

Application to Increase Insurance Cover

Complete this form if you wish to apply for new or increased Death only, Death and Total & Permanent Disablement (TPD) or Income Protection insurance with AGEST.

1. Your Personal Details

All members must complete this section.

Membership Number

Title (please tick)

Miss Ms Mrs Mr Dr

First name(s)

Family name

Date of birth

Gender

F M

Home phone number

Work phone number

Mobile phone number

Email address (work or home)

Home address

Suburb/Town

State/Territory

Postcode

Country (if not Australia)

Mailing address (if different to Home address)

Suburb/Town

State/Territory

Postcode

Country (if not Australia)

Your job title/occupation

What is the average number of hours worked each month in your main occupation?

Note: You need to work a minimum of 60 hours per month on a regular basis to be eligible to apply for Income Protection Cover.

Your Height

cms

Your Weight

kgs

2. Amount of cover required

Please refer to the Insurance Guide for information about your cover options.

Please note that the NEW level of cover you select below will, if accepted by the insurer, supersede your current level of cover. If you leave a 'NEW level of cover' field blank or your increase in cover is not accepted, your existing cover will remain unchanged.

Death Only Cover	Current level of cover <input type="text"/> Units OR Fixed Cover \$ <input type="text"/>	NEW level of cover <input type="text"/> Units OR Fixed Cover \$ <input type="text"/>
Death & TPD Cover	Current level of cover <input type="text"/> Units OR Fixed Cover \$ <input type="text"/>	NEW level of cover <input type="text"/> Units OR Fixed Cover \$ <input type="text"/>
Income Protection Cover	Current level of cover Monthly Benefit \$ <input type="text"/> per month Waiting Period (Days) 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/>	NEW level of cover Monthly Benefit \$ <input type="text"/> per month Waiting Period (Days) 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/>

Indexation

If you are applying for any fixed cover, please tick the following boxes if you wish to have any of your fixed cover automatically indexed (increased) by 5% each year on your birthday.

Death only Death & TPD Income Protection

Are you applying for:

Death only or Death and Total and Permanent Disablement (TPD) in excess of \$1,000,000? Yes No

Income Protection in excess of \$8,000 per month? Yes No

If you answered 'Yes' to any question in this section, please proceed to Section 4, otherwise go to Section 3.



3. Short personal statement

If you answer 'Yes' to any of the questions in this section, please do not continue completing this section. Instead, proceed to Section 4.

- 3.1 Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No Yes
- 3.2 Are you claiming or have you ever claimed any type of disability or sickness benefit from any source, e.g. TPD benefit from any superannuation fund, Workers' Compensation, Disability Pension, Veteran Affairs or any other insurance policy providing accident or sickness benefits? No Yes
- 3.3 Are you at the date of this application, due to injury, accident or illness:
- > off work? No Yes
 - > restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even though your actual employment can be on a full-time, part-time or casual basis? No Yes
- 3.4 Have you lost the sight of an eye or the total and permanent loss of the use of a limb ('limb' includes whole hand or whole foot)? No Yes
- 3.5 Excluding the contraceptive pill and inhaled asthma medication, have you been advised to take or been given prescribed medication by a medical practitioner that has intended to be used for three months or longer within the last year (including but not limited to blood pressure, diabetes, oral steroids for asthma or depression medication)? No Yes
- 3.6 Have you been unable to work because of sickness or injury for more than two consecutive weeks in the last three years? No Yes
- 3.7 Have you undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any illness or injury that would affect your long-term health and require ongoing medical supervision. This includes, but is not limited to:
- > Cancer or diabetes
 - > High blood pressure, cholesterol or any heart complaint
 - > Alcohol or drug abuse
 - > Stroke, paralysis, neurological disorder or multiple sclerosis? No Yes
- 3.8 Have you been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or Hepatitis B and C? No Yes
- 3.9 Have you received any medical advice or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any of the following:
- > Any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last twelve months AND/OR any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints? No Yes
 - > Depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder)? No Yes
 - > Chest pain, asthma, bronchitis or any other lung complaint requiring hospitalisation within the last five years? No Yes
 - > Disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel, or liver? No Yes
 - > Epilepsy? No Yes

Have you answered YES to any of the questions in Section 3 above?

No – Go straight to Section 5 (on page 7). Do not complete Section 4.

Yes – Go to Section 4.

Please note: Section 6 needs to be completed in all circumstances.

4. Full personal statement

4.1 Insurance history details

(a) Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

No Yes

If 'Yes', please provide details below:

Fund or insurance company name

Date

Terms offered and reason

(b) Are you claiming or have you ever claimed any type of disability or sickness benefit from any source, eg. TPD benefit from any superannuation fund, Workers' Compensation, Disability Pension, Veteran Affairs or any other insurance policy providing accident or sickness benefits?

No Yes

If 'Yes', please provide details below:

Claim type/source/reason for claim

Date claim submitted

Claim amount

Date claim finalised

\$

4.2 Activities and pastime details

Do you currently engage in or intend to engage in any of the following sports or hazardous activities:

- i. Flying (other than as a fare-paying passenger on a commercial airline?) No Yes
- ii. Underwater diving? No Yes
- iii. Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing? No Yes
- iv. Football of any code (including touch football or tag)? No Yes
- v. Any other sport or hazardous activities, eg. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports or recreations involving heights? No Yes

If you have answered 'Yes' to any of the above, please provide further details below:

What are the activity/ies you engage in?

At what level do you participate? (please tick the appropriate box)

Recreational only (non-competition) Recreational with competition Semi-professional/professional

Number of times you participate on average in this activity/ies per annum (eg. hours flown, number of drives, events etc.)

Do you receive any income from participating in this activity/ies?

No Yes

4.3 Personal health details

(a) Have you smoked tobacco or any other substance at any time during the last twelve months?

No Yes

If 'Yes', please indicate type (eg. cigarettes, cigars, etc.) and average amount smoked in **one** of the following boxes.

Substance smoked

Per day

Per week

Per year

(b) Do you drink alcohol?

No Yes

If 'Yes', please provide the average number of drinks consumed in **one** of the following boxes.

Per day

Per week

Per year

4.4 Family history

Have any of your immediate family (parents, brothers, sisters) suffered from or been diagnosed with any of the following?

- > Heart problems, stroke, high blood pressure, diabetes, cancer (breast, ovarian, cervical or other),
- > Hereditary disorders such as Huntington's disease, polycystic kidney, muscular dystrophy, familial polyposis etc. or any other inherited or hereditary disease.

Unknown No Yes

If 'Yes', please complete the following table:

Family member	Condition	Approximate age of onset	Age at death (if applicable)

4.5 Doctor details

(a) What is the name and address of the last doctor or medical centre you visited?

Full name of doctor or medical centre

Address

State Postcode

Telephone number

Fax number

(b) Is the doctor/medical centre mentioned above your usual doctor/medical centre? No Yes

(c) When was your last consultation?

Within the last month 1-3 months 4-6 months 7-12 months 13 months-2 years Over 2 years

(d) What was the reason for your last consultation?

(e) What was the result/outcome from your last consultation? (please tick)

- | | |
|---|--|
| <input type="checkbox"/> Referral to specialist/health professional | <input type="checkbox"/> Ongoing treatment (eg. ventolin inhaler) |
| <input type="checkbox"/> Tests conducted – results pending | <input type="checkbox"/> Routine tests conducted – results all clear/normal |
| <input type="checkbox"/> Not fully recovered yet | <input type="checkbox"/> All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication) |

4.6 Lifestyle declaration

To the best of your knowledge, is there any possibility that you have ever been infected with or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or Hepatitis or are you in a high-risk category (eg. injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or engaged the services of a prostitute)?

No Yes

If 'Yes', please provide details below:

Please note: If you answered 'Yes' to the declaration above, you will be asked to complete a specific lifestyle questionnaire.

4.7 Medical history

Have you ever had, or sought advice or treatment, experienced symptoms, or suffered from any of the following:

- (a) **Asthma, bronchitis** or any other lung complaint? No Yes
- (b) **Cysts, moles, sunspots** or skin lesions? No Yes
- (c) **Diabetes** or abnormal blood sugar? No Yes
- (d) **Back, neck, shoulder, knee, elbow complaints**, sciatica, disc or spine complaints, or injury of the joints, bones or muscles? No Yes
- (e) **Depression or mental disorder** (including but not limited to stress, anxiety, panic attacks, behavioural or nervous disorder)? No Yes
- (f) Chest pains, heart complaint, heart murmur, high blood pressure, raised cholesterol, palpitations or rheumatic fever? No Yes
- (g) Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder? No Yes
- (h) Cancer, tumour or melanoma? No Yes
- (i) Thyroid, glandular or pancreatic disorder? No Yes
- (j) Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder? No Yes
- (k) Any disorder of the gall bladder or liver (including hepatitis B, C or raised liver function)? No Yes
- (l) Varicose veins, haemorrhoids or hernia? No Yes
- (m) Disorder of the kidney, bladder or prostate, blood in urine or kidney stones? No Yes
- (n) Epilepsy, fits of any kind, fainting episodes or recurring headaches or migraines? No Yes
- (o) Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder? No Yes
- (p) Arthritis, gout, osteoporosis, fibromyalgia, repetitive strain injury (RSI) or any chronic pain syndrome? No Yes
- (q) Eczema, dermatitis, psoriasis or any other skin disorder? No Yes
- (r) Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? No Yes
- (s) Any impairment of sight (other than corrected by glasses or lenses) or blurred vision? No Yes
- (t) Any impairment of hearing, including tinnitus, or speech? No Yes
- (u) Any sexually transmitted diseases? No Yes
- (v) Any other illness, injury, disease or disorder not mentioned above? No Yes
- (w) Other than those conditions mentioned in this section, are you taking any regular prescribed medication (excluding contraceptives)? No Yes
- (x) Within the last three years, have you had:
 - i. Any blood tests which revealed an abnormality? No Yes
 - ii. Any tests such as ECG, X-ray (excluding broken bones or joint strains), genetic test or ultrasound (other than for pregnancy)? No Yes
- (y) Are you considering seeking medical advice, treatment, tests or surgery in the future? No Yes
- (z) (Females only) Are you currently pregnant? No Yes

i. Due date for birth of baby?

ii. Have you ever had any complications with pregnancy or childbirth (eg. diabetes, ectopic pregnancy)?

No Yes – If 'Yes', please provide details below:

Please note If you have answered 'Yes' to any part of Questions (a) to (e) in this section, we will ask you to complete a specific questionnaire on the related condition.

If you answered 'Yes' to any part of Questions (f) to (y) above, please provide full details in Section 4.8

4.8 General health questionnaire

If you have answered 'Yes' to any part of Questions (f) to (y) in Section 4.7, please complete the table below. Please ensure that you write the letter of each relevant question at the top of each column.

	Question <input type="checkbox"/>	Question <input type="checkbox"/>	Question <input type="checkbox"/>
(a) Name of condition	<input type="text"/>	<input type="text"/>	<input type="text"/>
(b) Date symptoms first started	<input type="text"/>	<input type="text"/>	<input type="text"/>
(c) Date symptoms ceased (if ongoing, please tick)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Ongoing
(d) How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half-yearly, yearly, one-off, other (please specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
(e) Severity of condition Please choose from one of the following: mild, moderate, severe, never had symptoms, symptoms have ceased	<input type="text"/>	<input type="text"/>	<input type="text"/>
(f) Did you take medication or have you had any other treatment (eg. physiotherapy or an operation) for this condition? (please tick)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If 'Yes', name the treatment/condition	Details <input type="text"/>	Details <input type="text"/>	Details <input type="text"/>
(g) Are you still on treatment, including medication? (please tick)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
(h) Have you ever been off work due to this condition? (please tick)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If there is insufficient space to supply details here, please attach an additional sheet	Details <input type="text"/>	Details <input type="text"/>	Details <input type="text"/>
If 'Yes', please state the total time off work in days, months and years	Days <input type="text"/> Months <input type="text"/> Years <input type="text"/>	Days <input type="text"/> Months <input type="text"/> Years <input type="text"/>	Days <input type="text"/> Months <input type="text"/> Years <input type="text"/>
(i) Have you had any residual, ongoing effects or restrictions as a result of this condition? (please tick)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If 'Yes', please provide details and dates	Details <input type="text"/>	Details <input type="text"/>	Details <input type="text"/>
If there is insufficient space to supply details here, please attach an additional sheet	<input type="text"/>	<input type="text"/>	<input type="text"/>

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