Christian Super

PERSONAL HEALTH STATEMENT

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Only complete this form if you are applying for new or increased insurance cover.

IMPORTANT: ĺComplete and return form to: Please read both the 'Duty to Take Reasonable Care' and 'Privacy Collection Notice' prior to completing this form. You can send this form alongside any extra documentation to the Christian Super Member Care Team. Christian Super, Locked Bag 5073, Parramatta NSW 2124.

The questions on this Personal Health Statement as to whether or not Hannover Life Re of Australasia (HLRA) offers you insurance, and the terms of any offer made. Please answer all questions correctly. The form must be completed in BLOCK letters. Dashes are not acceptable for use on this form. Please use Section I, or attach additional pages, if there is insufficient space to provide the information necessary for any question.

The duty to take reasonable care

When you apply for life insurance cover, you are treated as though you are applying for insurance cover under an individual consumer insurance contract. When you apply for cover under a consumer insurance contract, you have a legal duty to take reasonable care not to make a misrepresentation to us before the contract of insurance is entered into.

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

This duty 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. Your cover could be voided (treated as if it never existed), or its terms may be changed. 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.

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, you must tell us 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. Please contact us and ask for help if you have difficulty understanding the process or answering any of our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. If you want, you can have a support person you trust with you while speaking with us.

Privacy Collection Notice

This Privacy Collection Notice outlines how Hannover Life Re of Australasia Ltd (HLRA) and Christian Super (collectively, "we", "us" or "our") collects and handles your personal information in compliance with the Privacy Act 1988 (Cth).

Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details.

Generally, we collect this information so that HLRA can provide products and services to you and we can manage, administer, develop and improve our processes, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may on occasions collect it from a third party such as related bodies corporate, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, HLRA may be unable to provide such services to you.

Disclosure

The information you provide us will be collected by HLRA and may be disclosed to third parties that help HLRA deliver and improve HLRA products and services (including other insurance / reinsurance companies, legal practitioners, medical practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, HLRA parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist HLRA in carrying out HLRA business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

Overseas disclosure

We may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

Access

HLRA's Privacy Policy is available at www.hannover-re.com/1094181/australia_lh_privacy. Christian Super's Privacy Policy is available at www.christiansuper.com.au/privacy-policy/. You may contact either HLRA or Christian Super using the information contained in the contact section below. These documents outline our personal information handling practices, including details on how you can seek access or correction of the personal information that we hold about you, how to complain if you believe we have breached the Australian privacy laws and our complaint handling processes.

Contact

You may contact Hannover as follows:

The Privacy Officer
Hannover Life Re of Australasia Ltd
Tower 1, Level 33, 100 Barangaroo Ave
SYDNEY NSW 2000

Telephone: (02) 9251 6911
Facsimile: (02) 9251 6862
Email: privacyofficer@ hlra.com.au

You may contact Christian Super as follows:

The Privacy Officer
Christian Super
Suite 2, Building A, 1 Homebush Bay Drive, Rhodes, NSW 2138

Telephone: 1300 360 907
Facsimile: 1300 367 828
Email: privacy@christiansuper.com.au

Section A. Fund / Plan name and type of cover

Name of Fund/Plan

Type of Cover: (please tick appropriate box)	Amount of Benefit / Cover:
Death (Life) Only ☐	$
Death (Life) and Total and Permanent Disablement (TPD) ☐	$
Group Income Protection (GIP) ☐	$ (monthly benefit)

Section B. Member Details and Insurance History

1. Surname

   Given Names

   Sex | Date of birth

   Address

   State | Postcode

2. Occupation

3. Annual Salary ($)

4. Email

   Telephone | Mobile

   Please tick your preferred contact method and most convenient time to contact you: SMS ☐ Call ☐ Email ☐ AM ☐ PM ☐

Please tick No or Yes to each of the following:

5. Has Death (Life), TPD, GIP, Disability, Accident and Sickness or Superannuation cover on your life ever been declined, deferred or withdrawn from any insurance Company or accepted with a loading, exclusion or other than as applied?

   YES ☐ NO ☐

   If YES, please provide full details including dates, name of company and reason:

6. Have you ever made a claim for disability benefits under an Insurance, Superannuation or Worker's Compensation policy, Veteran's Affairs or under Social Security (including CTP and public liability)?

   YES ☐ NO ☐

   Please provide full details including dates, cause of claim, type of benefit and amount paid, claim number and insurance company:

7. Other than this application, do you have or are you applying for any Death (Life), TPD, Disability Income or GIP with any other company?

   YES ☐ NO ☐

Company	Type of Policy	Benefit Amount	Owner	To be Replaced
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

Section C. Other Member Details

1. Do you drink alcohol?

   YES ☐ NO ☐

   If 'Yes' please state type and weekly quantity:

2. Have you smoked in the past 12 months?

   YES ☐ NO ☐

   If 'Yes' please state type and weekly quantity:

3. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a recognised airline), motor racing of any kind, diving, football, parachuting, hang gliding, etc?

   YES ☐ NO ☐

   If 'Yes' please state type and weekly quantity:

4. Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's Visa?

   YES ☐ NO ☐

   If 'No' please give full details

5. Do you intend travelling overseas in the immediate future (i.e. next 2 years)?

   YES ☐ NO ☐

   If 'Yes' please give full details (where, when, duration and reason):

Section D. Occupation Details

1. Employer's Name

   Employer's Address State

   Postcode Phone

2. How long have you been in your current occupation?

3. Are you a Permanent or Casual employee? Please circle. Permanent Casual

   How many hours do you work per week?

   Are you self-employed (this means shareholder or employee of own company, sole trader or partner)?

   YES ☐ NO ☐

   If 'Yes' please give full details

   How long? % of business you own?

   Business/Company Name

   Business/Company address

   State Postcode

   How many employees do you have? (excluding yourself)

4 What industry do you work in?

Section D. Occupation Details (Continued)

5. What are the main duties of your occupation?

Duties (e.g., office work, sales, supervision, manual)	% of Time	Location (eg., office, on-site, travel, at home)	% of Time

6. Do you hold any professional/trade qualifications?

YES ☐ NO ☐

If 'Yes' please give full details

Professional / Trade Qualifications	% of Time

7. Has your main occupation, employer or employment status changed in the last 3 years?

YES ☐ NO ☐

If 'Yes' please give full details

Previous Occupation	Employer	Employment Status	Date from	Date to

* Employment Status (e.g. unemployed, employed, employed by own company, self employed, partnership)

8. Do you have any other occupation?

YES ☐ NO ☐

If 'Yes' please give full details

Type of occupation:

Name of your employer:

How many hours per week do you work in this other occupation? | How long have you been doing this other occupation?

What is your monthly gross income from this other occupation? $

Section E. Financial Details*

*** Only complete this section if applying for Group Income Protection – otherwise go to Section F.**
Please note that based on the financial information provided below, additional financial information may be required.

1. If disabled, would all or part of your income continue? (e.g., sick leave, other disability income policies, pension, investment, rental, company profit share, etc.)

YES ☐ NO ☐

If 'Yes' please give full details

Current Tax Year is	Commission/Bonus/Overtime component this amount is	Last Tax Year was	Commission/Bonus/Overtime component this amount is
	$		$

Section E. Financial Details*

2 Self-Employed only (i.e., sole trader, employed by/director of own company or trust, partnership)

YES ☐ NO ☐

If 'Yes' please give full details

Last Tax Year:		
	Business $	**Your Share $**
Gross Income	$	$
LESS Business Expenses	$	$
Net Income (Loss)	$	$
PLUS the following paid to you:		
Wages/Salary/Drawings/Director's Fees		$
Superannuation Costs		$
Total		$

Previous Tax Year:		
	Business $	**Your Share $**
Gross Income	$	$
LESS Business Expenses	$	$
Net Income (Loss)	$	$
PLUS the following paid to you:		
Wages/Salary/Drawings/Director's Fees		$
Superannuation Costs		$
Total		$

NB: any amounts received as wages/salary/drawings/director's fees must not be paid from past profits, capital or loans.

Section F. Medical Statement

1. Doctor's Name Telephone

Address

2. Details of last medical consultation, including doctors, physiotherapists, chiropractors or ANY other health professional.

Date	**Health Professional**	**Address**	**Reason**	**Outcome/Result**

3. Please state your

Height: Weight

Please tick No or Yes to each of the following:

4. Within the LAST THREE YEARS have you, other than advised above:

a. Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or other health care professional (naturopath, etc.) or been in a hospital or been advised to have an operation?

YES ☐ NO ☐

b. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection?

YES ☐ NO ☐

5. Have you EVER had an ECG, x-ray, transfusion, mammogram, surgery or any other investigation?

YES ☐ NO ☐

6. Have you EVER had any blood tests which revealed an abnormality, eg raised blood sugar, liver function or renal function results, or anaemia, etc?

YES ☐ NO ☐

7. Do you contemplate seeking any medical examination, advice, treatment or surgery in the future?

YES ☐ NO ☐

Dates from – to	**Name and address of Doctor or Hospital, Clinic, etc.**	**Conditions, Medications Treatment and Time off Work**	**Recovery %**

8. Please tick No or Yes to each of the following:

Have you EVER received any advice or treatment for:

a	High blood pressure, raised cholesterol, stroke or circulatory disorder?	YES ☐	NO ☐
b.	Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?	YES ☐	NO ☐
c.	Asthma, bronchitis or other lung complaint?	YES ☐	NO ☐
d.	Diabetes?	YES ☐	NO ☐
e.	Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?	YES ☐	NO ☐
f.	Hepatitis or other liver or gall bladder disease?	YES ☐	NO ☐
g.	Back, neck or knee complaint or any disorder of the joints, bones or muscles (e.g. gout, arthritis)?	YES ☐	NO ☐
h.	Kidney or bladder disease, renal colic, stones or blood in the urine?	YES ☐	NO ☐
i.	Depression, anxiety, stress, mental or nervous condition, or chronic fatigue?	YES ☐	NO ☐
j.	Cancer, tumour, melanoma, sunspots or growth of any kind?	YES ☐	NO ☐
k.	Eczema, dermatitis, psoriasis or any other skin condition?	YES ☐	NO ☐
l.	Tinnitus, hearing loss or any defect in hearing, sight or speech?	YES ☐	NO ☐
m.	Anaemia, leukaemia, haemophilia or other blood disorder?	YES ☐	NO ☐
n.	Thyroid or prostate disorder, any disorder of the reproductive organs, or sexually transmitted disease?	YES ☐	NO ☐
o.	Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	YES ☐	NO ☐
p.	Multiple sclerosis, epilepsy, fits of any kind, recurrent headaches, dizziness, fainting or any other neurological disorder?	YES ☐	NO ☐
q.	An autoimmune disease, immunodeficiency, immunosuppresion from medical therapies or any other disorder of the immune system?	YES ☐	NO ☐
r.	Any other physical impairment, congenital abnormality, or deformity?	YES ☐	NO ☐
	Females only:	YES ☐	NO ☐
s.	Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc)?	YES ☐	NO ☐
t.	Have you ever had any complications of pregnancy or childbirth?	YES ☐	NO ☐
u.	Are you currently pregnant?	YES ☐	NO ☐
	Delivery date	Date due:	
v.	Have you ever had a breast lump (even if you have not seen a doctor about it)?	YES ☐	NO ☐

Please provide full details for all YES answers above (if more space is required, please go to Section J).

Specific Condition	Question No.	Question No.	Question No.
1. Date symptoms first started and description of symptoms?			
2. What was the condition and which part of the body was affected?			
3. What was the medical diagnosis including results of x-rays and investigations?			
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?			
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
6. How long were you unable to work or perform your normal duties/activities?			

7. If a hospital visit was required, please provide date and duration of your stay.			
8. What advice/treatment did you receive?			
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
10. When did you last suffer from any symptoms			
11. Degree of recovery (%)			
12. Please supply name and address of all doctors or hospitals or other consultants			

Section G. Family History

1. Please tick No or Yes:

Have any of your parents, brothers or sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer, Huntington's Disease or any other hereditary disease?

YES ☐ NO ☐

If 'Yes' please provide full details (including age at diagnosis and age at death (if applicable):

Section H. Questions in relation to AIDS

Please tick No or Yes to each of the following:

a.	Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus)?	YES ☐	NO ☐
b.	Have you EVER sought or are you expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV?	YES ☐	NO ☐
c.	Have you EVER:	YES ☐	NO ☐
	i. Injected yourself with any drug not prescribed by a medical practitioner?	YES ☐	NO ☐
	ii. Worked as or engaged in sexual activity with a sex worker?	YES ☐	NO ☐
	iii. Engaged in sexual activity someone you know or suspect to be HIV positive?		
d.	Have you engaged in male to male anal sexual intercourse (except in a relationship between you and only one other person where neither of you had sex with anyone else in the past 5 years)?	YES ☐	NO ☐

Please note: if any of these questions are answered "Yes", we will send you a separate questionnaire.

Section I. Questions in relation to COVID-19

Please tick No or Yes to each of the following:

a.	Have you returned from overseas in the last 2 weeks?	YES ☐	NO ☐
b.	Have you had close contact with a person confirmed or suspected to have COVID-19 in the last 14 days?	YES ☐	NO ☐
c.	Have you been diagnosed with COVID-19 or is it likely that you have this disease?	YES ☐	NO ☐
d.	Have you suffered from one of the following symptoms in the last 14 days: sore throat, runny nose, fever of 38°celsius or above, cough, shortness of breath, difficulty breathing, chest pain or unexplained fatigue, aches and pains?	YES ☐	NO ☐
e.	Have you been advised to undergo a test for COVID-19 or do you currently await the result from a test for COVID-19?	YES ☐	NO ☐

If 'Yes' to any of the above, please provide further details:

Section J. Additional Information (to assist with clarification)

Section K. Consent for Accessing 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.

Hannover Life Re of Australasia Ltd (HLRA), 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. HLRA will require your consent to release information. Each time you apply for cover or make a claim, HLRA will ask you for a fresh consent. HLRA will respect your privacy by only asking for the information that is reasonably required. HLRA will tell you each time your consent is used.

Even if HLRA collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell HLRA every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms.

Please read each Authority carefully and the explanatory notes below.

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

☐ By ticking this box I .... whose date of birth is set out below, indicate that 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 Hannover Life Re of Australasia Ltd (HLRA) and Christian Super, or to third parties they engage.

I agree to all the following:
- My health information can be released in the form HLRA 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.
- HLRA and Christian Super 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 HLRA 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.

Applicant's Date of Birth ....

Date

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

☐ By ticking this box I .... whose date of birth is set out below, indicate that I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Hannover Life Re of Australasia Ltd (HLRA) and Christian Super or to third parties they engage, only if HLRA 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: HLRA and Christian Super can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and wAustralian Privacy Principles.
- This Authority is valid only while HLRA 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.

Applicant's Date of Birth ....

Date

Section L. Consent, Declaration & Authority to Provide Information

☐ By ticking this box you whose date of birth is set out below, indicate that by continuing with your application (and, any variation, extension or reinstatement of your application) or application for different insurance cover you agree that:

- You have read, understand and agree to the terms of our Duty to Take Reasonable Care and all your answers are correct. In particular, you give us ageneral authority to obtain information we reasonably believe is relevant to your application unless you tell us otherwise (e.g. where you request we only obtain particular information from particular sources or you have not consented for your health provider to release your health information to us) which may delay or invalidate your application and, if you fail to comply with your Duty to Take Reasonable Care, we may avoid your cover or reduce the amount of cover if it is within a 3 year period.
- You have read, understand and agree to the terms of our Privacy Collection Notice. In particular, you consent to us collecting and where required disclosing certain personal information and sensitive information (including medical and health information) from or to third parties (the details of which can be found in our Privacy Collection Notice www.hannover-re.com/1094181/australia_lh_privacy and/or www.christiansuper.com.au/files/Privacy-Policy-20200224.pdf) who may contact you and provide information to you about our or their services.
- As at the date of this application you are not absent from work for reason of illness or injury and you are performing all duties you would ordinarily perform in your occupation.

I accept that this electronic authority replaces the need for a personally signed Consent, Declaration and Authority to Provide Information.

Applicant's Date of Birth ....

Date