Application to Review Exclusions and Non-Medical Loadings

Full name of life to be insured | Date of Birth

Application/Policy/Fund No: | Member No: (if applicable)

Fund Name (if applicable)

Important Information: This form can only be used to review the following exclusions and loadings:
Please tick all exclusions/loadings you want to be reviewed

- ☐ **Travel** ⟶ Go to Question 1
- ☐ **Residency** ⟶ Go to Question 2
- ☐ **Territorial** ⟶ Go to Question 3
- ☐ **Pastimes** ⟶ Go to Question 4
- ☐ **Back/Neck/Spine** ⟶ Go to Question 5
- ☐ **Joint/Musculoskeletal** ⟶ Go to Question 6

Note: For all other exclusions and loadings a full application is required

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the *Insurance Contracts Act 1984* (Cth). When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so, on what terms and at what cost.

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

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty applies to a new contract of insurance and also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. There are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put us in the position we would have been in if the duty had been met.

Your cover could be avoided (treated as if it never existed), or its terms may be varied. This may also result in a claim being declined or a benefit being reduced.

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

Before we exercise any of these remedies, we will explain our reasons and what you can do if you disagree.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It's important that you understand this information and the questions we ask. Ask us or a person you trust, such as your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If you want, you can have a support person you trust with you.

Notifying the insurer

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

Form issued by: AIA Australia Limited (ABN 79 004 837 861 AFSL 230043), PO Box 6111, Melbourne VIC 3004.

1. Travel

a. Which travel exclusion/loading are you reviewing?

b. 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
				/ /
				/ /

Go to 'Declaration and Privacy Notification' section ▶

2. Residency

Please confirm the following:

a. I am an Australian citizen or permanent resident of Australia (as approved by the Department of Home Affairs) ☐ Yes ☐ No

b. Date permanent residency or citizenship was granted. / /

Go to 'Declaration and Privacy Notification' section ▶

3. Territorial

Please confirm the following:

a. I have returned from living and/or working outside of Australia. ☐ Yes ☐ No

b. Date of return to Australia. / /

c. 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
				/ /
				/ /

Go to 'Declaration and Privacy Notification' section ▶

4. Pastimes

a. Which pastime exclusion/loading are you reviewing?

b. Since your pastime was loaded or excluded by AIA, have you suffered any injury or illness, or exacerbated any underlying condition due to practice or participation in the excluded/loaded pastime. ☐ Yes ☐ No

If 'Yes', please provide full details:

i. Have you fully recovered from this injury or illness with no ongoing symptoms, treatment or medication? ☐ Yes ☐ No

If 'Yes', please provide the date of full recovery: / /

c. When did you cease your practice or participation in the excluded/loaded pastime? / /

d. Why did you cease your practice or participation in the excluded/loaded pastime?

e. I confirm that I have no intention to recommence the excluded/loaded pastime. ☐ Yes ☐ No

Go to 'Declaration and Privacy Notification' section ▶

5. Back/Neck/Spine Exclusion Review

a. Which exclusion are you reviewing?

[ ]

b. What area of the back is/was affected?
(Please complete a separate questionnaire for each area affected.)

☐ Neck (cervical) ☐ Upper/middle back (thoracic) ☐ Lower back (lumbar/sacral)

c. Which of these symptoms have you experienced?
(Tick all that apply.)

☐ Pain in the back/neck ☐ Stiffness/Restriction of movement ☐ Numbness/Pins and needles ☐ Pain in the leg/arm
☐ Other – please describe: [ ]

d. When did you **first** have symptoms? If you know the date, please let us know. [/ /]
If you don't know, please tick one of the boxes below:

☐ <3 months ago ☐ 3–6 months ago ☐ 6–12 months ago ☐ 1–2 years ago
☐ 2–3 years ago ☐ 3–5 years ago ☐ >5 years ago

e. What was the date of your **last** symptoms? If you know the date, please let us know. [/ /]
If you don't know, please tick one of the boxes below:

☐ <3 months ago ☐ 3–6 months ago ☐ 6–12 months ago ☐ 1–2 years ago
☐ 2–3 years ago ☐ 3–5 years ago ☐ >5 years ago

f. Are you now entirely symptom free?.. ☐ Yes ☐ No

g. How many times have you had symptoms per year?

☐ Single occurence only ☐ 1 per year ☐ 2–3 times ☐ 3–6 times ☐ More than 6 times

h. How long did the symptoms usually last each time?

☐ 1 day ☐ 2–3 days ☐ 3–7 days ☐ 1–2 weeks ☐ 2 weeks to a month
☐ 1–3 months ☐ >3 months or constant symptoms

i. What was the cause of/diagnosis for your symptoms?
(Tick all that apply.)

☐ Accident
☐ Sporting injury
☐ Muscle strain/sprain or inflammation
☐ Disc issue – such as bulge/narrowing/herniation/prolapse/protrusion/degeneration
☐ Sciatica
☐ Whiplash
☐ Osteoarthritis/Degeneration
☐ Ankylosing spondylitis
☐ Scoliosis
☐ Fracture
☐ Scheuermann's disease
☐ Rheumatoid or psoriatic arthritis
☐ Fibromyalgia
☐ Osteoporosis
☐ Unknown
☐ Other – please provide details:

[ ]

j. When were you diagnosed (month/year) [/]

k. What tests or investigations did you have?
(Tick all that apply.)

☐ X-ray ☐ MRI/CT scan ☐ Physio/Osteopath/Other
☐ Ultrasound ☐ GP/Specialist consult ☐ No tests or investigations

l. What treatment are you having, has been planned, or have you had in the past?

(Tick all that apply.)	Name of treatment provider	First treated (month/year)	Last treated (month/year)	How many times have you been treated?	How often have you been treated?	Are you still being treated or is any treatment planned?
☐ Surgery – arthroscopy/ joint or cartilage repair		/	/			☐ Y ☐ N
☐ Surgery – joint replacement		/	/			☐ Y ☐ N
☐ Physiotherapy/ Chiropractor/Osteopath		/	/			☐ Y ☐ N
☐ Steroid/Anti-inflammatory Injection		/	/			☐ Y ☐ N
☐ Medication Name: Dosage:		/	/			☐ Y ☐ N
☐ Other – please provide details:		/	/			☐ Y ☐ N
☐ Rest only:		/	/			☐ Y ☐ N
☐ No treatment						

m. Did you need to take time off work due to these symptoms?.. ☐ Yes ☐ No

If 'Yes', provide details below:

Month/Year	Duration (days)	Month/Year	Duration (days)	Month/Year	Duration (days)	Month/Year	Duration (days)
/		/		/		/	

n. What is your current occupation and what industry do you work in?

Occupation:

Industry:

o. 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%

p. Are your symptoms caused by, or made worse by your job?.. ☐ Yes ☐ No

If 'Yes', please provide details of any changes, restrictions or limitations to your work duties including duration.

(e.g. light duties for 3 months)	Duration (days)

q. Have you had to change your job, or change some of the duties of your job as a result of this condition?.................. ☐ Yes ☐ No

If 'Yes', provide details below:

r. Are your symptoms caused by, or made worse by your usual activities? .... ☐ Yes ☐ No

If 'Yes', provide details below:

(e.g. cricket caused lower back pain – stopped playing cricket in 2016)

s. Are you currently off work or receiving/planning to claim any type of disability or insurance benefits due to this condition? ☐ Yes ☐ No

If 'Yes', provide details below:

t. Please provide the contact details of the main treatment provider for this condition below.

Name:

Address:

Phone: Fax:

Go to 'Declaration and Privacy Notification' section and then 'Authority to Release Health Information' section ▶

6. Joint/Musculoskeletal Exclusion Review

a. Which exclusion are you reviewing?

b. What joint or part of the body is/was affected? (e.g. left knee)

(If more than one joint or part of the body, please complete a separate questionnaire for each area affected.)

c. Which of these symptoms have you experienced?

(Tick all that apply.)

☐ Pain ☐ Restricted movement ☐ Numbness/Pins and needles

☐ Other – please describe:

d. When did you **first** have symptoms? If you know the date, please let us know. / /

If you don't know, please tick one of the boxes below:

☐ <3 months ago ☐ 3–6 months ago ☐ 6–12 months ago ☐ 1–2 years ago

☐ 2–3 years ago ☐ 3–5 years ago ☐ >5 years ago

e. What was the date of your **last** symptoms? If you know the date, please let us know. / /

If you don't know, please tick one of the boxes below:

☐ <3 months ago ☐ 3–6 months ago ☐ 6–12 months ago ☐ 1–2 years ago

☐ 2–3 years ago ☐ 3–5 years ago ☐ >5 years ago

f. Are you now entirely symptom free?.. ☐ Yes ☐ No

g. How many times have you had symptoms per year?

☐ Single occurence only ☐ 1 per year ☐ 2–3 times ☐ 3–6 times ☐ More than 6 times

h. How long did the symptoms usually last each time?

☐ 1 day ☐ 2–3 days ☐ 3–7 days ☐ 1–2 weeks ☐ 2 weeks to a month ☐ 1–3 months ☐ >3 months

i. What was the cause of/diagnosis for your symptoms?
(Tick all that apply.)

☐ Accident
☐ Sporting injury
☐ Muscle strain/sprain or inflammation
☐ Tendon/ligament/cartilage injury or tear
☐ Fracture
☐ Repetitive strain injury (RSI)
☐ Dislocation
☐ Bursitis or frozen joint/area
☐ Osteoarthritis/Degeneration
☐ Rheumatoid or psoriatic arthritis
☐ Ankylosing spondylitis
☐ Fibromyalgia
☐ Osteoporosis
☐ Unknown

☐ Other – please provide details:

j. When were you diagnosed (month/year) /

k. What tests or investigations did you have?
(Tick all that apply.)

☐ X-ray ☐ Ultrasound ☐ MRI/CT scan ☐ GP consult ☐ Osteopath/Other ☐ No tests or investigations

l. What treatment are you having, has been planned, or have you had in the past?

(Tick all that apply.)	Name of treatment provider	First treated (month/year)	Last treated (month/year)	How many times have you been treated?	How often have you been treated?	Are you still being treated or is any treatment planned?
☐ Surgery – arthroscopy/ joint or cartilage repair		/	/			☐ Y ☐ N
☐ Surgery – joint replacement		/	/			☐ Y ☐ N
☐ Physiotherapy/ Chiropractor/Osteopath		/	/			☐ Y ☐ N
☐ Steroid/Anti-inflammatory Injection		/	/			☐ Y ☐ N
☐ Medication Name: Dosage:		/	/			☐ Y ☐ N
☐ Other – please provide details:		/	/			☐ Y ☐ N
☐ Rest only:		/	/			☐ Y ☐ N
☐ No treatment						

m. Did you need to take time off work due to these symptoms?........ ☐ Yes ☐ No
If 'Yes', provide details below:

Month/Year	Duration (days)	Month/Year	Duration (days)	Month/Year	Duration (days)	Month/Year	Duration (days)
/		/		/		/	

n. What is your current occupation and what industry do you work in?

Occupation:

Industry:

o. 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%

p. Are your symptoms caused by, or made worse by your job?.. ☐ Yes ☐ No

If 'Yes', please provide details of any changes, restrictions or limitations to your work duties including duration.

(e.g. light duties for 3 months)

	Duration (days)

q. Have you had to change your job, or change some of the duties of your job as a result of this condition?.................. ☐ Yes ☐ No

If 'Yes', provide details below:

r. Are your symptoms caused by, or made worse by your usual activities? .... ☐ Yes ☐ No

If 'Yes', provide details below:

(e.g. netball caused knee pain – stopped playing netball as a result)

s. Are you currently off work or receiving/planning to claim any type of disability or insurance benefits due to this condition? ☐ Yes ☐ No

If 'Yes', provide details below:

t. Please provide the contact details of the main treatment provider for this condition below.

Name:

Address:

Phone: Fax:

Go to 'Declaration and Privacy Notification' section and then 'Authority to Release Health Information' section ▶

Declaration and Privacy Notification

Privacy Notification

Personal (including sensitive) information provided will be handled in the manner described in the AIA Australia Group Privacy Policy as updated from time to time, accessible by visiting our website at www.aia.com.au, or by contacting us on 1800 333 613 to request a copy. AIA Australia handles and collects personal 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 personal 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 information as described in the AIA Australia Group 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 information about someone else, you must have their consent to provide their information to us in the manner described in the AIA Australia Group Privacy Policy.

Decaration

I declare that the answers I have provided to the questions in this form are honest, true and correct to the best of my knowledge. I understand that this document will form part of my application for insurance and the answers provided will be used by AIA Australia to determine whether to offer insurance and if so on what terms.

I understand my obligations under the Duty to take reasonable care not to make a misrepresentation and am aware of the consequences of not meeting this duty.

Signature of Life Insured	Name of Life Insured (as per legal identity)	Date
✗		DD / MM / YYYY

POLICY OWNER/S (Please complete one section below)

All correspondence directly relating to the insurance policy/ies arising from this application will be issued to Policy Owner 1. By signing this application form you acknowledge that Policy Owner 2 (or any other Policy Owner) will not receive any correspondence directly related to this insurance application.

1. Individual/s

Signature of Policy Owner 1	Name of Policy Owner 1	Date
✗		DD / MM / YYYY
Signature of Policy Owner 2	**Name of Policy Owner 2**	**Date**
✗		DD / MM / YYYY

2. Company/Corporate Trustee/Business Partnership

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

Signature of Director/Business Partner	Name of Director/Business Partner	Date
✗		DD / MM / YYYY
Signature of Director/Secretary/Business Partner	**Name of Director/Secretary/Business Partner**	**Date**
✗		DD / MM / YYYY

☐ 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	Name of Trustee 1	Date
✗		DD / MM / YYYY
Signature of Trustee 2	**Name of Trustee 2**	**Date**
✗		DD / MM / YYYY
Signature of Trustee 3	**Name of Trustee 3**	**Date**
✗		DD / MM / YYYY
Signature of Trustee 4	**Name of Trustee 4**	**Date**
✗		DD / MM / YYYY

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.

Authority to Release Health Information

Notes on releasing information about your health

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

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

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

Please read each Authority carefully and the explanatory notes below.

Authority 1

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

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

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

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

I agree to all the following:

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

Name:

Signature:

✗

Date:

Authority 2

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

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

Your General Practitioner maintains consultation notes to support quality care, your wellbeing, and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above. If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

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

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

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

I agree to all the following:

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

Name:

Signature:

✗

Date:

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