               | <input type="text"/> %  |                            | <input type="text"/> %  |
| Add backs (your own portion of personal salary/wages, superannuation contributions, spouse's income if income splitting, share of depreciation) | +                         | \$ <input type="text"/> | +                             | \$ <input type="text"/> | +                          | \$ <input type="text"/> |
| Total net earned income (before tax)  | =                         | \$ <input type="text"/> | =                             | \$ <input type="text"/> | =                          | \$ <input type="text"/> |

**Note: These figures disclosed should coincide with returns lodged with the Australian Taxation Office.**

2. Please note different requirements apply where Indemnity/Agreed Value or Extended Indemnity benefit types have been selected.

Is your current remuneration package or net income different than that stated above for the last financial year (for Indemnity/Agreed Value) or 2 years (for Extended Indemnity)? ..... Yes  No

If 'Yes', state reasons for the change below. Current income \$

3. Do you earn commission or bonuses? ..... Yes  No

If 'Yes', please state percentage of total income.  %

4. If providing financial evidence, have you provided full financial documentation\* for all entities listed in Section K, Question 2? ..... Yes  No

If 'No', please provide reason/s.

**Please note different requirements apply where Indemnity/Agreed Value or Extended Indemnity benefit types have been selected.**

\*Income Tax Returns and Profit & Loss statements for the last 2 years (for Indemnity/Agreed Value) or 3 years (for Extended Indemnity).

5. Will any of your income (from any source) continue if you become disabled? ..... Yes  No

If 'Yes', state source (eg. sick leave, directors' fees, salary, renewal or trail commission, salary continuance insurance, profit share from the business etc?)

(a) For how long will it continue?

(b) Amount of income (per month). \$

(c) Is there an agreement in place in the business/practice limiting profit share or other income in the event of disability? ..... Yes  No

If 'Yes', provide details.

6. Do you receive any unearned income from investments (eg. rental property, dividends etc.)? ..... Yes  No

If 'Yes', please state the amount per month (net of costs and expenses). \$  (Do not include negatively geared investments)

Please state the source.

7. If you have a second occupation, please provide the following details.

|                           |                         |                                 |                         |                                 |   |
|---------------------------|-------------------------|---------------------------------|-------------------------|---------------------------------|---|
| Nature of occupation      | <input type="text"/>    |                                 |                         |                                 | <b>Where the benefit type selected is Extended Indemnity provide information for:</b> |
| Hours worked per week     | <input type="text"/>    | Number of weeks worked per year | <input type="text"/>    | Number of weeks worked per year | <input type="text"/>  |
| Last financial year 30/6/ | <input type="text"/>    | Previous financial year 30/6/   | <input type="text"/>    | Third financial year 30/6/      | <input type="text"/>  |
| Net income (before tax)   | \$ <input type="text"/> | Net income (before tax)         | \$ <input type="text"/> | Net income (before tax)         | \$ <input type="text"/>   |

## M. Business Expenses

(Life insured to complete this section in full only if Business Expenses/Incorporated Business Expenses is being purchased.)

1. Please state the value of all monthly business expenses. (**Do not include** personal remuneration, mortgage principal, depreciation on real estate, cost of goods, wares and merchandise, equipment, fixtures and fittings, salaries of revenue producing employees.)

**Alternatively, the supply of copies of taxation returns and profit and loss statements for all entities associated with your business will be accepted in place of completing the details below.**

| Eligible Expenses   | Monthly Expenses        |
|---|-------------------------|
| (a) Rent, property rates and taxes* .....   | \$ <input type="text"/> |
| (b) Insurance of premises (eg. fire etc)* .....   | \$ <input type="text"/> |
| (c) Security costs* .....   | \$ <input type="text"/> |
| (d) Electricity, gas, water, heating, telephone and cleaning* .....   | \$ <input type="text"/> |
| (e) Mobile phone .....  | \$ <input type="text"/> |
| (f) Bank fees/charges and interest repayments on business loans .....   | \$ <input type="text"/> |
| (g) Hire and lease of plant and equipment .....   | \$ <input type="text"/> |
| (h) Business insurance premiums (eg. liability, professional indemnity) .....   | \$ <input type="text"/> |
| (i) Membership fees, publications and subscriptions to professional bodies .....  | \$ <input type="text"/> |
| (j) Accountant's and auditor's fees .....   | \$ <input type="text"/> |
| (k) Regular advertising expenses, postage, printing and stationery .....  | \$ <input type="text"/> |
| (l) Salaries and costs of employees who <b>do not</b> generate revenue (eg.: superannuation contributions, payroll tax, workers' compensation for employees who <b>do not</b> generate revenue) ..... | \$ <input type="text"/> |
| (m) Net cost of locum, ie. cost to employ less revenue generated by locum .....   | \$ <input type="text"/> |
| (n) Other fixed business expenses – <b>please specify</b> .....   | \$ <input type="text"/> |
| .....   | \$ <input type="text"/> |
| .....   | \$ <input type="text"/> |
| .....   | \$ <input type="text"/> |
| .....   | \$ <input type="text"/> |
| (o) <b>Total Monthly Business Expenses</b> .....  | \$ <input type="text"/> |

\*Not insurable if working from home

2. What percentage of Monthly Business Expenses are you responsible for/liable to pay?.....  %

# N. Family Protection, Carer's Allowance, School Fees Protector

(Policy Owner to complete if purchasing one or more of these benefits.)

## Child 1 (Personal Details)

**Note: If you are applying for the School Fees Protector benefit but not for the Family Protection or Carer's Allowance benefit, you only need to complete questions 1 to 5 in respect of each insured Child.**

1. Surname   
Given name

2. Sex  3. Country of birth

4. Date of birth  /  /  5. Age next birthday

6. Is the child a permanent resident of Australia?  Yes  No

7. State your relation to the child.

8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for?  Yes  No  
If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms?  Yes  No  
If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment?  Yes  No  
If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury?  Yes  No  
If 'Yes', please give details below.

|                                      |                  |   |                       |
|--------------------------------------|------------------|---|-----------------------|
| Illness or injury:                   | Date started:    | / | /                     |
| Details of treatment:                |                  |   |                       |
| Length of treatment:                 | Time off school: |   |                       |
| Date of last symptom:                | /                | / | Degree of recovery: % |
| Name and address of doctor/hospital: |                  |   |                       |
| <input type="text"/>                 |                  |   |                       |

12. Name and address of the child's family doctor.

13. Has the child's biological mother or father or any brother or sister suffered from diabetes, cancer, heart disease, haemophilia, Huntington's disease, polycystic kidney disease or any other hereditary disease?  Yes  No  
If 'Yes', please give details below.

| Family Member (relationship to child) | Condition/Illness (for cancer/heart disease – specify type) | Age at onset         | Age at death         |
|---------------------------------------|---|----------------------|----------------------|
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |

## Child 2 (Personal Details)

**Note: If you are applying for the School Fees Protector benefit but not for the Family Protection or Carer's Allowance benefit, you only need to complete questions 1 to 5 in respect of each insured Child.**

1. Surname   
Given name

2. Sex  3. Country of birth

4. Date of birth  /  /  5. Age next birthday

6. Is the child a permanent resident of Australia?  Yes  No

7. State your relation to the child.

8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for?  Yes  No  
If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms?  Yes  No  
If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment?  Yes  No  
If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury?  Yes  No  
If 'Yes', please give details below.

|                                      |                  |   |                       |
|--------------------------------------|------------------|---|-----------------------|
| Illness or injury:                   | Date started:    | / | /                     |
| Details of treatment:                |                  |   |                       |
| Length of treatment:                 | Time off school: |   |                       |
| Date of last symptom:                | /                | / | Degree of recovery: % |
| Name and address of doctor/hospital: |                  |   |                       |
| <input type="text"/>                 |                  |   |                       |

12. Name and address of the child's family doctor.

13. Has the child's biological mother or father or any brother or sister suffered from diabetes, cancer, heart disease, haemophilia, Huntington's disease, polycystic kidney disease or any other hereditary disease?  Yes  No  
If 'Yes', please give details below.

| Family Member (relationship to child) | Condition/Illness (for cancer/heart disease – specify type) | Age at onset         | Age at death         |
|---------------------------------------|---|----------------------|----------------------|
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |

# N. Family Protection, Carer's Allowance, School Fees Protector

(Policy Owner to complete if purchasing one or more of these benefits.)

## Child 3 (Personal Details)

Note: If you are applying for the School Fees Protector benefit but not for the Family Protection or Carer's Allowance benefit, you only need to complete questions 1 to 5 in respect of each insured Child.

1. Surname   
Given name

2. Sex  3. Country of birth

4. Date of birth  /  /  5. Age next birthday

6. Is the child a permanent resident of Australia?  Yes  No

7. State your relation to the child.

8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for?  Yes  No  
If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms?  Yes  No  
If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment?  Yes  No  
If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury?  Yes  No  
If 'Yes', please give details below.

|                                      |                       |
|--------------------------------------|-----------------------|
| Illness or injury:                   | Date started: / /     |
| Details of treatment:                |                       |
| Length of treatment:                 | Time off school:      |
| Date of last symptom: / /            | Degree of recovery: % |
| Name and address of doctor/hospital: |                       |
| <input type="text"/>                 |                       |

12. Name and address of the child's family doctor.

13. Has the child's biological mother or father or any brother or sister suffered from diabetes, cancer, heart disease, haemophilia, Huntington's disease, polycystic kidney disease or any other hereditary disease?  Yes  No  
If 'Yes', please give details below.

| Family Member (relationship to child) | Condition/Illness (for cancer/heart disease – specify type) | Age at onset         | Age at death         |
|---------------------------------------|---|----------------------|----------------------|
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |

## Child 4 (Personal Details)

Note: If you are applying for the School Fees Protector benefit but not for the Family Protection or Carer's Allowance benefit, you only need to complete questions 1 to 5 in respect of each insured Child.

1. Surname   
Given name

2. Sex  3. Country of birth

4. Date of birth  /  /  5. Age next birthday

6. Is the child a permanent resident of Australia?  Yes  No

7. State your relation to the child.

8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for?  Yes  No  
If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms?  Yes  No  
If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment?  Yes  No  
If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury?  Yes  No  
If 'Yes', please give details below.

|                                      |                       |
|--------------------------------------|-----------------------|
| Illness or injury:                   | Date started: / /     |
| Details of treatment:                |                       |
| Length of treatment:                 | Time off school:      |
| Date of last symptom: / /            | Degree of recovery: % |
| Name and address of doctor/hospital: |                       |
| <input type="text"/>                 |                       |

12. Name and address of the child's family doctor.

13. Has the child's biological mother or father or any brother or sister suffered from diabetes, cancer, heart disease, haemophilia, Huntington's disease, polycystic kidney disease or any other hereditary disease?  Yes  No  
If 'Yes', please give details below.

| Family Member (relationship to child) | Condition/Illness (for cancer/heart disease – specify type) | Age at onset         | Age at death         |
|---------------------------------------|---|----------------------|----------------------|
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/> | <input type="text"/> |

**O. Aviation Questionnaire**

- Please state the number of hours flown where applicable:
  - 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"/> |
  - 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"/> |
  - 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"/> |
- Are your flying activities:
   
 Recreational, or  Required for your occupation?
   
Please provide details.
- Name of aircrafts flown.
  - Make and model of the aircrafts.
  - If pilot only.**
    - Age of the aircrafts flown.
    - Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced?  Yes  No
- Do you fly or intend to fly outside Australia?  Yes  No
   
If 'Yes', please provide details.
- 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
- Have you ever been involved in any aviation accidents? If 'Yes', please provide details.  Yes  No

**O. Activities/Pursuits Questionnaire**

- Please describe the activity or pursuit.
- Please advise the number of times you engage in the activity per year.
- How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?
- What qualifications, certificates, licences, associations and club memberships do you hold?
- How long have you been involved in this activity?
- Where do you engage in this activity and in what locations?
- Do you ever engage in this activity alone, or are you always with a group?
- Do you compete in this activity?  Yes  No
   
If 'Yes', please advise the level of competition and names of events.
- Do you receive any payments for your involvement in this activity?  Yes  No
   
If 'Yes', please advise details.
- Please advise the maximum heights, speeds, depths the activity includes.
- Are any of the above likely to change over the next 2 years?  Yes  No
   
If 'Yes', please provide full details.
- Are you involved in any record attempts?  Yes  No
   
If 'Yes', please provide details.
- Are all recognised/standard safety measures and precautions followed? Please provide any additional details.
- 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.
- Have you ever been involved in any accident/mishap whilst participating in this activity?  Yes  No
   
If 'Yes', please provide details.



**P. 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.

**Q. 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.

**R. 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.

**S. 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.

**T. Check-up Questionnaire**

1. Please state the reason/s for your regular check-up/blood test.

|  |
|--|
|  |
|--|

2. Please state the dates of your last two check-ups and results.

| Date | Details | Results | Name of doctor |
|------|---------|---------|----------------|
|      |         |         |                |
|      |         |         |                |
|      |         |         |                |
|      |         |         |                |

3. Were any test/s or further investigation/s performed?  Yes  No  
If 'Yes', please provide details or attach copies of reports.

| Date | Type of tests/investigations | Results |
|------|------------------------------|---------|
|      |                              |         |
|      |                              |         |
|      |                              |         |
|      |                              |         |
|      |                              |         |

4. Was any treatment prescribed?  Yes  No  
If 'Yes', please provide details.

| Date | Type of treatment<br>(eg. medications & dosage, physiotherapy, procedures, etc) |
|------|---|
|      |   |
|      |   |
|      |   |
|      |   |

5. Are you required to return for a follow up?  Yes  No  
If 'Yes', please state when and reason.

|  |
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**U. Multi-Purpose Questionnaire  
(may be photocopied for additional conditions)**

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.

|  |
|--|
|  |
|--|

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## V. Private/Self-Managed Superannuation Fund

The following is to be completed where the benefit is to be owned by the Trustee of a Private/Self-Managed Superannuation Fund.  
Please note: the Trustee is also required to complete the Declaration in Section W.

When selecting benefits please ensure that the benefits can be paid from a superannuation fund in accordance with the Superannuation Industry (Supervision) Act 1993 (SIS Act). Please note there may be situations where even though a benefit, such as a Total and Permanent Disablement benefit, is paid to the trustee of the superannuation fund, superannuation legislation or the rules of the superannuation fund may prevent the release of the benefit.

### Declaration

I/We, the trustee/s of the superannuation fund named below, request AIA Australia to issue the insurance policy/ies described on this form. The policy document/s will be held subject to the rules of the superannuation fund.

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

I/We confirm that the superannuation fund of which I am/we are trustee is a complying superannuation fund within the meaning of the Superannuation Industry (Supervision) Act 1993 (**SIS Act**) and Income Tax Assessment Act (Tax Act).

I/We undertake to advise AIA Australia immediately if the superannuation fund at any time ceases to be a complying fund as defined in the SIS Act and/or the Tax Act.

I/We confirm that I/we have the power under the trust deed governing the superannuation fund to effect the policy/ies described on this form.

### Details of policy owner/s

To be completed by the trustee/s of the superannuation fund which will own the policy/ies.

Full name of the superannuation fund

ABN/ACN

Trustee's address for communications

State

Postcode

Phone (home)

Phone (work)

### Corporate Superannuation Trustee details

Company Trustee name

ABN/ACN

If applicable, the common seal of: (name of Corporate Trustee)

Was hereto affixed in accordance with the Constitution of the company in the presence of:

Director Signature

Director/Company Secretary Signature

Date (dd/mm/yyyy)

If you are a sole director please tick here.

For Corporate Trustee, this section is to be signed either by: (1) Two directors; or (2) one director and company secretary; or (3) for a proprietary company that has a sole director who is also the sole company secretary, that director.

If you completed this section, please also complete Section W Number 2.

And/or

### Non-corporate Superannuation Trustee

#### First Individual Trustee

Title

Surname

Given Name/s

Signature

Date (dd/mm/yyyy)

#### Third Individual Trustee

Title

Surname

Given Name/s

Signature

Date (dd/mm/yyyy)

#### Second Individual Trustee

Title

Surname

Given Name/s

Signature

Date (dd/mm/yyyy)

#### Fourth Individual Trustee

Title

Surname

Given Name/s

Signature

Date (dd/mm/yyyy)

For individual trustees, this section is to be signed either by: (1) All individual trustees; or (2) for single member fund, minimum 2 individual trustees.

If you completed this section, please also complete Section W Number 3.

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## W. Financial Adviser Authority

This section needs to be completed if you wish to allow your financial adviser to provide AIA Australia with instructions relating to your policies on your behalf and to authorise AIA Australia to accept those instructions. If you allow your financial adviser to provide AIA Australia with instructions on your behalf, this authority will apply to in relation to the policy contemplated by this application form and any other retail life insurance policies underwritten by AIA Australia (and associated AIA Vitality membership/s) where the policies are arranged by your adviser as long as those policies cover a Life Insured who has signed this form and is owned by any of the Policy Owners who sign this form ('your policies').

To establish the adviser authority, all Policy Owners, Lives Insured and their adviser need to complete and sign this application form.

**NOTE: If the identity of one of the Policy Owners, one of the Lives Insured or the adviser, changes after this authority takes effect, a new authority will be required.**

The financial adviser nominated in this application form will have authority to instruct on the following matters relating to your policies as well as any AIA Vitality membership/s referable to your policies:

- Credit card expiry update
- Change of address or other contact details
- Change of payment details (where a completed credit card authority or direct debit request has been provided by the Policy Owner)
- Removing/decreasing a benefit or other policy feature or AIA Vitality feature
- Adding/amending or terminating an AIA Vitality membership
- Change in cover due to age parameters
- Cancel cover/policy
- Change occupation class
- Change of premium pattern
- Change of smoker status
- Instructions relating to benefit indexation on your policy/policies
- Suspending premium payments
- Reinstating a policy where underwriting is not required
- Apply to remove loadings or exclusions
- Removing payment details (stop debits)

### IMPORTANT NOTES

The authority allows the adviser to give instructions on your behalf in connection with the matters described in the bullet points above and authorises AIA Australia to accept those instructions. This means, for example, that your adviser will be able to instruct us to make changes to your policy/policies or AIA Vitality membership/s and we may make those changes without confirming the adviser's instructions directly with you in some circumstances.

**AIA Australia may not have the functionality to accept every type of instruction on your behalf at any given time. The adviser authority features are being progressively rolled out.**

Accordingly, AIA Australia reserves the right to request additional information, forms, documents or confirmations from a person (including from the Policy Owner/s, the Lives Insured, the adviser or another person) before an instruction is processed.

Under the terms of this authority, the Policy Owner/s and the Lives Insured will generally be responsible for the adviser's conduct under this authority and AIA Australia will not generally be responsible for such conduct (subject to applicable law).

If required, you should obtain your own legal or other professional advice before signing this authority.

### GENERAL TERMS

- This authority will take effect on the date the policy or policies resulting from this application are issued, or for existing policies, from the date this application is processed.
- All Policy Owner/s, Lives Insured and the adviser must agree to this authority in order for it to take effect.
- This authority applies to any retail life insurance policy underwritten by AIA Australia and associated AIA Vitality membership/s where the policy is owned by the Policy Owner/s signing this form, covers the Lives Insured signing this form and is arranged by the adviser signing this form.
- AIA Australia excludes all liability in relation to this authority, except that which cannot be excluded by law.
- AIA Australia may, at its sole and absolute discretion, immediately terminate any authority given to the adviser nominated below at any time by notifying the Policy Owner/s, and the Lives Insured if relevant, in writing.
- This authority will immediately terminate in respect of a policy on cancellation of that policy and AIA Australia may also terminate this authority in its discretion in respect of a policy on death of the Policy Owner or Life Insured under that policy.
- AIA Australia may, at its sole and absolute discretion, decline to act on an instruction received from an adviser under this authority or may choose not to act on such an instruction unless a person (including the adviser, Policy Owner/s or Lives Insured or another person) provides additional information, forms, documents or confirmations requested by and satisfactory to AIA Australia.
- AIA Australia may, at its sole and absolute discretion and at any time, conduct an audit of the adviser's performance of its obligations under this authority.
- The adviser nominated below may not appoint any third party (including, without limitation, the adviser's support staff) to give instructions to AIA Australia that the adviser is permitted to give under this authority.
- For the avoidance of doubt, this authority does not require AIA Australia to act on instructions that would not be valid if provided by the Policy Owner/s or Lives Insured.
- If the Policy Owner/s and Lives Insured if relevant, cease their relationship with the adviser nominated in this application form, this authority will terminate.
- If the adviser nominated in this application form moves to a new adviser firm or dealer group and retains a relationship with the Policy Owner/s, and if relevant the Lives Insured, AIA Australia may, at its sole and absolute discretion and provided the new adviser firm or dealer group has an existing distribution agreement with AIA Australia, allow this authority to continue.
- The adviser nominated in this application form agrees to abide by all instructions issued by AIA Australia in relation to this authority (including, without limitation, document retention instructions) and indemnifies AIA Australia for losses sustained by AIA Australia as a result of a failure to abide by such instructions.
- In the case where there is more than one Policy Owner, the adviser must obtain and confirm instructions from all Policy Owners and, where relevant, the Lives Insured.

Do you wish to appoint the financial adviser nominated in this application form under this authority?  Yes  No

If yes, the financial adviser nominated will be able to provide AIA Australia with instructions relating to your policies (including the policy contemplated by this application form and any other retail life insurance policies underwritten by AIA Australia (and associated AIA Vitality membership/s)) on your behalf and AIA Australia will be authorised to accept those instructions.

## X. Declaration and Privacy Notification (Life insured and Policy Owner/s must complete this section.)

### Privacy Notification

Personal and sensitive information provided will be handled in the manner described in the AIA Australia Privacy Policy as updated from time to time, accessible by visiting our website at [www.aia.com.au](http://www.aia.com.au), or by contacting us on 1800 333 613 to request a copy. AIA Australia 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 our Privacy Policy. By providing information to us or your adviser (and the Australian financial services licensee 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 AIA Australia Privacy Policy as updated from time to time on our website. We rely on the accuracy of the personal information provided to us. If any of your personal information reflected in this form or any of the attachments is 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 us with personal and sensitive information about someone else, you must have their consent to provide their information to us in the manner described in the AIA Australia Privacy Policy.

#### **Adviser appointment – Policy Owner and Life Insured**

**Please read this important section and make sure you understand it, obtain advice in relation to it (if required) and agree to it before submitting your application.**

You agree to appoint advisers assisting you with your insurance application (and AIA Vitality application, if relevant) to progress and finalise it on your behalf and to arrange for the policy to be issued without further involvement from you.

By signing this application you (being the proposed Policy Owner and the proposed Life Insured) agree that:

- your adviser is authorised to provide any further instructions, information, consents or declarations in relation to your insurance application (and your AIA Vitality application, if relevant) on your behalf and that we can request and rely on such instructions, information, consents or declarations from your adviser without further confirmation from you;
- where we offer to provide insurance cover on special terms (including, without limitation, premium loadings or special exclusions), you authorise your adviser to accept those special terms on your behalf. Where this occurs, you agree that we may rely on such acceptance by your adviser as if you accepted those special terms without further confirmation from you;
- we, or persons acting on our behalf, may verify any instruction, information, consents, declarations or agreement received from your adviser in our absolute discretion before acting on it. However, we are not obliged to do so and our failure to do so does not mean that we have waived our right to rely on the instruction, information, consents, declarations or agreement received from your adviser.
- you agree to indemnify us against all loss or liabilities and costs incurred as a result of this adviser appointment, except to the extent that we remain liable for such losses or liabilities by operation of a law that we cannot exclude.


#### **Financial Adviser Authority – if you ticked ‘Yes’ under section W. Financial Adviser Authority – Policy Owner and Life Insured**

- I/We jointly and separately indemnify AIA Australia against any claim, liability, loss, damage, expense (including legal costs on a full indemnity basis) that I/we suffer as a result of AIA Australia acting on instructions received from the adviser nominated above.
- I/We agree to immediately notify AIA Australia in writing if I/we wish to revoke or alter the authority given to the adviser nominated under this application form.
- I/We have read and agree with the information in section W of this application form, including the important notes, the general terms and this declaration. I/We appoint the adviser nominated under this application form to instruct AIA Australia in accordance with the information contained in section W and otherwise in accordance with the terms of this authority. I/We authorise AIA Australia to accept those instructions (in its discretion) as if those instructions were provided by me/us.

### Declaration

Life insured and Policy Owner/s must complete this section (or if applying on-line, have declared the following) except where the Life Insured and/or Policy Owner is under 16, where in such circumstances the parent/guardian of that Life Insured and/or Policy Owner must complete this section (or if applying on-line, have declared the following) on behalf of the Life Insured and/or Policy Owner.

- I/We declare that the information contained in the personal statements (whether written in my/our hand or not, attached, input into the computer using the electronic application system or are otherwise provided to AIA Australia in any manner that is acceptable to AIA Australia) is true and correct and that no information material to the insurance has been withheld.
- Where I/we have completed the personal statements electronically using the electronic application system, I/we acknowledge that AIA Australia will send a copy of the statements I/we have provided to my personal address, that I/we must review this information and advise AIA Australia of any inaccuracies or omissions, and of any changes in health or circumstances up until the time a policy is issued.
- I/We agree that any personal statements made, completed electronically or otherwise provided to AIA Australia in any manner that is acceptable to AIA Australia together with any relevant documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I/We acknowledge that these personal statements may result in certain exclusions or special acceptance terms becoming applicable to me. Where my/our adviser has indicated that the exclusions or special terms may apply, each of these exclusions and special acceptance terms has been explained to me/us. I/We confirm that I/we understand those terms and where they are applicable to me/us I/we agree to be bound by them.
- I/We have read the Priority Protection Product Disclosure Statement or the Priority Protection for Platform Investors Product Disclosure Statement (as applicable) (PDS) and any relevant Supplementary PDS (SPDS), current at the time of this application, including Your Duty of Disclosure notice set out in the Significant Risks section and understand its contents and what is meant by my/our duty to disclose.
- To the maximum extent permissible by law, I/We agree to receive any communications relating to AIA Australia's products and services electronically, including by way of a physical or electronic notice (such as an email, SMS, facsimile, webpage transmitted to a browser or other notice transmitted via any other electronic means that contains a hyperlink to the communication). Such communications may include (without limitation) the PDS, policy documents (including any schedules and endorsements), Financial Services Guide (FSG) as well as other disclosure documents and communications. For example (and without limitation) I/we agree to receive the PDS, policy document (including any endorsements and schedules) and policy related communications, via email or by accessing a webpage that contains hyperlinks to such documents and communications. Electronic communications must be regularly checked and it is my/our responsibility to ensure that I/we provided to AIA Australia an up to date, unblocked and unfiltered electronic address, if requested by AIA Australia.
- I/We warrant that, where this application is being submitted on behalf of a business partnership, I/we are authorised by and directed on behalf of the business partnership to enter into this contract of insurance and to do all things necessary to ensure the business partnership satisfies all of its obligations under this contract of insurance.
- I/We understand that if I/we have indicated I/we intend to replace an existing policy with this AIA Australia policy, I/we will be required to cancel my/our existing policy. I/We acknowledge that in this case the replacement policy issued by AIA Australia only starts when my/our existing policy is canceled. I/We acknowledge that failure to cancel my/our existing policy within a reasonable time will render my/our AIA Australia policy void.
- I/We agree that cover will not commence until AIA Australia has accepted the risk under my/our policy.
- I/We also understand that my/our duty to disclose continues after I/we have completed this application until AIA Australia has accepted the risk under my/our policy. I/We understand that AIA Australia underwriting does not have access to my/our AIA Vitality information (including health and medical information) unless I/we disclose that information as part of my/our insurance application. I/We understand that any health, medical or other information

Continued overleaf 



## X. Declaration and Privacy Notification (continued) (Life insured and Policy Owner/s must complete this section.)

that may affect the risk under my/our policy needs to be provided to AIA Australia underwriting (including in this form) even if it was also provided as part of the Life Insured's participation in AIA Vitality.

- If I/we am/are a Policy Owner, in that capacity I/we agree that the premium relating to my/our policy may be discounted in some circumstances based on the Life Insured's conduct in respect of AIA Vitality where the Life Insured is a member of AIA Vitality. This declaration is part of my/our application for Priority Protection or Priority Protection for Platform Investors despite anything to the contrary in this document.
- I/We acknowledge and confirm that the discounts and benefits in respect of AIA Vitality are not guaranteed and AIA Australia reserves the right to vary or withdraw the discounts and benefits or the AIA Vitality product.
- I/We have been notified of, have read and consented to the handling, collection, use and disclosure of my/our personal and sensitive information, including the exchange of personal and sensitive information with third parties located in Australia and overseas in the manner described in the Privacy section in the current PDS and any relevant SPDS and the Privacy Policy on the AIA Australia website [www.aia.com.au](http://www.aia.com.au) and on the AIA Vitality website [www.aiavitality.com.au](http://www.aiavitality.com.au) which were provided to me/us. I/We agree that any personal information AIA Australia holds will be governed by the most current Privacy Policy. I/We agree that Australian Privacy Principle 8.1 will not apply to the disclosure of personal and sensitive information overseas, and I/we understand that AIA Australia will not be accountable for those overseas parties and I/we may not be able to seek redress under the Privacy Act for breaches by overseas parties. I/We also agree that AIA Australia may update its Privacy Policy from time to time by posting an updated version on these websites and that a separate notice about the Privacy Policy may not be provided in each instance of collection.
- I/We confirm that AIA Australia and its related entities, subsidiaries, affiliates and partners may use my/our personal information to provide marketing communications that may be of interest to me/us, including about insurance and financial products and services, wellness products and services and, if I am a member of AIA Vitality, products and services of our AIA Vitality partners. Communications may be provided on an ongoing basis by telephone, electronic messages (e.g. email and pop-ups), online (including websites and mobile apps) and other means. If I/we do not wish to receive these marketing communications I/we will follow unsubscribe instructions in the communications themselves where prompted or contact AIA Australia on 1800 333 613.
- If I/we am/are a Policy Owner who is/are a natural person applying for an ordinary money Priority Protection or Priority Protection for Platform Investors policy, I/we agree to pay fees that the Life Insured is required to pay in respect of the Life Insured's AIA Vitality membership on behalf of the Life Insured unless otherwise agreed with AIA Australia and to the extent permitted by law. This declaration is not part of my/our application for Priority Protection or Priority Protection for Platform Investors despite anything to the contrary in this document.
- I/We authorise and consent to AIA Australia disclosing information that relates to me/us or to the insurance policy and/or AIA Vitality membership referable to this application to my/our adviser and the licensed dealer or broker they represent), my/our distributor, to the Policy Owner of any eligible AIA Australia insurance policy that I am insured under and/or the Life Insured under my policy (as applicable) and to their related parties including if applicable, the platform operator to which this application relates. Such information may include (without limitation), personal and sensitive information including lifestyle, health and medical information that relates to my/our application or that relates to the ongoing servicing and administration of insurance (including, without limitation, in relation to insurance claim management and assessment) and/or my AIA Vitality membership and other information such as my AIA Vitality status, membership number, whether I have purchased or used certain devices and/or accessories or whether I have visited or used certain AIA Vitality partners, to earn AIA Vitality points.
- I/We authorise and consent to any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter) disclosing to AIA Australia personal and sensitive information about me, including full details of my health and medical history. I/We understand and agree that any photocopy, email or facsimile of these declarations (or any part thereof) should be considered as effective and valid as the original and that AIA Australia may provide a copy of this authority (or any part thereof) to any third party to evidence authority and consent for disclosure.
- If this is an application for Priority Protection for Platform Investors I/we acknowledge there is a valid and current account in my/our name with the platform operator to which this application relates and that I/we have provided all of the information required about this account in this application form.
- Where I am the Life Insured and I have indicated that I would like to apply for an AIA Vitality membership, I declare that:
  - I have read the terms and conditions of AIA Vitality that were provided to me together with this application (also available on the AIA Vitality Member website at [www.aiavitality.com.au](http://www.aiavitality.com.au)) and I agree to those terms. I do so in my personal capacity and not in my capacity as a Policy Owner under an eligible life insurance policy or a member of a superannuation fund.
  - I consent to receive information about AIA Vitality electronically to the email address indicated in this form. Electronic communications must be regularly checked and it is my responsibility to ensure that I provided to AIA Australia an up to date, unblocked and unfiltered email address and that email from AIA Australia is not filtered. I acknowledge that hard copies of AIA Vitality information may not always be provided but that they may be sent at AIA Australia's discretion. I may withdraw my consents by following the unsubscribe instructions in the communications themselves.
  - I understand and agree that the AIA Vitality section of this application and (unless otherwise indicated) any consents, declarations, authorities and other matters relating to AIA Vitality in this application are not part of the application for Priority Protection or Priority Protection for Platform Investors and are part of my application for AIA Vitality.

A copy of the quotation is attached to this application

**Note:** This application form was designed for the product with the name and version listed on the top of first page and summarised in the code at the bottom of most pages in this application form.

AIA Australia may, in its absolute discretion, accept the information and statements you provide in an application form (including your agreement to any declarations) even when the application form was not designed for the product and version for which you are applying. In these circumstances, AIA Australia may treat such information and statements as being part of your application for insurance (and AIA Vitality, if relevant). AIA Australia may also, in its absolute discretion, require that you provide additional information or statements or that you complete further forms or that you provide further agreements or consents before your application is progressed.

**To help avoid delays in processing your application, please ensure that the product and version in this application form (see the top of page 1) corresponds to the product name and version you are applying for as per your quotation.**

**Note:** Your premium(s) will be held in a trust account administered by us until the policy is issued to you.

Signature of Life Insured

X

Name of Life Insured

Date

/ /

If the Life Insured is under 16 years old, please provide parent or guardian details.

Signature of parent/guardian

X

Name of parent/guardian

Date

/ /

Continued overleaf 

## X. Declaration and Privacy Notification (continued) (Life insured and Policy Owner/s must complete this section.)

Not applicable to policies owned by netwealth Superannuation Master Fund.

### POLICY OWNER/S (Please complete one section below)

#### 1. Individual/s

Signature of Policy Owner 1  Date

Name of Policy Owner 1

Signature of Policy Owner 2  Date

Name of Policy Owner 2

#### 2. Company/Corporate Trustee/Business Partnership

Executed by (Company/Business Partnership Name)  Company/Business Partnership ABN/ACN

Signature of Director/Business Partner  Date

Name of Director/Business Partner

Signature of Director/Secretary/Business Partner  Date

Name of Director/Secretary/Business Partner

If you are a sole director please tick here.

When a company is to be the policyholder it is important that the application is signed either by: (1) Two directors; or (2) one director and company secretary; or (3) for a proprietary company that has a sole director who is also the sole company secretary, that director.

#### 3. Non-corporate Trustee (including Self Managed Super funds)

Signature of Trustee 1  Date

Name of Trustee 1

Signature of Trustee 2  Date

Name of Trustee 2

Signature of Trustee 3  Date

Name of Trustee 3

Signature of Trustee 4  Date

Name of Trustee 4

When the trustee of a Self Managed Superannuation Fund is to be the policyholder it is important that the application is signed either by: (1) All individual trustees; or (2) for single member fund, 2 individual trustees.

Platform ID:

NETWEALTH

netwealth Adviser Code:

00

**Adviser 1 details (Servicing Adviser)**

Name of Adviser  Adviser Code

Company Name of Adviser (if applicable)  ABN/ACN (if applicable)

Name of Dealership  AFSL Number

Telephone number  Fax number  Email

**Adviser 2 details**

Name of Adviser  Adviser Code

Do you agree to AIA Australia contacting the Life Insured directly, if necessary, in order to obtain information required to facilitate the underwriting of the application?  Yes  No

Has a medical examination, HIV or other test been arranged?  Yes  No

If 'Yes', please provide details of name and address of medical examiner or clinic in the space below.

Special Instructions

Would you like us to arrange any required medical examinations or blood tests directly with your client?  Yes  No

**English literacy**

Can the proposed policy owner/s and/or life/lives to be insured read and understand English?  Yes  No

If 'No', what language was used to explain the policy?

Quote No.

**Adviser Declaration**

- I confirm that I have given each Policy Owner and/or Life Insured a copy of the current:
  - Priority Protection Product Disclosure Statement or Priority Protection for Platform Investors Product Disclosure Statement (as applicable) (PDS) and any relevant Supplementary PDS;
  - AIA Australia Privacy Policy; and
  - where AIA Vitality is being applied for, a copy of the AIA Vitality Terms and Conditions (and where given electronically, the Policy Owner and/or Life Insured agree to receive information/disclosure electronically).
- I confirm that each Policy Owner and/or Life Insured has checked the details provided in the Application Form, the Life Insured has checked the health information provided and that I have authority from the Policy Owner and/or Life Insured to proceed with the application and will be able to provide evidence of the authority to AIA Australia upon request. I acknowledge and agree that evidence may include, but is not limited to, adviser file notes, voice recording and/or signed declaration in my records.
- I understand that where the Policy Owner and/or Life Insured is less than 16 years of age, I declare that the parent or guardian of the Policy Owner and/or Life Insured has made the above declarations and confirmations to me on behalf of the Policy Owner and/or Life Insured.
- I agree to be appointed on behalf of the proposed Policy Owner and Life Insured as described in the 'Adviser appointment – Policy Owner and Life Insured' sub-section in section X of the application form. I agree to only exercise the authority granted as part of that appointment in line with the proposed Policy Owner's and Life Insured's instructions (as relevant) and agree to maintain satisfactory evidence of those instructions. I further agree to indemnify AIA Australia and persons acting on its behalf against all loss or liabilities and costs incurred as a result of this adviser appointment, except to the extent that AIA Australia remains liable for such losses or liabilities by operation of a law that it cannot exclude.

**Financial Adviser Authority – if your client ticked 'Yes' under section W. Financial Adviser Authority**

- I confirm I have fully explained to each Policy Owner and each Life Insured the consequences and implications of the Financial Adviser Authority.
- I accept and agree to my appointment to act on behalf of the Policy Owner/s and the Lives Insured in accordance with the Financial Adviser Authority as outlined in this application form.
- I have read and agree with the information in section W of this application form, including the important notes, the general terms, and this adviser declaration.
- I accept and agree to act honestly and in accordance with specific instructions I receive from the Policy Owner/s and Lives Insured, and only in accordance with this authority. In the case where there is more than one Policy Owner, I accept and agree to obtain and confirm instructions from all Policy Owners, and Lives Insured if relevant.
- I agree to provide evidence of any instructions I receive from the Policy Owner/s or Lives Insured, if and when requested by AIA Australia.
- I agree to retain evidence of any instructions I receive from the Policy Owner/s or Lives Insured indefinitely, unless otherwise advised by AIA Australia. I acknowledge and agree that this obligation continues even if I cease to have a relationship with the Policy Owner/s, and if relevant the Lives Insured.
- I agree to cooperate and comply with all reasonable requests made by AIA Australia in relation to an audit of my performance under this authority.
- I agree to immediately inform the Policy Owner/s and, where relevant, the Lives Insured of any instructions I have provided AIA Australia on their behalf.
- I agree to immediately notify AIA Australia if I move to a new adviser firm or dealer group, or otherwise cease to have a relationship with the Policy Owner/s, and if relevant the Lives Insured.
- I agree to immediately notify AIA Australia if there is any actual or apparent dispute in relation to any instructions I have provided AIA Australia under this authority.

Adviser 1 Signature

Date

Adviser 2 Signature

Date

Continued overleaf

## Adviser Use Only (continued)

### Remuneration Structure – please select either (A) or (B):

A) Same remuneration structure to apply to all Policies (please select):

Upfront     Level (where applicable)

OR

B) Different remuneration structures to apply by Policy (please select and specify Plan type eg. Life Cover Plan):

|          |                    |                      |                                  |   |
|----------|--------------------|----------------------|----------------------------------|---|
| Policy 1 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 2 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 3 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 4 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 5 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 6 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 7 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |
| Policy 8 | Specify Plan type: | <input type="text"/> | <input type="checkbox"/> Upfront | <input type="checkbox"/> Level (where applicable) |

### Remuneration Plan (Commission Dial Up/Dial Down)

Please specify if other than standard

### Remuneration Split

Please specify if more than one adviser

Adviser 1

%

Adviser 2

%

**Note:** Selecting 'Upfront' will apply the 'Upfront' commission rate as at the issue date of the policy.

## Adviser Notes

The following Direct Debit Request and/or Credit Card Authority are only required to be completed where premiums for non-superannuation benefits are to be paid for from a financial institution other than netwealth. Payment of policy premiums from a financial institution other than the applicant's netwealth account can only occur if there is a linked policy which has premiums paid from either the applicant's netwealth Investment Wrap account or their netwealth Superannuation Master Fund account.

## Direct Debit Request

If this Direct Debit Request is for more than one policy then please list all relevant policy numbers.




Payment options: 1.  Initial payment and all future payments 2.  All future payments

Where you are paying from a business, super, SMSF or platform account, and are applying for AIA Vitality, please also complete the AIA Vitality Payment form.

**Request and Authority to debit the account named below to pay AIA Australia**  Monthly  Half-yearly  Yearly

Please refer to the Direct Debit Request Service Agreement in the Product Disclosure Statement.

I/We

|                      |                      |                         |                      |
|----------------------|----------------------|-------------------------|----------------------|
| Account holder 1     | Title                | Surname or Company Name | Given Name or ABN    |
| <input type="text"/> | <input type="text"/> | <input type="text"/>    | <input type="text"/> |

|                      |                      |                         |                      |
|----------------------|----------------------|-------------------------|----------------------|
| Account holder 2     | Title                | Surname or Company Name | Given Name or ABN    |
| <input type="text"/> | <input type="text"/> | <input type="text"/>    | <input type="text"/> |

**request and authorise** AIA Australia Limited (Direct Debit User ID 000142) to arrange for any amount payable in relation to my policy and (where applicable) AIA Vitality contributions to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement.

**Insert details of account to be debited**

Name account is held in

BSB number    -    Account number

**Acknowledgment** I/We have read and understood the terms and conditions governing the debit arrangements between myself and AIA Australia as set out in this Request and in the Direct Debit Request Service Agreement.

**Insert the name and address of financial institution at which account is held**

|                            |                               |
|----------------------------|-------------------------------|
| Financial institution name | <input type="text"/>          |
| Address                    | <input type="text"/>          |
|                            | Postcode <input type="text"/> |

**Insert your signature**

Account Holder 1 Signature

Account Holder 2 Signature

Date (dd/mm/yyyy)

## Credit Card Authority

If this Credit Card Authority is for more than one policy then please list all relevant policy numbers.




Payment options: 1.  Initial payment only 2.  All future payments 3.  Initial payments and all future payments

Where you are paying from a business account, and are applying for AIA Vitality, please also complete the AIA Vitality Payment form.

**Please debit my**  Visa  MasterCard  Diners  AMEX

No.

Expiry Date   /

This authority enables AIA Australia Limited to debit your credit card for any amount payable in relation to your policy and (where applicable) AIA Vitality contributions until you advise AIA Australia in writing to cancel this authority. The amount debited may vary from time to time as a result of contractual variations (this only applies if option 2 or 3 above is chosen).

If you choose the option of using a credit card for the one-off payment of the deposit please enter the amount.

\$

Name as shown on credit card

Cardholder's Signature

Date (dd/mm/yyyy)

**IMPORTANT NOTICE:**

**Credit Card refunds will be processed by us in the ordinary course of business. We will not accept any responsibility for credit card charges or fees incurred due to expired or cancelled cards or timing delays in processing refunds by the credit card issuer.**

## Authority to Release Medical Information

I,

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. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured

Date

## Authority to Release Medical Information

I,

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. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured

Date



Priority Protection for Platform Investors  
Direct Debit Request  
(see over)



Priority Protection for Platform Investors  
Credit Card Authority  
(see over)



Priority Protection for Platform Investors  
Authority to Release Medical  
Information  
(see over)



Priority Protection for Platform Investors  
Authority to Release Medical  
Information  
(see over)



# AIA Vitality Payment Direct Debit Request

Policy No.

This authority will be used for collection of your AIA Vitality contributions at the same frequency as the premiums under the associated policy. Please note: AIA Vitality contributions cannot be funded by superannuation or SMSF monies or from a platform account.

## Request and Authority to debit the account named below to pay AIA Australia

Please refer to the Direct Debit Request Service Agreement in the Product Disclosure Statement.

I,  Title  Surname or Company Name  Given Name or ABN

Account holder

**request and authorise** AIA Australia Limited (Direct Debit User ID 000142) to arrange for any amount payable in relation to AIA Vitality contributions to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement.

**Insert details of account to be debited**

Name account is held in

BSB number    -    Account number

**Acknowledgment** I/We have read and understood the terms and conditions governing the debit arrangements between myself and AIA Australia as set out in this Request and in the Direct Debit Request Service Agreement.

## Insert the name and address of financial institution at which account is held

Financial institution name

Address  Postcode

## Insert your signature

Account Holder Signature  X Date (dd/mm/yyyy)

NB4002



# AIA Vitality Payment Credit Card Authority

Policy No.

This authority will be used for collection of your AIA Vitality contributions at the same frequency as the premiums under the associated policy.

## Request and Authority to debit

Visa  MasterCard  Diners  AMEX

No.                      Expiry Date   /

This authority enables AIA Australia Limited, to debit your credit card for any amount payable in relation to your AIA Vitality contributions until you advise AIA Australia in writing to cancel this authority. The amount debited may vary from time to time as a result of contractual AIA Vitality variations which apply to your AIA Vitality membership.

Name as shown on credit card

Cardholder's Signature  X Date (dd/mm/yyyy)

## IMPORTANT NOTICE:

Credit Card refunds will be processed by us in the ordinary course of business. We will not accept any responsibility for credit card charges or fees incurred due to expired or cancelled cards or timing delays in processing refunds by the credit card issuer.

**AIA Vitality**

Direct Debit Request  
(see over)

**AIA Vitality**

Credit Card Authority  
(see over)