Insurance Personal Statement

How to use this form

You should complete this form if:

- You have applied to change your cover using the Change of Insurance form or Member Online and we asked you for additional information to assess your application.
- You want to apply to have the pre-existing exclusion period removed from your cover.

Before you start:

- Don't complete this form if you have just started your job, as you'll soon be receiving a welcome letter that will detail what insurance you have.
- Any requested changes to your insurance won't apply until we confirm we've accepted this form and processed your changes. You shouldn't cancel any cover you have with other super accounts or insurers until you receive this confirmation.
- Replacing your existing cover may result in the loss of any accrued benefits or waiting periods restarting. Deciding what is best for you will depend on your personal circumstances, and you may want to seek personal financial advice to get the most from your super. You can find out more about financial advice options at qsuper.qld.gov.au/advice.

Before completing this form, please read our Insurance Guide, available at **qsuper.qld.gov.au/pds**

1 Personal details

Client number

You can find your client number on your annual statement or by logging in to Member Online.

Title

First name/s

Last name

Previous name (if we know you by another name)[1]

Date of birth (dd/mm/yyyy)

/ /

Residential address

State Postcode

Postal address ☐ As above

State Postcode

We are committed to assessing your application as quickly as possible. To do this, we may need to contact you for additional information to help speed up the process.

Are you happy if we call/email you to clarify or gain further information?

◯ Yes ◯ No

If 'yes', please provide details below. If 'no', we will post you any requests for information.

Mobile phone number

Preferred contact time

Landline phone number

Preferred contact time

Email address

2 Duty to take reasonable care explained

When applying for insurance, you have a legal duty to take **reasonable care not to make a misrepresentation** to Australian Retirement Trust or the insurer (ART Life[2]) before the contract of insurance is entered into. A misrepresentation is a false answer, an answer that is only partially true, or an answer that 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 avoided (treated as if it never existed), or its terms may be

1 If your name has changed and you work for the Queensland Government or default employer, let your payroll office know and they'll then let us know. Otherwise, please send us a certified copy of either a marriage certificate or other legal change of name document. **2** ART Life Insurance Limited (ABN 79 607 345 853, AFSL 483057) 'ART Life' is a registered life company that is ultimately owned by the Australian Retirement Trust Pty Ltd as trustee for Australian Retirement Trust.

changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where the insurer may later investigate whether the information you provided to us was true. For example, the insurer may do this when a claim is made. As part of these investigations, the insurer may require you to supply health and other information and require you to attend medical examinations.

Guidance for answering our questions

When we ask you questions, we do so on behalf of the insurer. You are responsible for the information provided to us and the insurer. 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 that we ask you.
- Do not assume that we will contact your doctor for any medical information.
- 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, please tell us about any changes that mean you and each person that answered our questions would now answer 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 your adviser for help if you have difficulty understanding the process of applying for insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, please let us know so we can discuss any additional support you may need. If you want, you can have a support person you trust with you or receive assistance from the Australian Government's Translating and Interpreting Service (TIS National) on 131 450. It's available to anyone, 24/7 (all day, every day).

About this application

When you apply for insurance, we conduct a process called underwriting. It's how the insurer decides whether it can cover you, and if so on what terms and at what cost.

You will be asked questions that the insurer needs 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 in response to these questions is vital to the insurer's decision.

Notifying the insurer

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

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position they would have been in if the duty had been met.

For example the insurer may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

- whether, when you answered our questions, you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was.
- what the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before the insurer exercises any of these remedies, the insurer will explain its reasons, how to respond and provide further information, and what you can do if you disagree.

3 Tell us the total amount of cover you want

☐ **Death cover (include any cover you already hold and want to keep)**

Fixed amount ($3 million maximum in multiples of $1,000) OR **Number of units**

☐ **Total and permanent disability cover (include any cover you already hold and want to keep)**

Fixed amount ($3 million maximum in multiples of $1,000) OR **Number of units**

☐ **Income protection cover**

Number of units (units are each worth $500 per month)

(If you have salary-based cover of 87.75% of insured salary and wish to keep this level of cover, you don't need to complete this field.)

Benefit period ◯ 2 years ◯ 5 years ◯ To age 65

Waiting period ◯ 30 days ◯ 60 days ◯ 90 days

☐ **I am requesting removal of a pre-existing exclusion period on any existing cover.**

☐ **I want to cancel cover that I currently hold that I have not listed above.**

4 Permanently opt in to cover

Complete this section if you want to permanently opt in to your insurance cover.[3]

☐ I want to opt in to keep the type of cover that I currently hold (being death cover, total and permanent disability cover, and/or income protection cover) and any new types of cover I am applying for on this form (subject to acceptance), even if:

- My Accumulation account becomes inactive by not having money added in the last 13 months, and/or
- My Accumulation account balance has not reached $6,000 or has not been over $6,000 and/or
- I am under 25 years of age.

I understand that the permanent opt in will only apply to the type of cover I currently hold. I understand that I will need to permanently opt in again for any new types of cover I apply for, or any new types of cover that I may be given automatically because of my employment status.

5 General health questions

Before we can make any changes to your insurance, we need to know about your general health and insurance history. Complete this section to tell us about your general health history. You don't need to complete this section if you are returning this form with a *Change of Insurance* form.

Q1. Are you currently off work, restricted, or unable to fully perform without limitation all the duties of your usual occupation on a full-time basis (for at least 30 hours per week), due to sickness, illness, or injury, even if your actual employment may be full-time, part-time, casual, or contract basis?

◯ Yes ◯ No

Q2. Are you:

a) Currently being paid, or have you been paid, a benefit through any life insurance policy (including total and permanent disability (TPD) and trauma) or any source of income support (e.g. Workers' Compensation or income protection benefits) replacing all or part of your income while unable to work as a result of accident, injury, or sickness?

AND/OR

b) In the process of, or are you considering, submitting a claim through any life insurance policy (including total and permanent disability (TPD) and trauma) or any source of income support (e.g. Workers' Compensation or income protection benefits) to replace all or part of your income if unable to work as a result of accident, injury, or sickness?

◯ Yes (please provide details below) ◯ No

Reason for claim(s):

Type of claim(s) (e.g. income protection, TPD or Workers' Compensation):

Dates (dd/mm/yyyy) – (dd/mm/yyyy)

Q3. Have you ever had, or received medical advice or treatment for, any of the following:

a) Any cancer, tumour, or melanoma, or diabetes type 1 or 2?
b) Multiple sclerosis (MS), cerebral palsy, any form of plegia (paralysis), or any neurological disorder?
c) Stroke, aneurysm, heart disease, cardiovascular disease, arrythmia, heart valve problem, or heart attack?
d) Alcohol and/or drug abuse, Hepatitis B or C, HIV, or AIDS?
e) Schizophrenia, personality disorder, bipolar disorder, psychotic disorder, eating disorder, or post-traumatic stress disorder (PTSD)?
f) Huntington's disease, Parkinson's disease, Alzheimer's disease or any form of dementia, or motor neurone disease?

◯ Yes ◯ No

Q4. In the last 5 years have you had, or received medical advice or treatment for:

a) Any symptoms of stress (for which you have sought and/or received medical advice)?
b) Any mental health conditions such as anxiety or depression, or any behavioural condition?
c) Any injury to, disease, or disorder of the back, or neck?
d) Any injury to, disease, or disorder of the knee, shoulder, or any other joint or bone, or arthritis? (Note: You do not need to tell us about strains, sprains, or minor fractures that have fully resolved.)
e) Any autoimmune disease (e.g. rheumatoid or psoriatic arthritis, lupus, inflammatory bowel disease), chronic pain, chronic fatigue, or fibromyalgia?
f) Any disease or disorder of the liver or kidney, or organ transplant as a recipient?
g) Any lung disease or disorder (excluding asthma or bronchitis), sleep apnoea, coronavirus (COVID-19), loss of hearing, or loss of sight? (Note: You don't need to tell us if you are short or long-sighted.)

◯ Yes ◯ No

3 There are various circumstances when cover will end. See the Insurance Guide at qsuper.qld.gov.au/pds

Q5. Aside from your answers to the previous questions, are you currently under investigation, awaiting investigation, or considering seeking medical advice or treatment for any symptoms, condition, or any abnormal test results?

(Note: You don't need to tell us about any routine annual health checks or age-related surveillance checks that have been confirmed to you to be normal with no treatment or subsequent investigations or tests required.)

◯ Yes ◯ No

Q6. What is your current height and weight?

cm kg

6 Occupational rating questions

You'll need to complete these questions before we can assess your application. These questions refer to the role you spend the most time performing. You don't need to complete this section if you are returning this form with a *Change of Insurance* form.

Q1. Are you:

- A registered or enrolled nurse or assistant in nursing who is qualified and currently practicing, or
- Working in the retail sector, or food and beverage service?

◯ Yes ◯ No

Q2. Are you:

- A qualified tradesperson working in your area of expertise (e.g. hairdresser, chef, plumber, electrician, plasterer, or concreter), or
- A skilled worker with light manual duties (e.g. jeweller, building inspector, laboratory technician, foreman, or office equipment technician)?

◯ Yes ◯ No

Q3. Are you:

- A police officer, firefighter, paramedic, or other emergency or protective services worker, including security guard or corrections officer, or
- A professional sportsperson, or
- Working in a manual occupation that does not require trade specific qualifications and may be subject to accident or environmental hazards (e.g. earthmover, driver, cleaner, labourer, factory worker, or agricultural worker)?

◯ Yes ◯ No

Q4. Are the usual work activities of your job considered office-based or school teaching (meaning you spend at least 80% of your work time doing clerical, call centre, administrative, or other office or classroom-based activities)?

OR

Are you a medical practitioner, lawyer, or engineer who spends at least 80% of your work hours in an office or clinical environment?

◯ Yes ◯ No

Q5. Do you currently perform or intend to work in a job within the next three months that includes any of the following risky activities:

- Handling firearms (other than as a police officer, correctional officer, or licensed security guard), dangerous chemicals, or explosives, or
- Offshore work – oil and gas platforms or ships at sea, or
- Being underground (in construction and mining environments) or underwater for more than 20% of total at work time, or
- Working at heights over 20m in any environment requiring hard hat and harness for safety by law, or
- Crop dusting, aerial mustering, or any low level flying activity (defined as below 150m or 500ft), or
- Flying more than 200 hours per annum as a passenger other than on a commercial airline, or as a pilot (fixed wing or helicopter)?

◯ Yes ◯ No

Q6. Are you earning more than $120,000 a year (before tax and employer paid superannuation) from your job?

◯ Yes ◯ No

Q7. Do you have a university qualification that you are using or that is required in your current role?

◯ Yes ◯ No

Q8. Do you have a senior/executive level management role in your company? (Your direct reports would be mid-level managers or skilled specialists in a sedentary setting.)

OR

Is your role considered professional (e.g. doctor, solicitor, accountant – requiring membership of a professional or government body to practise in your occupation)?

◯ Yes ◯ No

7 Employment and income questions

Q1. Are you a citizen or permanent resident of Australia?
(Australian resident has a specific meaning that can be found in the Definitions section of the Insurance Guide.)

◯ Yes ◯ No

Q2. What is your job?

Q3. What is your current annual income (gross income before tax, excluding super)?

Employee: Your remuneration from your package includes your base salary, regular bonuses and allowances, regular overtime, and commissions. Mandated superannuation, investment income, or interest are not included.

You should base bonuses, overtime earnings, and commissions on the average of the last three years received by you from your employer.

Self-employed: Gross income of your business (based on your personal efforts), less any business expenses incurred to earn that income, over the last 12 months.

$

Q4. Do you earn income from more than one job?

◯ Yes ◯ No

If 'yes', please provide details, including a breakdown of the annual income earned from each job.

Q5. What is your employment status?

◯ Self-employed ◯ Full-time ◯ Part-time
◯ Casual ◯ Contractor ◯ Student
◯ Home maker ◯ Unemployed ◯ Retired

Q6. Do you have any definite plans to change your job, usual duties, and/or employment situation?

◯ Yes ◯ No

If 'yes', please provide details:

8 Tell us what other life insurance cover you have

Q1. Other than this application, do you **have** or have you **recently applied** for any death cover, total and permanent disability cover, or income protection cover?

◯ Yes (complete the table below) ◯ No

Insurer	Type of cover	Insured amount	Replaced by your Australian Retirement Trust cover?	Policy number	Date policy commenced
		$	◯ Yes ◯ No		
		$	◯ Yes ◯ No		
		$	◯ Yes ◯ No		
		$	◯ Yes ◯ No		

Q2. Have you ever had an application for death cover, income protection, total and permanent disability, trauma, accident, or sickness insurance declined, deferred, or accepted with special terms, e.g. a premium loading or exclusion/s?

◯ Yes (complete the table below) ◯ No

Insurer	Type of cover	Terms offered	Reasons for terms	Date

If you need to list more, please provide information about the benefit at the end of this form or attach a separate sheet with the details.

9 Tell us about your lifestyle

Q1. Have you smoked tobacco, used e-cigarettes (vaping), or any other substance including nicotine replacement products in the last 12 months?

◯ Yes (tell us your average tobacco or nicotine use in the table below) ◯ No

Type smoked/used		Per day		Per month
Cigarettes			OR	
Other – specify type			OR	

If you've stopped using tobacco, e-cigarettes, or any other substance in the last 12 months, what date did you stop? **Date** (dd/mm/yyyy)

Q2. **How many standard drinks would you consume in a typical week?** A standard drink is equivalent to 1 nip of spirits, 1 glass/100mL of wine, or 330mL/stubby of beer.

Per day		Per week		Per month		Per year
	OR		OR		OR	

Q3. Have you ever received advice, treatment, or counselling to reduce or stop drinking alcohol?

◯ Yes ◯ No

If 'yes', please provide details including type of advice/treatment, dates, and doctor's details (if different to your usual GP).

Q4. Within the last 10 years, have you used any illegal or recreational drugs, or prescription drugs that were not prescribed for you?

Note: You do not need to tell us about over-the-counter medications.

◯ Yes (complete the below section) ◯ No

What drug/s did/do you take?

When did you start taking the drug/s? (dd/mm/yyyy)

When did you last take these drugs? (dd/mm/yyyy)

Did you receive counselling and/or treatment for drug abuse/misuse?

◯ Yes ◯ No

If 'yes', when did you receive counselling/advice/ treatment?

Start: (dd/mm/yyyy) **Last:** (dd/mm/yyyy)

Would your usual doctor have information on this matter?

◯ Yes ◯ No

If 'no', please provide doctor or medical centre contact details.

Doctor's name or medical centre

Address

State **Postcode**

Phone number

Email address

10 Pastimes and activities

Q1. Do you take part in, or have definite plans to take part in, any of the following pastimes or sports?

a) Aviation (other than as a passenger on a recognised carrier)

◯ Yes ◯ No

b) Scuba diving

◯ Yes ◯ No

c) Motor sports of any kind (e.g. motor cross, rally driving, ocean racing, trail bike, and quad bike riding)

◯ Yes ◯ No

d) Football of any code (excluding touch football and Oztag)

◯ Yes ◯ No

e) Any other sport or hazardous activities (e.g. parachuting, hang-gliding, martial arts, mountaineering)

◯ Yes ◯ No

If you have answered 'yes' to any of the above, please complete the specific questions on the related activity in sections 23-27.

11 Doctor details

Q1. Please provide your regular doctor's details.

Doctor's name or medical centre

Address

State **Postcode**

Phone number

Email address

Q2. Have you been a patient of this doctor or medical centre for less than 12 months?

◯ Yes ◯ No

If you answered 'yes', please provide details of your previous doctor or the medical centre you consulted.

Doctor's name or medical centre

Address

State **Postcode**

Phone number

Email address

12 Family history details

Q1. Have any of your first-degree blood-related relatives (parents, brothers, or sisters) been diagnosed with any of the following conditions before age 65?

a) Heart disease, heart attack, cardiomyopathy, stroke, or diabetes
◯ Yes ◯ No ◯ Unknown

b) Motor neurone disease, Alzheimer's, Parkinson's disease, or multiple sclerosis (MS)
◯ Yes ◯ No ◯ Unknown

c) Cancer of any type (specify type of cancer in table below, e.g. breast, ovarian, bowel, or melanoma)
◯ Yes ◯ No ◯ Unknown

d) Huntington's disease, muscular dystrophy, polycystic kidney disease, or any other hereditary disease
◯ Yes ◯ No ◯ Unknown

If you answered 'yes' to any of the previous questions, please provide details in the table below

Relationship to you

Condition

Approximate age of onset | **Age at death** (if applicable)

Relationship to you

Condition

Approximate age of onset | **Age at death** (if applicable)

Relationship to you

Condition

Approximate age of onset | **Age at death** (if applicable)

If you need to include additional family members, please provide information at the end of this form or attach a separate sheet with the details.

13 Genetic testing

If you have had a genetic test, you only need to tell us about this if your total Australian Retirement Trust insurance cover exceeds:

- $500,000 life (death) cover, or
- $500,000 total and permanent disability (TPD) cover, or
- $4,000 per month income protection cover.

If your cover exceeds the amounts outlined above, please complete the question below. If your cover does not exceed the amounts outlined above, please move on to the next section.

Have you ever had, or are you currently waiting for a result of, or are you considering having a genetic test? (Note: You don't have to provide a result if you were or are taking part in a medical research project or trial and haven't been or will not be provided with your individual result.)
◯ Yes ◯ No

If 'yes', please provide details including the date of the test, the reason for the test, and the result of the test:

14 Medical history details

Q1. Have you ever had any symptoms, or received medical advice or treatment for:

a) Back or neck pain or any condition affecting your back or neck?
◯ Yes ◯ No

b) Any arthritis or disorder or injury of any joint, bone, muscle, ligament, or tendon including pain, strain, fracture, or osteoporosis?
◯ Yes ◯ No

c) Any mental health condition such as anxiety, depression, post-traumatic stress disorder (PTSD), schizophrenia, bipolar disorder, eating disorder, or any other mental health disorder?
◯ Yes ◯ No

d) Any disorder of the lungs or issues with your breathing, such as asthma, bronchitis, pneumonia, snoring, or sleep apnoea?
◯ Yes ◯ No

e) Any skin lesions, cysts, or non-cancerous lumps or growths?
◯ Yes ◯ No

f) Diabetes, raised blood sugar, gout, or any thyroid disorder?
◯ Yes ◯ No

g) High blood pressure or cholesterol?
◯ Yes ◯ No

Q2. Have you ever had any symptoms, or received medical advice or treatment for:

a) Any disorder of the heart or blood vessels, such as heart attack, chest pain, cardiomyopathy, heart murmur, palpitations, abnormal heartbeat, or blood vessel disease?

◯ Yes ◯ No

b) Stroke, transient ischaemic attack, multiple sclerosis (MS), Parkinson's disease, or motor neurone disease?

◯ Yes ◯ No

c) Any neurological disorder, such as epilepsy or seizures, paralysis, muscle weakness, tingling, or head injury?

◯ Yes ◯ No

d) Any cancer such as skin cancer, melanoma, tumour, leukaemia, Hodgkin's disease, lymphoma, or any other malignant condition?

◯ Yes ◯ No

e) Lethargy, chronic fatigue, pain syndrome, glandular fever, fibromyalgia, or stress?

◯ Yes ◯ No

f) Any disorder of the gall bladder, oesophagus, stomach, persistent indigestion, GORD, or gastric or duodenal ulcer?

◯ Yes ◯ No

g) Any disorder of the liver or bowel, such as hepatitis, abnormal liver function, Crohn's disease, or ulcerative colitis?

◯ Yes ◯ No

h) Any disorder of the kidneys and urogenital tract, such as kidney stones, urinary tract infections (UTI), blood, protein, sugar in the urine, or bladder disorder?

◯ Yes ◯ No

i) Haemochromatosis, haemophilia, clotting disorders, anaemia, thrombosis, or DVT?

◯ Yes ◯ No

j) Any disorder of the skin, such as dermatitis, eczema, or psoriasis?

◯ Yes ◯ No

k) Any autoimmune disorder, such as lupus, scleroderma, or any other connective tissue disease?

◯ Yes ◯ No

l) Any disease of your eyes including blindness, cataracts, glaucoma, keratoconus, macular degeneration, or retinal detachment?

(Note: You don't need to tell us if you are short or long-sighted.)

◯ Yes ◯ No

m) Any disease or disorder affecting your ears or hearing such as tinnitus (ringing in the ears), partial or permanent deafness, or Meniere's disease?

◯ Yes ◯ No

n) A positive HIV test, AIDS, or are you awaiting the results of an HIV test?

◯ Yes ◯ No

o) A sexually transmitted disease?

◯ Yes ◯ No

p) Coronavirus (COVID-19) - or have you had direct contact with anyone diagnosed with coronavirus (COVID-19)?

◯ Yes ◯ No

Q3. Other than what you have already disclosed, within the last 5 years, have you:

a) Been prescribed medication or received medical treatment including surgery?

(Note: You do not need to tell us about minor ailments such as colds, hayfever, or dental work.)

◯ Yes ◯ No

b) Had any abnormal test results that your doctor advised would need to be followed up or monitored?

◯ Yes ◯ No

Q4. For completion by FEMALES ONLY

a) Are you pregnant? (If yes, please provide your estimated due date.)

◯ Yes ◯ No

Due date (dd/mm/yyyy)

Have you ever had any symptoms, or received medical advice or treatment for:

b) Any breast-related conditions, such as but not limited to cysts, lumps, and/or fibroadenomas, even if you haven't seen a doctor about it?

◯ Yes ◯ No

c) Any gynaecological disorder relating to the cervix, uterus, or ovaries, such as but not limited to abnormal pap smear, endometriosis, fibroids, or cysts?

◯ Yes ◯ No

Q5. For completion by MALES ONLY

Have you ever had any symptoms or received medical advice or treatment for:

a) Any disorder or problems of the prostate, including prostate enlargement or abnormal PSA (prostate specific antigen)?

◯ Yes ◯ No

If you answered 'yes' to any of the questions in section 14 about your medical history:

- For Q1(a) to (g), please complete the applicable underwriting questionnaire(s) found in sections 16 – 22.
- For all other questions, please complete the health questions in section 15 below.

15 Your health

In relation to	Question	Question	Question
Name of condition			
Please describe the symptoms you have experienced			
Date symptoms first started			
Date symptom stopped (if ongoing please state)	☐ Ongoing	☐ Ongoing	☐ Ongoing
How often do/did you have symptoms? Please choose from one of the following:	◯ Daily ◯ Quarterly ◯ Weekly ◯ Half-yearly ◯ Monthly ◯ Yearly ◯ One-off ◯ Other – please specify	◯ Daily ◯ Quarterly ◯ Weekly ◯ Half-yearly ◯ Monthly ◯ Yearly ◯ One-off ◯ Other – please specify	◯ Daily ◯ Quarterly ◯ Weekly ◯ Half-yearly ◯ Monthly ◯ Yearly ◯ One-off ◯ Other – please specify
Severity of condition – please choose from one of the following:	◯ Mild ◯ Moderate ◯ Severe ◯ Symptom-free ◯ Symptoms stopped	◯ Mild ◯ Moderate ◯ Severe ◯ Symptom-free ◯ Symptoms stopped	◯ Mild ◯ Moderate ◯ Severe ◯ Symptom-free ◯ Symptoms stopped
Have you ever had an X-ray, scan, or blood test for this condition?	◯ Yes ◯ No **Details** **Dates** (dd/mm/yyyy) **Results**	◯ Yes ◯ No **Details** **Dates** (dd/mm/yyyy) **Results**	◯ Yes ◯ No **Details** **Dates** (dd/mm/yyyy) **Results**
Did you take medication or have any other treatment (e.g. physiotherapy, operation) for this condition? If 'yes', name the treatment/ medication.	◯ Yes ◯ No **Details**	◯ Yes ◯ No **Details**	◯ Yes ◯ No **Details**
Are you still on treatment (including medication)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

If you need to include information about additional conditions, please provide information at the end of this form or attach a separate sheet with the details.

Have you ever been off work as a result of this condition? If 'yes', please state the total time off work in days, months, or years.	◯ Yes ◯ No Details	◯ Yes ◯ No Details	◯ Yes ◯ No Details
Have you had any residual, ongoing effects or restrictions as a result of this condition? If 'yes', please provide dates and details.	◯ Yes ◯ No Details Dates	◯ Yes ◯ No Details Dates	◯ Yes ◯ No Details Dates
Is your treating doctor/ medical centre different from your usual doctor? If 'yes', please provide the doctor's details.	◯ Yes ◯ No Name of doctor/specialist Doctor's address State Postcode Phone number Email address	◯ Yes ◯ No Name of doctor/specialist Doctor's address State Postcode Phone number Email address	◯ Yes ◯ No Name of doctor/specialist Doctor's address State Postcode Phone number Email address

16 Back/neck questions

a) Which area of your back/neck is/was affected?

◯ Neck ◯ Upper back ◯ Lower back

b) Please describe the nature of your symptoms and include a doctor's diagnosis (if known)

c) When did your symptoms first occur?

d) Have you had any investigations, e.g. CT scans, X-rays, etc.?

◯ Yes – please provide details including type of investigation, dates, and results

◯ No

e) Are you still experiencing symptoms?

◯ Yes

◯ No – please provide date of last experienced symptoms

Date (dd/mm/yyyy)

f) How often do/did you have symptoms?

◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly

◯ Other

g) Do you have, or have you ever had pain, numbness, or 'pins and needles' in your arms, shoulders, buttocks, or legs?

◯ Yes – please provide details

◯ No

h) Have you ever been off work due to your back/neck symptoms?

◯ Yes – please provide details

When and for how long?

◯ No

i) What is/was your treatment (e.g. surgery, spinal manipulation, deep tissue massage, physio, medication, etc.)?

Please include type of treatment and dates below.

j) Are you still receiving treatment?

◯ Yes

◯ No – when did you stop treatment?

Date (dd/mm/yyyy)

k) Please provide details of your most recent visit to any doctor or therapist for this condition

Doctor's name

Address

State Postcode

Phone number

Email address

Date of most recent visit (dd/mm/yyyy)

l) If you're under the care of a specialist, please provide details (otherwise, provide your usual doctor's details)

Doctor's name

Address

State Postcode

Phone number

Email address

17 Joint, bone, and/or arthritis questions

a) **Which joint/s or areas of the body are affected?**
Note: Please indicate if left or right.

b) **What is/was the nature of the injury or disorder?**
Note: Please write the doctor's diagnosis here (if known).

c) **When did you first experience symptoms?**

d) **When did you last experience symptoms?**

e) **What caused the injury or condition?**

f) **Have you had recurrent episodes of this condition?**

◯ Yes ◯ No

If 'yes', please provide details including the number of episodes and the date and duration of your most recent episode.

g) **Has the injury or condition caused you to have any time off work?**

◯ Yes ◯ No

If 'yes', please specify total number of days off work, including approximate dates.

h) **Please provide treatment details below, including type of treatment (e.g. massage, physiotherapy, surgery, medication) and dates**

i) **Are you still receiving treatment?**

◯ Yes – please provide details

◯ No – when did you stop treatment?

j) **Do you have any residual pain or restrictions of any kind?**

◯ Yes – please provide details

◯ No

k) **Are your work duties or daily activities limited or affected in any way by this condition?**

◯ Yes – please provide details

◯ No

l) **If you're under the care of a specialist, please provide details (otherwise, provide your usual doctor's details)**

Doctor's name

Address

State Postcode

Phone number

Email address

18 Mental health questions

a) **Please indicate the symptoms you've had and/or the conditions you have been diagnosed with**

Anxiety – including generalised anxiety, panic, or phobic disorder

◯ Yes ◯ No

Eating disorder – including anorexia nervosa or bulimia

◯ Yes ◯ No

Depression – including major depression or dysthymia

◯ Yes ◯ No

Manic depressive illness or bipolar disorder

◯ Yes ◯ No

Alcohol or substance abuse or addiction

◯ Yes ◯ No

Post-traumatic stress disorder

◯ Yes ◯ No

Schizophrenia or any other psychotic disorder

◯ Yes ◯ No

Stress, sleeplessness, or chronic tiredness

◯ Yes ◯ No

Grief or relationship issues

◯ Yes ◯ No

Other (please describe)

b) **Please describe your symptoms including the date they started and how long they lasted (your best recollection of timeframes)**

Describe your symptoms

Date started (dd/mm/yyyy)

Date stopped (dd/mm/yyyy)

Describe your symptoms

Date started (dd/mm/yyyy)

Date stopped (dd/mm/yyyy)

c) **Has any reason for your condition been identified?**

◯ Yes – please complete below

◯ No

Are the reasons/causes persisting?

◯ Yes ◯ No

d) **Please describe how this condition/s has impacted you, including any limitations to your ability to work or effect on your daily activities**

e) **Has your condition ever caused you to take time off work?**

◯ Yes – please complete below

How many days/weeks and when?

◯ No

f) Have you had any recurrences of your condition or symptoms?

- ◯ Yes – please give details
- ◯ No

g) Have you ever received treatment for any of your conditions or symptoms? (e.g. medication, counselling, cognitive behaviour therapy)

Type of treatment

Date started (dd/mm/yyyy)

Date stopped (dd/mm/yyyy)

Type of treatment

Date started (dd/mm/yyyy)

Date stopped (dd/mm/yyyy)

h) Have you ever had suicidal ideation, hurt yourself, or attempted to take your own life?

- ◯ Yes – please complete below
- ◯ No

What occurred?

When?

Doctor consulted

i) Have you ever been hospitalised or required in-patient treatment?

- ◯ Yes – provide details including dates, length of hospital stay, and doctor/s consulted
- ◯ No

j) Please tell us the names and addresses of the doctors you've consulted and the date you first and last consulted them

Doctor's name

Address

State Postcode

Phone number

Email address

Date first consulted (dd/mm/yyyy)

Date last consulted (dd/mm/yyyy)

Doctor's name

Address

State Postcode

Phone number

Email address

Date first consulted (dd/mm/yyyy)

Date last consulted (dd/mm/yyyy)

Doctor's name

Address

State Postcode

Phone number

Email address

Date first consulted (dd/mm/yyyy)

Date last consulted (dd/mm/yyyy)

19 Asthma, bronchitis, or any other lung complaint questions

a) Please tick the appropriate box(es)

- ◯ Asthma ◯ Bronchitis
- ◯ Other (please specify):

b) Frequency of symptoms in the last two years? Please tick the appropriate box(es)

- ◯ Daily ◯ One-off episode
- ◯ Weekly ◯ None, childhood only
- ◯ Occasionally

c) Severity of symptoms? Please tick the appropriate box(es)

- ◯ Mild – infrequent attacks, exercise-induced, or seasonal
- ◯ Moderate – frequent symptoms, no specific triggers, occasional oral steroid therapy
- ◯ Severe – very frequent attacks and wheezing, may restrict work duties, and frequent use of oral steroids

d) In the last two years, have you required hospitalisation or emergency treatment for your respiratory condition?

- ◯ Yes ◯ No

e) In the last 12 months, has this caused you to have time off work?

- ◯ Yes (complete below) ◯ No

Number of consecutive days you had off work in the last 12 months:

f) In the last two years, have you required any form of treatment, lung function tests, or a specialist referral?

- ◯ Yes ◯ No

If 'yes', please provide details including type of treatment, dates, and results of any tests performed.

g) Is your treating doctor different from your usual doctor?

- ◯ Yes (complete below) ◯ No

Doctor's name or medical centre

Address

State Postcode

Phone number

Email address

20 Cysts, moles, sunspots, or skin lesion complaint questions

a) Please tick the appropriate box(es)

- ◯ Cyst
- ◯ Mole
- ◯ Sunspot
- ◯ Skin lesion
- ◯ Melanoma
- ◯ Other (please specify):

b) Location of growth/s (e.g. face, back, right arm)

c) Have you been advised that your growth/s or skin lesion were cancerous or malignant?

- ◯ Yes
- ◯ No

d) How many growths or skin lesions did you have?

e) Have all your growths or skin lesions been removed or treated?

- ◯ Yes (complete below)
- ◯ No

How were they removed or treated?
Please tick the appropriate box(es)

- ◯ Surgically removed or cut off
- ◯ Frozen, burnt off, or cream

Date/s of removal (dd/mm/yyyy)

f) Were any further tests, investigations, treatments, or follow-ups recommended?

- ◯ Yes (complete below)
- ◯ No

Please provide dates and outcomes of any recommendations that were completed.

g) Is your treating doctor different from your usual doctor?

- ◯ Yes (complete below)
- ◯ No

Doctor's name or medical centre

Address

State Postcode

Phone number

Email address

21 Diabetes and abnormal blood sugar questions

a) Please confirm the condition you were diagnosed with

- ◯ Type 1 – insulin dependent
- ◯ Type 2 – diet-controlled, oral medication
- ◯ Gestational diabetes
- ◯ Impaired glucose tolerance
- ◯ Impaired fasting glucose

b) What type of treatment are you on?

- ◯ Diet only
- ◯ Insulin (confirm number of daily units)
- ◯ Oral drug treatment (medication name and dosage)
- ◯ Other (please specify)

c) When were you diagnosed with this condition?

d) In the last 12 months, have you had a HbA1c (Glycosylated Haemoglobin) test?

- ◯ Yes (please provide results below)
- ◯ No (go to **e**)

HbA1c (Glycolsylated Haemoglobin)

Please tick the appropriate box.

- ◯ Up to 7%
- ◯ 7.1-8.99%
- ◯ 9% or more
- ◯ Don't know

e) As a result of your condition, have you ever experienced any of the following complications (please select all that apply)?

- ☐ Eye problems
- ☐ Numbness or tingling in your feet or legs
- ☐ High blood pressure or any other heart or circulatory problems
- ☐ Kidney problems, including protein in the urine
- ☐ Diabetic or insulin coma

If 'yes', please provide details including complications, severity, treatment, and dates.

f) Is your treating doctor different from your usual doctor?

- ◯ Yes (complete below)
- ◯ No

Doctor's name or medical centre

Address

State Postcode

Phone number

Email address

22 High blood pressure and raised cholesterol questions

High blood pressure

a) When were you diagnosed with this condition?
Date (dd/mm/yyyy)

b) When did you last have your blood pressure checked and what was the result?
Date (dd/mm/yyyy)

Result

c) Are you taking regular medication for this condition?
◯ Yes ◯ No

If 'yes', please confirm the treatment, dosage, and date you commenced treatment.

d) Is your blood pressure being monitored by your doctor and considered to be well-controlled and within normal limits? (e.g. less than 140/90)
◯ Yes ◯ No

If 'no', please confirm the result of your most recent blood pressure reading(s).

e) Is your treating doctor different from your usual doctor?
◯ Yes (complete below) ◯ No

Doctor's name or medical centre

Address

State Postcode

Phone number

Email address

Raised cholesterol

a) When were you diagnosed with this condition?
Date (dd/mm/yyyy)

b) Are you taking regular medication for this condition?
◯ Yes ◯ No

If 'yes', please confirm the treatment, dosage, and date you commenced treatment.

c) When did you last have your cholesterol checked?
Date (dd/mm/yyyy)

d) Is your cholesterol being monitored by your doctor and considered to be well-controlled and within normal limits (e.g. total cholesterol less than 6.5mmol/l)?
◯ Yes ◯ No

If 'no', please confirm the result of your most recent test.

e) Is your treating doctor different from your usual doctor?
◯ Yes (provide details) ◯ No

Doctor's name or medical centre

Address

State Postcode

Phone number

Email address

The next section relates to your pastimes and activities. Please only complete the sections where you answered 'Yes' in section 10.

23 Flying questions

a) **What type of aircraft do you fly? Please tick the appropriate box(es).**

☐ Fixed wing (private/recreational/commuter travel)

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Fixed wing (charter flying)

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Helicopter (charter flying)

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Fixed wing and helicopter (agriculture/crop/mustering)

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Helicopter (private/recreational/commuter travel)

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Ballooning

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Gliding

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Hang-gliding

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Ultra-light/gyroplanes

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Parachuting/paragliding/skydiving

Number of hours flown in the last 12 months | Number of hours in the next 12 months

☐ Aerobatics/stunt

Number of hours flown in the last 12 months | Number of hours in the next 12 months

b) **Do you hold a Civil Aviation Safety Authority licence?**

◯ Yes ◯ No

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

◯ Yes (complete below) ◯ No

Please state the change in scope of your present licence.

d) **Have you ever had an accident or been charged with violating civil aviation regulations?**

◯ Yes (complete below) ◯ No

Please provide details.

e) **Do you intend to engage in any form of aviation other than already mentioned?**

◯ Yes (complete below) ◯ No

Please provide details.

24 Underwater diving questions

a) At what level do you participate?

- ◯ Recreational only (non-competition)
- ◯ Amateur including regular or occasional organised, unpaid competition
- ◯ Semi-professional/professional

b) How many times per year do you participate in this activity?

c) Do you ever dive:

Alone? e.g. without a buddy	◯ Yes	◯ No
More than 40 metres in depth?	◯ Yes	◯ No
In wrecks, caves, or potholes?	◯ Yes	◯ No

If 'yes' to any of the above, please provide details.

d) Have you ever had a diving accident, suffered from decompression sickness, the bends, or burst eardrums?

- ◯ Yes (provide details below)
- ◯ No

e) What type of diving qualification do you hold?

- ◯ No qualification
- ◯ PADI
- ◯ NAUI
- ◯ BSAC
- ◯ Other (please specify)

25 Motorsports of any kind questions

a) What type of vehicle or motor activity do you engage in?

b) At what level do you participate?

- ◯ Recreational only (non-competition)
- ◯ Amateur including regular or occasional organised, unpaid competition
- ◯ Semi-professional/professional

c) Have you ever been involved in any accidents while practising, testing, or racing?

- ◯ Yes (complete below)
- ◯ No

Provide details of when this occurred and whether you have, or have had, any restrictions of your work duties or activities as a result.

d) Do you participate in record attempts or prototype testing?

- ◯ Yes
- ◯ No

e) Which events do you race in?

Please provide details.

f) How many times per year do you participate in this activity?

26 Football of any code questions

a) What type of football code do you participate in?

- ◯ Rugby league
- ◯ Rugby union
- ◯ Australian rules football
- ◯ American football
- ◯ Soccer

b) At what level do you participate?

- ◯ Recreational only (non-competition)
- ◯ Amateur including regular or occasional organised, unpaid competition
- ◯ Semi-professional/professional

c) In the last two years, have you had an injury that required any time off work?

◯ Yes (complete below) ◯ No

27 Other sport or hazardous activities

a) What activity do you engage in?

b) At what level do you participate?

- ◯ Recreational only (non-competition)
- ◯ Amateur including regular or occasional organised, unpaid competition
- ◯ Semi-professional/professional

c) How many times per month do you play or participate in this activity?

d) Provide further details as applicable to the activity, such as maximum depths, heights, grades, or speeds.

Additional information about this form

You can return your competed form to us via email or mail.

To email us, please scan your completed form and send it as an attachment to **underwriting_team@qsuper.qld.gov.au**

You'll need to include your **last name** and **client number** in the subject line.

We value your security, and we recommend that you don't keep copies of sensitive information in your email account, or cloud storage service, to protect yourself in the event your account or password are ever compromised.

If you don't want to use email, you can return your completed form to:

Attention: Underwriting
GPO Box 200
Brisbane QLD 4001

The information you've provided will be used to assess your application to change your insurance. You should keep a copy of your completed form as you may want to refer to it in the future.

On the following page, please complete:

- Your declaration and authorisation
- Medical history authorisation

Your Privacy

Information collected on this form and in connection with your application is collected by Australian Retirement Trust Pty Ltd as trustee for Australian Retirement Trust and ART Life Insurance Limited (ART Life), our registered life insurance company. This information may be shared with other entities that are ultimately owned by Australian Retirement Trust Pty Ltd when it is necessary.

We take protecting your privacy seriously. We are collecting your personal and sensitive information in order to assess your application for insurance cover.

Without this information we may be unable to assess your application or provide you with cover for which you may be eligible. We may share your personal information with third parties if we need to, if you have provided consent, or if we are required to by law. Some third parties may be located overseas. More information about how we may use or disclose your personal information or how individuals can access or correct their information, is set out in our Privacy Policy, available from **qsuper.qld.gov.au/privacy.**

28 Your declaration and authorisation

By signing this application, I am making the following statements:

- I have read the Product Disclosure Statement for Accumulation Account and the Insurance Guide.
- I authorise Australian Retirement Trust and the insurer to disclose my personal and medical information (if collected) to their appointed service providers in connection with assessing my application.
- I have read and understood this form, and the information I've given in this application and any separate statements I have given with it are true.
- I have read and understand my legal duty to take reasonable care not to make a misrepresentation to Australian Retirement Trust and the insurer. I understand that If I do not meet my legal duty, my cover could be avoided (treated as if it never existed) or its terms may be unfavourably changed. In addition, if I make a claim, it may be declined or the applicable benefit reduced.
  - I agree to assist the insurer to investigate any claim or representation I make by:
    a) providing all information and third party consents reasonably required by the insurer, and/or
    b) attending all medical examinations reasonably required by the insurer.
- I authorise Australian Retirement Trust and the insurer and persons I have appointed (or authorised) to obtain and refer to:
  - Any statements that have been made in connection with my application for insurance
  - Any medical reports to other entities involved in providing or administering my insurance (e.g. reinsurers, third party administrators or specialist claims providers, and legal advisers)
  - Financial, employment, or medical related information in support of the assessment of my claims from any other entity holding information on me.
- I understand that Australian Retirement Trust deducts a fee (insurance premium) from my Accumulation account to cover the cost of any insurance.
- I understand Australian Retirement Trust will cancel my insurance if I don't have enough funds available in my Accumulation account to cover the cost of my insurance premiums, or if I stop being a member with an Accumulation account.
- I understand Australian Retirement Trust will cancel my insurance in certain circumstances.[4] I know I can permanently opt in[5] to this cover to prevent my cover being cancelled, subject to certain eligibility terms and conditions.[6]
- I understand that the changes I've applied for will take effect from the date Australian Retirement Trust accepts my application.
- I understand I can cancel my insurance at any time using Member Online or by completing an Application to Cancel Insurance form.

Name

Signature

Date signed (dd/mm/yyyy)

4 There are various circumstances when cover will end. See the Insurance Guide at **qsuper.qld.gov.au/pds**
5 To permanently opt in to insurance you hold, visit Member Online or complete our Change of Insurance form.
6 For details on available insurance, including eligibility and exclusions, please refer to the Insurance Guide available at **qsuper.qld.gov.au/pds**

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.

The insurer[7] collects and uses 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 to obtain your health information, unless we reach a different agreement with you.

Please sign to accept both Authorities. Withholding your consent can result in delays and might mean we are unable to process your application or claim.

Before signing, 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 20 business days from our request; 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.

7 ART Life Insurance Limited (ABN 79 607 345 853, AFSL 483057) ('ART Life') is a registered life insurance company that is ultimately owned by the Australian Retirement Trust Pty Ltd as trustee for Australian Retirement Trust

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 the insurer, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form the insurer 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.
- The insurer 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 the insurer 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 physically or electronically.

Name

Signature

Date signed (dd/mm/yyyy)

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 the insurer, or to third parties they engage, only if the insurer 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 20 business days; or
- The report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- The insurer 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 the insurer 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 physically or electronically.

Name

Signature

Date signed (dd/mm/yyyy)

Adviser authorisation (to be completed only by a financial adviser who is acting on your behalf)

For what reason is the information in this Insurance Personal Statement being provided?

- ◯ Transfer of insurance (ordinary to super or super to super)
- ◯ Adding or removing cover options

Underwriting pre-assessment details

Pre-assessment underwriting reference number (if applicable)

If the applicant has a significant medical condition or is overweight/obese, have you pre-positioned your client that non-standard terms or a decline may apply?

◯ Yes ◯ No

Concurrent applications

Are you submitting any life or disability insurance applications for this customer through any other insurer? If 'yes', please provide details:

◯ Yes ◯ No

Product name

Proposal/policy number

English literacy

Can the proposed life insured read and understand English?

◯ Yes ◯ No

If 'no', what language was used to explain the policy?

Your details

Adviser 1 name

Agency name and AFSL

Agency's ABN/ACN

Phone number

Email address

Adviser 2 name

Agency name and AFSL

Agency's ABN/ACN

Phone number

Email address

Adviser declaration

I certify that I have provided my client with the current Insurance Guide.

Signature of adviser 1 Date

Signature of adviser 2 Date

Member declaration

(If applicable) I authorise Australian Retirement Trust and the insurer to provide the financial adviser listed above with information relating to my application for insurance, including copies of any statements or medical reports, which may include information about my health, financial, and insurance information.

Member signature Date

Provide additional information here

Member Centres
Visit **qsuper.qld.gov.au/membercentres**
for locations

Member Services team
Phone 1300 360 750
Overseas +61 7 3239 1004
Monday to Friday 8.00am – 6.00pm (AEST)

Postal address GPO Box 200, Brisbane QLD 4001
Email qsuper@qsuper.qld.gov.au
Fax 1300 242 070
Website qsuper.qld.gov.au

247868. FO113. 01/25.