

# Application for Changes to Insurance Cover CORE SUPER



For assistance & enquiries: Ph 132 467

Please send this completed form to: Intrust Super, GPO Box 1416, Brisbane QLD 4001

Please write in BLOCK letters and use a BLUE or BLACK pen. This request will be invalid if unsigned or undated.

**Please complete this form to request new insurance cover through Intrust Super after joining the Fund. This form can be used to request or make changes to PayGuard (Income Protection Insurance) or Life or combined Life & Total and Permanent Disablement (TPD) Insurance. This form should also be completed if you wish to change your existing level of Life or combined Life & TPD Insurance after joining the Fund.**

**To request PayGuard (Income Protection Insurance) cover please complete SECTION A. To make changes to your existing Life or combined Life & TPD Insurance please complete SECTION B.**

## DUTY OF DISCLOSURE

Before the trustee enters into a contract of insurance with an insurer, it has a duty to disclose to the insurer every matter that it knows or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk and, if so, on what terms.

The trustee has the same duty to disclose those matters to the insurer before they extend, vary or reinstate a contract of life insurance.

However, a trustee's duty of disclosure does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that the insurer knows or, in the ordinary course of its business, ought to know, or
- where the insurer has waived disclosure.

The duty of disclosure continues until we are informed that an application for cover is accepted or declined.

## NON-DISCLOSURE

The trustee has a duty to disclose to the insurer, every matter that is relevant to the insurer's decision whether to accept the risk of insurance and if so, on what terms. The trustee will rely on the information provided by you and your employer.

If the trustee fails to comply with its duty of disclosure as a result of relying on information provided by you or your employer and the insurer would not have entered into a contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If the trustee fails to comply with its duty of disclosure that was fraudulently provided by you or your employer, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may within 3 years of entering into it, elect not to avoid it but to reduce the sum you have been insured for, in accordance with a formula that takes into account the premium that would have been payable, if the trustee had disclosed all relevant information to the insurer.

The trustee relies on the information provided by you and your employer. If the insurer refuses to pay an insured benefit to the trustee as a result of non-disclosure or misrepresentation by you or your employer, the trustee will not pay the insured benefit to you

## Member Details (Please complete in full)

Member Number

(This can be found on your Member Statement)

Mr/Mrs/Ms/Miss

Surname

Given Names

Date of Birth (ddmmyyy)

Gender (M/F)

## Street Address

Street Number

Street Name

Suburb

State

Postcode

## SECTION A: Changes to PayGuard (Income Protection Insurance)

Please provide me with PayGuard Cover

Please remove my current PayGuard Cover

I declare that I have read the Core Super Member Information Guide as it relates to PayGuard (Income Protection Insurance) cover.

Signature of applicant

Dated (ddmmyyy)

If you wish to make changes to PayGuard Cover only, please finish here, at Section A.

## SECTION B: Changes to Life or combined Life & TPD Insurance

Please refer to the Core Super Member Information Guide for important information and premium rates. Choose ONE option:

1.  **I wish to remove my current cover.**
2.  **I wish to reduce my current cover.** Please indicate below the number of units you now require:
 

<input type="text"/>	<input type="text"/>	units of Life Insurance. (You may not hold TPD Insurance without Life Insurance. Value of units must not exceed \$10 million.)
<input type="text"/>	<input type="text"/>	units of TPD Insurance. (You may hold Life Insurance without TPD Insurance. Value of units must not exceed \$3 million.)
3.  **I wish to apply for cover.** Please indicate below the number of units you require:
 

<input type="text"/>	<input type="text"/>	units of Life Insurance. (You may not hold TPD Insurance without Life Insurance. Value of units must not exceed \$10 million.)
<input type="text"/>	<input type="text"/>	units of TPD Insurance. (You may hold Life Insurance without TPD Insurance. Value of units must not exceed \$3 million.)

Your elected level of cover is subject to satisfactory assessment and acceptance by the insurer.
4.  **I wish to increase my current level of cover.** Please indicate below the number of units you require:
 

<input type="text"/>	<input type="text"/>	units of Life Insurance. (You may not hold TPD Insurance without Life Insurance. Value of units must not exceed \$10 million.)
<input type="text"/>	<input type="text"/>	units of TPD Insurance. (You may hold Life Insurance without TPD Insurance. Value of units must not exceed \$3 million.)

Your increased level of cover is subject to satisfactory assessment and acceptance by the insurer.

### PERSONAL HEALTH STATEMENT (Only complete this section if you have ticked option 3 or 4 above.)

Height  CM      Weight  KG

Please tick YES or NO to each of the following

YES NO

- | 1. In the last 12 months, have you smoked tobacco in any form?  | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|
| 2. Have you ever been declined for cover under a policy of life, disability or health insurance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you lost the sight of any eye or the use of a limb (limb includes the hand or foot) or do you have any defect of vision or hearing or speech?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. To your knowledge have you ever suffered from,   |                          |                          |
| a. Diabetes, epilepsy, multiple sclerosis or hepatitis B or C?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Anaemia, leukemia, haemophilia or any other blood disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cancer or tumor of any type?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, high blood pressure, heart or vascular complaint, paralysis or stroke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Disease or complaint related to kidney, bladder, lung, bower, liver, or stomach including gastric or duodenal ulcer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Mental or nervous disorder (including stress, anxiety or depression episodes)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Any disease of, or injury to, the head, neck or back involving a joint or limb including back strain, disc disorder or lumbago?  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Chronic fatigue syndrome or other immune disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Tendonitis, tenosynovitis, RSI or regional pain syndrome, arthritis or gout or any injury, deformity or disease involving any muscle, joint or limb?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Unintentional significant weight loss or persistent night sweats, persistent fever, persistent diarrhea or persistent swollen glands?  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Asthma or any other respiratory disorder (other than hay fever or the common cold) to the extent that medical treatment has been required?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In connection with AIDS or AIDS related conditions,  |                          |                          |
| a. to the best of your knowledge, have you or any of your partners been infected with the AIDS virus or carried antibodies of the virus which causes AIDS (Human Immunodeficiency Virus)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. have you within the last five (5) years, engaged in or are you currently engaging in any of the following:   |                          |                          |
| i. Sexual activity with, or as, a prostitute?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ii. Male to male anal sexual intercourse?   | <input type="checkbox"/> | <input type="checkbox"/> |
| iii. Intravenous drug use not prescribed for you by a medically registered practitioner?  | <input type="checkbox"/> | <input type="checkbox"/> |

**If you answered yes to any of the above aids questions, please give full details. We may need more information in order to assess your application. Please see question 10.**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 6. a. Have you ever made a claim for any form of disability benefit including disability insurance or workers compensation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever been paid a benefit for total and permanent disablement from a superannuation fund or life insurance policy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you contemplate seeking any examination, advice or treatment (including medical or surgical) in the future?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you any intention to engage in aerial travel other than as a fare paying passenger, or in pursuits or pastimes considered hazardous by the average person, e.g. motor racing, hang gliding, rock climbing?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have any near relatives suffered from nervous disorders, epilepsy, diabetes, stroke, heart disease, mental disorders/breakdown, haemophilia, Huntington's Chorea or any hereditary disease? If Yes, please give details | <input type="checkbox"/> | <input type="checkbox"/> |

10. If you answered Yes to any question, please provide the following details.

- a. Nature of condition/complaint
- b. Date commenced
- c. Duration of injury/illness
- d. Time off work
- e. Details of any operation performed
- f. Degree of recovery
- g. Name(s) and address(es) of doctor(s) or hospital(s) consulted

If more space is required attach additional page(s) and clearly indicate your name and date of birth on each page.

11. Name and address of your regular doctor, or the last medical practitioner you visited.

Doctor's Name

Street Number

Street Name

Suburb

State

Postcode

Date of last visit (ddmmyyyy)

Phone Number

Reason for and result of last visit

#### DECLARATION

I have read and carefully considered the questions on this application and can confirm all statements are true and correct in relation to me.

I acknowledge:

- a. This Declaration is part of an application for Life or combined Life & TPD cover, and that the making of a false statement or failure to comply with my duty of disclosure may invalidate my application.
- b. That, if I fail to provide all or part of the information required, or consent to the Insurer obtaining such information, as it requires, this application will not be assessed and processed.
- c. That at the date of this application I am not absent from work for reasons of illness or injury and I am performing all the duties of my usual occupation.

Signature of applicant



Dated (ddmmyyyy)

## CONSENT

I understand that in order to assess and process my application, HLRA may need health and employment information about me. I consent to HLRA obtaining information about me from any medical practitioner or health professional that I have or may consult in the future, or that HLRA appoints to examine me, and from my employers.

I further understand that if I apply for increased or different insurance cover HLRA may require further information about. I now consent to HLRA obtaining such further information as and when required, from any medical practitioner or health professional that I have consulted or may consult in the future, or that HLRA appoints to examine me, and from my employers.

I understand that if I or anyone else on my behalf, makes a claim for a benefit, HLRA will need information about me in order to assess and process the claim. I hereby consent to HLRA obtaining information about me from any of the following:

Medical practitioners that I have consulted at any time and any that HLRA wishes to appoint to examine me, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers and interpreters.

For the purpose of this application and any future application and any claim for a benefit, I also consent to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosure is necessary for HLRA to perform its functions.

### Signature of applicant



Dated (ddmmyyyy)

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## DISCLOSURE OF INFORMATION – DOCTOR'S AUTHORITY

For the purpose of assessing my eligibility for Life Insurance, I authorise my current medical practitioner, and any other medical practitioner or health professional I have consulted or may consult in the future, or that Hannover Life Re of Australasia Ltd ("HLRA") appoints to examine me, to disclose information about my health and related matters to HLRA. A photocopy of this authorisation will be as valid as the original.

### Signature of applicant



Dated (ddmmyyyy)

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## PRIVACY ACT 1988 - OUR OBLIGATIONS UNDER THE ACT

The Privacy Act 1988 ("the Act") sets out a number of principles that we must comply with in the collection, security, storage, use and disclosure of personal information. These principles are known as the National Privacy Principles.

The following information is provided to you in accordance with these Principles.

The organisation collecting information about you is IS Industry Fund Pty Ltd, the Trustee of Intrust Super Fund. The information will be passed directly on to Hannover Life Re of Australasia Ltd ("HLRA"). It will not be used for any other purpose. Both organisations can be contacted care of the address shown on the Statement of Personal Health, either in writing, by telephone or by email.

If you ask us, we must provide you with access to the personal information we hold about you. We may be entitled to refuse access to some information as set out in the Act.

Your right to access this information is set out in our Privacy Policy document, which is available on request.

The information we collect will be used to assess and process your application for life insurance. We may also use the information if a claim is submitted by you, or by someone acting on your behalf.

The information we collect may be disclosed to other organisations, including but not limited to, medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, the trustees of a superannuation fund you belong to, an organisation that is duly appointed to manage the administration of such fund and interpreters.

If you fail to provide us with all or part of the information we require, we will be unable to assess and process your application.