

# Virgin Superannuation Personal Health Statement



Dated 20 July 2005

## Important Notice

ING Life Limited (ING Life) ABN 33 009 657 176 Australian Financial Services Licence number (AFSL) 238341 is Virgin Superannuation's group insurer. Make sure you read and understand the Virgin Superannuation for Business Product Disclosure Statement (PDS) if you are joining through your employer or for Personal, the current Virgin Superannuation (PDS) for cover you are individually applying for.

Please complete this form if one of the following applies to you:

- You want Death only cover for more than \$350,000; or
- You want Death and Total Permanent Disablement (TPD) cover for more than \$350,000; or
- You want Income Protection cover; or
- You're an existing Virgin Superannuation member and you want to add to your existing cover.

ING Life requires this insurance form and other health information to help them make a decision on your proposed insurance cover.

You may wish to send it in an envelope to:

Customer Care Team  
Virgin Superannuation  
Locked Bag 8  
Haymarket, NSW 1236

The information you provide on this insurance form is confidential.

Please refer to the Privacy Statement in the relevant PDS for information on how we use your personal information.

## Your Duty of Disclosure

Before you enter into a contract of insurance with a life insurer you have to, under the Insurance Contracts Act 1984, disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk for the insurance and if so on what terms. You have the responsibility to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of life insurance.

You do not have to disclose any matter:

- that diminishes the risk undertaken by the insurer,
- that is of common knowledge,
- that the insurer knows or, in the ordinary course of business ought to know,
- to which the insurer waives your duty of compliance.

## Non-Disclosure

If you fail to comply with your duty of disclosure, and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may void the contract within the first three years of entering into it. If your non-disclosure is fraudulent, the insurer may void the contract at any time. An insurer who is entitled to void a contract of life insurance may, within three years of entering into it, elect not to void it but reduce the sum that you have been insured for according to the premium that would have been payable if you had let the insurer know all relevant matters.

STEP  
1

## TYPE OF COVER YOU ARE APPLYING FOR

	Amount of benefit/cover
<input type="checkbox"/> Death Only	\$ <input type="text"/>
<input type="checkbox"/> Death and Total and Permanent Disablement (TPD)	\$ <input type="text"/>
<input type="checkbox"/> Income protection (monthly benefit)	\$ <input type="text"/>

STEP  
2

## VITAL STATISTICS

Membership number (if applicable)	<input type="text"/>		
Title	Given name(s)	Family name	<input type="text"/>
Date of birth	Gender	Employer name	<input type="text"/>
Employer Address	Level No.	Street No.	Street Name
	Suburb	State	Postcode
Occupation	<input type="text"/>		
Occupation duties (include the percentage of time spent in each)	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		

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## STEP 3 CURRENT INSURANCE DETAILS

1. Have you previously applied to ING Life or do you currently have other applications that have been submitted to ING Life? Yes  No   
 If YES provide Application No. or Policy No.

2. Have you any Life, TPD, Income Protection and/or Trauma cover with ING Life or any other company or as a part of your employment or have you recently asked for such cover with any other company? If YES, please provide details of cover. Yes  No   
 Name of Company  Type of Cover  Sum Insured \$  Date Commenced  /  /

3. If this application is accepted, do you intend this cover to replace any cover mentioned above? If YES, provide the following, if known. Yes  No   
 Name of Company  Alteration  Reason  Date  /  /

4. Have you ever had an application for life insurance declined, postponed or accepted with a higher than normal premium or otherwise than as submitted? If YES, please provide details. Yes  No   
 Amount \$  Period Paid  Type  Disability Suffered  Date  /  /

## STEP 4 LEAVING OR STAYING?

1. Are you a permanent resident of Australia? Yes  No  2. How long have you lived in Australia?

3. Do you have any intention to travel outside Australia within the next two years? Yes  No  If YES, please complete the following:  
 Date of departure (if known)  /  /  Duration of stay  Destination

4. What is the purpose of your stay? Holiday  Business  Residing  Other (please specify)

## STEP 5 USUAL DOCTOR OR MEDICAL CENTRE DETAILS

1. Full name of usual doctor  Phone number ( )

2. Full address of usual doctor Street No.  Street Name  Suburb  State  Postcode   
 How many years have you been attending this doctor?  years  months

3. If known for less than 12 months, please tell us the name and address of another doctor who has details of your medical history.  
 Name  Phone number ( )   
 Address Street No.  Street Name  Suburb  State  Postcode

4. If you have more than one usual doctor, please provide details of additional doctors below.  
 Name  Phone number ( )   
 Address Street No.  Street Name  Suburb  State  Postcode   
 How many years have you been attending this doctor?  years  months

5. Please give details of your last consultations with ANY doctors, and if applicable, outcome or degree of recovery. If more space is required, attach an additional page.  
 Name  Phone number ( )   
 Address Street No.  Street Name  Suburb  State  Postcode   
 Date  /  /  Reason for consultation   
 Outcome

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## STEP 6 PERSONAL HEALTH STATEMENT

If a medical examination is required, or if you are completing a Paramedical Report, please go to Step 10 of this form. Otherwise, complete Steps 6, 7, 8 and 9.

1. What is your current height and weight? Height (cm)  Weight (kg)

2. Has your weight varied by more than 10 kg during the past 12 months? Yes  No   
 If YES, please provide details.

3. During the past 12 months have you smoked tobacco or any other substance? Yes  No   
 If YES, please state type and daily quantity.

4. Non-smokers – Have you ever smoked regularly in the past? Yes  No   
 If YES, please state date ceased and daily quantity.

5. Do you consume alcohol? Yes  No   
 If YES, state type and daily quantity (please do not write 'social').

6. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? Yes  No   
 If YES, please provide full details.

## STEP 7 FAMILY HISTORY (BLOOD RELATIVES)

1. Have any of your parents, brothers or sisters (living or dead) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary or familial disorder? If YES, please complete the following: Yes  No   
 Relation  Condition (disorder)  Age diagnosed   
 Attach additional pages as necessary.

2. Have any of your parents, brothers or sisters (living or dead) been diagnosed prior to age 60 with any of the following conditions: diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease. If YES, please complete the following: Yes  No   
 Relation  Condition (disorder)  Age diagnosed   
 Attach additional pages as necessary.

## STEP 8 HEALTH HISTORY

**To the best of your knowledge, have you ever had any of the following?**  
 If the answer is YES, please circle the specific conditions and follow the instructions in the box on the next page.

1. Asthma, sleep apnoea, bronchitis, persistent cough or any other chest or lung troubles or allergy? Yes  No

2. Heart trouble, murmur, high blood pressure, high cholesterol, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? Yes  No

3. Diabetes, thyroid or glandular trouble? Yes  No

4. Ulcers, bowel trouble or recurring indigestion? Yes  No

5. Epilepsy, fits or dizziness of any kind or persistent headaches? Yes  No

6. Stress, anxiety, depression, mental or nervous disorders? Yes  No

7. Kidney or bladder problems, renal colic or stones, nephritis, pyelitis or cystitis? Yes  No

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## STEP 8 HEALTH HISTORY (CONTINUED)

- 8. Back, neck, shoulder or knee pain or strain, sciatica or any other disorder of the spine or neck, any disorder of the joints, muscles, ligaments, cartilage or limbs, including broken bones? Yes  No
- 9. Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? Yes  No
- 10. Cancer, tumour, cyst, growths of any kind or breast lumps (even if you have not seen a doctor)? Yes  No
- 11. Varicose veins, hernia or skin trouble? Yes  No
- 12. Any abnormality affecting eyesight, hearing, speech or physical mobility? Yes  No
- 13. Anaemia, haemophilia or any other disease of the blood? Yes  No
- 14. Bowel, liver or gall bladder disease, or hepatitis? Yes  No
- 15. Coughing of blood, passing of blood from the bowel or in the urine? Yes  No
- 16. Any sexually transmittable disease including but not limited to AIDS or its positive antibodies, gonorrhoea or syphilis? Yes  No
- 17. Within the last five years, have you had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? Yes  No
- 18. Due to injury or illness have you ever been off work for more than seven consecutive days? (for a condition not already mentioned) Yes  No
- 19. Do you currently have any symptoms of ill health or disability? Yes  No
- 20. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation in the future? Yes  No
- 21. Do you take, or have you EVER taken, drugs, tablets or any medications on a regular or ongoing basis? Yes  No
- 22. Have you EVER used or injected any drugs not prescribed by a medical attendant? Yes  No
- 23. AIDS Statement (i) Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes  No
- (ii) Have you EVER worked as, or engaged in sexual activity with, a prostitute, or engaged in anal sexual activity? Yes  No
- (iii) Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Yes  No
- 24. Females only – Have you ever had any complications with pregnancy or childbirth? Yes  No
- Are you currently pregnant? Yes  No
- Have you ever had an abnormal pap smear, breast ultrasound or mammogram? Yes  No

### FOR ANY YES ANSWER ABOVE

If a condition is named please complete Additional Medical Questionnaire in Step 9 of this form.

**Otherwise, complete the following table and include full details. If there isn't enough space, please attach an additional statement. This does not mean that insurance is not available, but ING Life may require additional information from you to assess your application.**

Question No.	<input type="text"/>	Illness, injury or tests	<input style="width: 100%;" type="text"/>			
Date commenced	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time off work	Years <input type="text"/>	Months <input type="text"/>	Days <input type="text"/>	Degree of recovery (%) <input type="text"/>
Full details of treatment	<input style="width: 100%;" type="text"/>					
Date of last symptom	<input style="width: 100%;" type="text"/>					
Full name and address of doctor or hospitals consulted	<input style="width: 100%;" type="text"/>					
Other information	<input style="width: 100%;" type="text"/>					

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**STEP 9** **ADDITIONAL MEDICAL QUESTIONNAIRE – TO BE COMPLETED IF YOU HAVE OR HAVE HAD A CONDITION NAMED IN STEP 8**

1. Please name the condition(s) from Step 8.

2. What were the main symptoms and/or what caused the condition?

3. Date symptoms commenced  /  /  Date symptoms ceased  /  /

4. Time off work  Years  Months  Days

5. Did you experience your condition more than once? Yes  No  If YES, please complete the rest of this question.  
Date condition occurred  /  /  Date condition lasted until  /  /  Time off work

6. Have you fully recovered from the condition? Yes  No   
7. If YES, when did you fully recover from the condition?  /  /

8. What test/treatment/medication have you had for this condition? Please give details.

9. Which doctor did you last consult about this condition and what was the date of that consultation?  
Doctor's name  Date  /  /

10. Does your usual doctor have details of this condition? Yes  No

11. Has further treatment been recommended by your doctor for this condition? Yes  No  If YES, please give details.  
Date commenced  /  /  Time off work  Years  Months  Days Degree of recovery (%)

Full details of treatment   
  
 Date of last symptom  /  /

Full name and address of doctor or hospitals consulted

Other information

Date commenced  /  /  Time off work  Years  Months  Days Degree of recovery (%)

Full details of treatment   
  
 Date of last symptom  /  /

Full name and address of doctor or hospitals consulted

Other information

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## STEP 10 SPORTS AND PASTIMES

Do you intend to take part in:

1. Aviation, other than as a fare-paying passenger? Yes  No
2. Any hazardous activities or sports, e.g. motor or water sports (e.g. scuba, skin diving), football, parachuting, gliding, recreations involving heights, underground sports, underwater sports, caving, body contact sports, hang gliding etc? Yes  No
3. Motorcycle riding/motor racing other than as a means of transportation to and from work? Yes  No

If you have answered NO to questions (1), (2) and (3) above, please proceed to Step 11.

If you answered YES to any of the questions (1), (2) or (3) above, please continue completing Step 10 below for any relevant activities. If necessary, please elaborate on any YES answers, i.e. type of sport, time spent training and participating, number of times per annum, receipt of fees or payments, any injuries sustained, in the following pages.

### Sports and pastimes

#### Motorcycle/Motor racing

Vehicle type  Races per annum  Engine size  Maximum speed (km/h)  Yes  No

Class professional/amateur  Competitive/recreational

#### Scuba/Skin Diving

Average depth (m)  Maximum depth (m)  Dives per annum  Do you use explosives? Yes  No

If you dive in caves or potholes, give details.

#### Football/Soccer/Aussie Rules, etc.

Code played  Grade  Yes  No

Games per annum professional/amateur  Competitive/recreational

If you are a member of a club, give details

Do you receive any income from participating in football/soccer/Aussie Rules etc.?

Yes  No

If YES, provide amount and details.

#### Aviation/Flying – Civil Aviation Safety Authority (CASA)

Do you hold a CASA licence?

Yes  No

Yes  No

If YES, state type and period held

Type  Period held

Do you intend to change the scope of your present licence?

Yes  No

Have you ever had an accident or been charged with violating CASA Regulations?

Yes  No

Do you always use authorised landing areas?

Yes  No

Number of hours flown

Past 12 months  Future  Annual average

#### Type of aircraft

Crew Passenger  Commercial airline  Charter  Private  Aero club/flying school  Agriculture  Helicopter  Ultralight aircraft

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**STEP  
10**

## SPORTS AND PASTIMES (CONTINUED)

### Other activities

Do you intend to take part in any form of aviation other than the above categories? (e.g. ballooning, aerobatics, parachuting, paragliding, etc.)

Yes  No

If YES, provide amount and details.

### Other sports or pastimes

Do you currently, or intend to, p

Yes  No

If YES, provide amount and details.

On what basis do you consider that you partake in this activity?

Professional/amateur

Competitive/recreational

**STEP  
11**

## DECLARATION BY THE LIFE INSURED OR APPLICANT

I acknowledge that:

- I have read and carefully considered the questions in this application and all answers provided are true and correct. I have told ING Life everything I know that could affect its decision to accept my application.
- I have read the Duty of Disclosure and understand my obligations under the Insurance Contracts Act 1984 as explained above.
- This application for cover is being made to ING Life Limited ABN 33 009 657 176. AFSL 238341.
- I have read the Privacy Statement in the PDS and I consent to the collection, use and disclosure of my personal information (including my health information) in accordance with the Privacy Statement. I understand that ING Life will not be able to process this application, accept cover or process a claim without this consent.
- I am not restricted by injury or illness from carrying out all my normal work duties and I am working my normal hours.
- If I do not complete this application correctly, or I do not sign and date this form, my application will be invalid and will not be considered by ING Life.
- I hereby authorise the release to ING Life, or any other organisation duly appointed by ING Life, of any medical information needed in connection with this application, including full details of my past medical history. A photocopy (or similar reproduction) of this authorisation will be as valid as the original.

Autograph of applicant

Date

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**STEP  
12**

## DOCTOR'S AUTHORISATION

To be completed and signed by the applicant.

### Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 or any organisation duly appointed by ING. A photocopy (or similar reproduction) of this authorisation shall be as valid as the original.

My name	<input type="text"/>				
My autograph	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you have supplied the details of another doctor, please authorise them to release your medical history by completing the information below.

### 2nd Doctor's authorisation

To be completed and signed by the applicant.

### Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 or any organisation duly appointed by ING. A photocopy (or similar reproduction) of this authorisation shall be as valid as the original.

My name	<input type="text"/>				
My autograph	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



Customer Care Team  
Virgin Superannuation, Locked Bag 8  
Haymarket, NSW 1236



**1300 652 770**  
8am – 8pm (EST)  
Monday – Friday  
if you need any help.

ABN: 88 436 608 094 SFN: 51 166 1052  
SPIN: TCS0005AU Licence Number: 286869  
Trustee ABN: 49006 421 638