

# APPLICATION FOR VOLUNTARY COVER

## IMPORTANT INFORMATION

This form is for members who hold insurance in the DEFAULT DIVISION. Generally, you're in the Default Division if you joined the Fund on or after 20 May 2024, are eligible for insurance and haven't opted in to the MINING DIVISION (or are ineligible to do so).

If you hold insurance in the MINING DIVISION you're covered under different insurance arrangements.

If you currently have insurance, you can find the Division you're part of by logging in to your online account at [teamsuper.com/login](https://teamsuper.com/login) or by calling us on 13 64 63.

## Before you start...

Fill this form out in **BLOCK** letters using a black or blue pen. Write 'X' to mark boxes.

Use this form if you want to:

- apply for Death and Terminal Illness (DTI) and Total and Permanent Disablement Insurance (TPD) Cover.
- apply for Income Protection insurance.

Please note, if you're aged 65 or older you're not eligible for Income Protection insurance and if you are aged 70 or older you're not eligible for Death and Terminal Illness (DTI) or Death and Terminal Illness (DTI) and Total and Permanent Disablement (TPD) Cover.

### The duty to take reasonable care

If you apply for life insurance, you will be treated as if you are applying for cover under an individual consumer insurance contract. The Insurer will conduct a process called underwriting. It's how it decides whether it can cover you, and if so on what terms and at what cost.

As part of underwriting, the Insurer will ask questions it 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 provide in response to those questions will be vital to the Insurer's decision. As such, when applying for life insurance you have a legal duty to take reasonable care not to make a misrepresentation to the Insurer. A misrepresentation is a false answer, 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 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 changed.

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

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

- whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances.
- what the Insurer would have done if the duty had been met - for example, whether it 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 any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

## Turn over to finish filling out this form...

Locked Bag 2020 Newcastle NSW 2300 | T 13 64 63 | [teamsuper.com](https://teamsuper.com)  
Insurance is provided by TAL Life Limited ABN 70 050 109 450 AFS licence 237848 under a life insurance policy issued to Team Super Pty Ltd ABN 70 003 566 989 AFS licence 246864 as trustee of Team Superannuation Fund ABN 16 457 520 308 MySuper authorisation number 16457520308485.



## 1. Your personal details

Mr Ms Mrs Miss Dr Other

     

Male Female

 

Member number

               

Given names

Surname

Date of birth (DD-MM-YYYY)

  -   -    

Residential address

Suburb

State

  

Postcode

   

Postal address. If the same as your residential address, mark 'X' in this box

Suburb

State

  

Postcode

   

Mobile phone

Home phone

Work phone

Preferred email

Other email

## 2. Your employment details

Are you employed?  No  Yes

If yes, what is the name of your employer.

Date you started as an employee/ contractor

  -   -    

Address

Suburb

State

  

Postcode

   

Daytime telephone

Turn over to finish filling out this form...

### 3. Occupation Group

The following questions will help us determine how much insurance cover you will receive and how much that cover costs.

Occupation:

Average number of hours worked per week:

Main duties performed:

#### Tell us your Occupation Group and make sure you're not paying too much for insurance

The type of work you do affects the cost of your insurance with us. Until you tell us your Occupation Group, you will be given a Group 1 - High Risk (Undeclared) Occupation Group. It's important you provide an Occupation Group as soon as possible as you could pay more for your insurance than you have to.

Occupation Group (mark 'x' in one box)	You qualify for this Group if...
<input type="checkbox"/> <b>Group 1 - High Risk</b>	Your occupation is considered dangerous (see below) and you do not meet the definition of Group 2 - Non-manual or Group 3 - Professional.
<input type="checkbox"/> <b>Group 1 - Manual</b>	Your occupation is not considered dangerous (see below), <b>AND</b> You do not meet the definition of Group 2 Non-manual or Group 3 Professional.
<input type="checkbox"/> <b>Group 2 - Non manual</b>	Your occupation is not considered dangerous (see below), <b>AND</b> You work at least 75% of the time in an office environment and perform only non-manual duties.
<input type="checkbox"/> <b>Group 3 - Professional</b>	Your occupation is not considered dangerous (see below for a list of occupations), <b>AND</b> You tell us you work 100% of the time in an office in a sedentary capacity, earn more than \$100,000 a year (or pro-rata if not working full time), and have an accredited higher education qualification or are eligible to belong to a recognised professional body.

#### Dangerous occupations

To understand if your occupation is considered dangerous, please refer to the Occupation Group descriptions above together with the following broad occupation categories:

- Automotive and Engineering Trades Workers
- Construction and Mining Labourers
- Construction Trades Workers
- Design, Engineering, Science and Transport Professionals
- Electrotechnology and Telecommunications Trades Workers
- Factory Process Workers
- Health and Welfare Support Workers
- Machinery and Stationary Plant Operators
- Mobile Plant Operators
- Other Labourers
- Protective Service Workers
- Road and Rail Drivers
- Store persons

Turn over to finish filling out this form...

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#### 4. What are you applying for?

##### A. Death and Terminal Illness (DTI) and Total and Permanent Disablement Insurance (TPD) Cover

Complete this section if you want to apply for (or top up) your DTI and/or DTI and TPD Cover.

Please refer to the **Insurance Guide - Default Division** at [teamsuper.com/pds](https://teamsuper.com/pds) for the premiums that apply to your age and Occupation Group.

You can apply for up to \$2.5 million of DTI Cover and up to \$2.5 million of TPD Cover. You can only apply for TPD Cover if you already hold, or are applying for, DTI Cover. Your level of TPD cover must be equal to or lower than the total amount of DTI cover you hold, including any existing cover.

Voluntary DTI and TPD Cover cease at age 70.

Please complete this section with the amount of cover you are applying for (excluding any existing cover you already hold).

DTI Cover \$     ,     ,  0  0  0

TPD Cover \$     ,     ,  0  0  0

##### B. Income Protection insurance

Complete this section if you want to apply for Income Protection insurance.

Please read the **Insurance Guide - Default Division**, available at [teamsuper.com/pds](https://teamsuper.com/pds), for more information about Income Protection insurance, including the premiums that apply to your age, Occupation Group and waiting period. A minimum level of cover of \$1,000 per month applies.

If you make a successful claim, your income protection benefit will be paid monthly in arrears after your waiting period ends.

**Choose the monthly benefit you want to apply for (in addition to any existing cover you already hold).**

\$    ,   0  0

Note that the maximum benefit payment you are eligible to receive is the lower of 86.5% of your pre-disability income, your agreed value of Income Protection insurance or the \$30,000 maximum monthly benefit limit. Your monthly benefit maximum will be rounded up to the next \$100; for example, a monthly benefit amount of \$2,002 would be rounded up to \$2,100.

**Choose your waiting period**

30 days     60 days     90 days

A 30 day waiting period will apply if you do not select a waiting period.

Higher premiums apply for a 30 day waiting period. If you are entitled to income protection payments from another fund or insurer, you can apply to have the waiting period extended. Refer to the **Insurance Guide - Default Division** for more information.

Turn over to finish filling out this form...

## 5. Your declaration

### I declare that I:

- have read and carefully considered the questions in the Application for insurance cover form and all the answers provided on this form are true and correct.
- have read and understood the **PDS** and **Insurance Guide – Default Division** to which this application is related.
- am aware of the terms and conditions for insurance cover (including defined terms) as summarised in the **PDS** and **Insurance Guide – Default Division** and acknowledge that the terms and conditions apply to me.
- understand that depending on the type and level of insurance cover I am applying for, the insurer may contact me seeking further information to support my application.
- consent to the collection, use and disclosure of my personal information in accordance with the Team Super privacy policy outlined in the Team Super PDS and our insurer's privacy policy at [tal.com.au/privacy-policy](http://tal.com.au/privacy-policy) or available on request.
- Legislation requires all members, except those in the Group 1 - High Risk or Group 1- High Risk (Undeclared) Occupation Groups, to elect for insurance cover when their account balance is below \$6,000 and/or they are aged under 25. By choosing to proceed with his application, you are electing to:
  - retain your existing insurance cover (if you already have cover); or
  - be provided the insurance cover specified in this application (if you don't already have cover), where your account balance is below \$6,000 and/or you are aged under 25.

Your signature



Date (DD-MM-YYYY)

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## TAL Member's Personal Statement

**You must now complete and sign the TAL Member's Personal Statement attached to this form.**

You may be asked to provide additional medical evidence based on your age or the amount of cover you are applying for. If this is required, TAL will contact you directly.

**When complete return this form to us by:**

**Post** Team Super  
Locked Bag 2020 Newcastle NSW 2300  
**Email** [help@admin.teamsuper.com](mailto:help@admin.teamsuper.com)

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# Member's Personal Statement

[SAVE](#)[PRINT](#)

## 1. YOUR DUTY TO TAKE REASONABLE CARE

When you apply for insurance with TAL (the Insurer), you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, 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. Under the *Insurance Contracts Act 1984 (Cth)* there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it 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 reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances.
- what the Insurer would have done if the duty had been met – for example, whether it 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 any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

### Guidance for answering the questions in this form

You are responsible for the information provided to the Insurer. When answering 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.

Please note that there may be circumstances where the Insurer later investigates whether the information given to it was true. For example, it may do this when a claim is made.

### Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances.

### If you need help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know 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.

## 2. PERSONAL DETAILS

Please print your answers clearly

Title  Mr  Mrs  Miss  Ms  Other

Given name(s)

Last name

Date of birth

Gender  Male  Female

Street address

Suburb  State  Postcode

**TAL may contact you directly to clarify or gather information in relation to this application.**

Please advise your preferred method of contact:

Telephone

Email

Please ensure the email address provided is your personal address as we may send information of a sensitive and personal nature to it.

## 3. COVER REQUESTED

BENEFIT TYPE	EXISTING SUM INSURED	ADDITIONAL SUM INSURED	NEW TOTAL SUM INSURED
Death	<input type="text" value="\$"/>	<input type="text" value="\$"/>	<input type="text" value="\$"/>
Total & Permanent Disablement (TPD)	<input type="text" value="\$"/>	<input type="text" value="\$"/>	<input type="text" value="\$"/>
Income Protection (IP)			
Existing monthly benefit	<input type="text" value="\$"/>		
Additional monthly benefit	<input type="text" value="\$"/>		
New total monthly benefit	<input type="text" value="\$"/>		
Income level (% of your salary)	<input type="checkbox"/> 75% <input type="checkbox"/> Other (enter value) <input type="text"/>		
Waiting period (days)	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other (enter value) <input type="text"/>		
Benefit period period	<input type="checkbox"/> 2yr <input type="checkbox"/> 5yr <input type="checkbox"/> to age 65 <input type="checkbox"/>		
	Other (enter value) <input type="text"/>		

## 4. YOUR OCCUPATION AND INCOME DETAILS

1. Please select your employment status and complete details

Self-employed  Employee full-time  Employee part-time

a) Hours worked per week

b) Weeks worked per year

2. Occupation name

**4. YOUR OCCUPATION AND INCOME DETAILS** (continued)

3. Industry

4. Duties performed including % of time in each

5. Annual income before tax

**5. YOUR INSURANCE AND CLAIM HISTORY**

1. Apart from this application, do you have or are you applying for any other Life, Total and Permanent Disablement (TPD) or Income Protection (IP) insurance? (Please include cover held or applied and/or applied for through TAL or under superannuation.)
 

No  Yes
  
2. Are you claiming or have you ever claimed a benefit from any source e.g. Total and Permanent Disablement benefit from any superannuation fund, workers' compensation, disability pension, Veterans' Affairs or any other insurance cover providing accident or illness benefits?
 

No  Yes
  
3. Has an application for life, disability, trauma, accident or illness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?
 

No  Yes

If yes to 1, 2 or 3, please provide full details below.

NAME OF COMPANY	COVER TYPE	SUM INSURED/ MONTHLY BENEFIT	DATE OF APPLICATION OR CLAIM	STATE ANY LOADINGS / EXCLUSIONS	REASON FOR DECISION / CLAIM	DURATION OF CLAIM	RECOVERY	IS COVER TO BE REPLACED
<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	\$ <input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="DD / MM / YYYY"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="%"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	\$ <input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="DD / MM / YYYY"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="%"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	\$ <input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="DD / MM / YYYY"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 50px;" type="text" value="%"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

Before deciding to replace any existing cover, you should compare and consider the policy terms and conditions to work out if the insurance cover is right for you. If you decide to replace existing cover you hold with another superannuation fund or insurer, please do not cancel your existing cover until we have told you that your application has been accepted, and on what terms. This is because there are some risks associated with replacing your existing cover, such as:

- If you have experienced any new health issues you may not be covered for these under your new replacement cover. But these health issues may be covered under your existing cover, depending on when they arose and your policy terms.
- You may be subject to new or restarted waiting periods before you can make a claim on the new replacement cover
- If you make a misrepresentation in your application for the replacement cover, the new insurer may avoid your cover (treat it as if it never existed) or vary the cover provided (including reducing the cover amount).



## 6. YOUR HABITS AND ACTIVITIES

1. Do you drink alcohol?

No  Yes → State type, number of standard drinks per day and number of days per week when alcohol is consumed. (A standard drink = 1 nip spirits, 1 x 100ml glass of wine, 1 x 10oz/285ml of beer.)

2. In the last 12 months, have you used any tobacco, e-cigarettes, vapes or products containing nicotine, including patches?

No  Yes → Please select which of the following nicotine products you use, and add quantity and frequency of use if smoking cigarettes.

Cigarettes quantity per day  or week  or month

Cigars/pipe tobacco

E-cigarettes or vapes

Nicotine replacement e.g. patches or gum

Other – please provide details:

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 commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing?

No  Yes → State activity/ies performed, frequency of participation, level of participation (e.g. amateur or professional), maximum depth/speed, equipment used and location (if applicable).

4. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months?

No  Yes → State where, when, duration and reason.

5. Are you an Australian citizen, a New Zealand citizen residing in Australia, a holder of an Australian permanent visa or a person who resides in Australia on an approved working visa?

Yes  No → State type of visa you hold, expiry date, plans for applying for permanent residency and nationality/current citizenship.

## 7. MEDICAL DETAILS

1. Please state your:

Height  cm

Weight  kg

Should we require further medical information from your health providers we will seek your consent via requesting you to complete a "Consent for accessing health information".

## 7. MEDICAL DETAILS (continued)

### 2. Name and address of your usual doctor or medical centre

Doctor's last name

Doctor's given name

Doctor's address

Suburb  State  Postcode

### 3. Details of last medical consultation with your usual doctor or medical centre

Date

Reason

Outcome/results

### 4. If you have attended that doctor for less than 12 months, state name and address of previous doctor

Doctor's last name

Doctor's given name

Doctor's address

Suburb  State  Postcode

## 8. YOUR FAMILY HISTORY

Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 65: Heart disease (e.g. angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, Huntington's disease or any other inherited blood or neurological disorder?

No  Yes → Provide details in the table below.

RELATIONSHIP TO MEMBER	MEDICAL CONDITION (eg breast cancer, heart attack, type 2 diabetes)	AGE WHEN DIAGNOSED	AGE AT DEATH (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 9. YOUR MEDICAL HISTORY

Please provide details for all 'Yes' answers in the general medical questionnaire at section 10.

1. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?
- a) Chest pain, high blood pressure, raised cholesterol or any heart / circulatory disorder?  No  Yes
- b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition?  No  Yes
- c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder?  No  Yes
- d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)?  No  Yes
- e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout?  No  Yes
- f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition?  No  Yes
- g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind?  No  Yes

**9. YOUR MEDICAL HISTORY** (continued)

- h) Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse?  No  Yes
- i) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)?  No  Yes
- j) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus?  No  Yes
- 2. Have you been infected with the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?  No  Yes
- 3. Apart from treating any condition already disclosed, have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives)?  No  Yes
- 4. Apart from any condition already disclosed, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms?  No  Yes
- 5. Apart from any condition already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis?  No  Yes
- 6. Apart from any condition already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years?  No  Yes

**10. GENERAL MEDICAL QUESTIONNAIRE**

Please provide details for all 'Yes' answers in Section 9, Q's 1a-j and Q's 2-6. Please complete on a separate sheet if you need to provide additional information.

	QUESTION NUMBER _____	QUESTION NUMBER _____	QUESTION NUMBER _____
1. Date symptoms first started and description of symptoms	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
2. What was the condition and which part and side of the body was affected (if applicable)?			
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.	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
8. What advice/treatment did you receive?			

## 10. GENERAL MEDICAL QUESTIONNAIRE (continued)

	QUESTION NUMBER _____	QUESTION NUMBER _____	QUESTION NUMBER _____
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.	<input type="text"/>	<input type="text"/>	<input type="text"/>
10. Date treatment/ medication ceased (if applicable).	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>
11. When did you last suffer from any symptoms?	<input type="text"/>	<input type="text"/>	<input type="text"/>
12. Degree of recovery (%).	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 11. PRIVACY

TAL and its related entities are committed to ensuring that your information is handled responsibly in accordance with the Privacy laws, including the Privacy Act 1988 (Cth) and the Australian Privacy Principles. The way in which TAL collects, uses, secures and discloses your information is set out in the TAL Privacy Policy available at <http://www.tal.com.au/Privacy-Policy> or free of charge on request to TAL by telephoning 1800 666 136.

### Collection and use of personal information

We collect personal information, including, but not limited to, your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and processing claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay a claim.

We may take steps to verify the information that you provide, for example we may obtain independent medical reports regarding information about your past and current medical conditions, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

### Disclosure of your information

We disclose relevant information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you. The types of people and organisations to which we may disclose information includes, but is not limited to the following:

- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Reinsurers, other insurers and their administrators;
- The trustee, or administrator of your superannuation fund; and
- Other organisations to whom we outsource certain functions during the assessment process of your application process, such as obtaining blood tests.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

Useful information regarding privacy rights is available at the website of the Office of the Privacy Commissioner at [www.oaic.gov.au](http://www.oaic.gov.au)

## 12. DECLARATION

- I have read the duty to take reasonable care as set out in this Personal Statement and understand that this applies to any information I provide to TAL in connection with my application for insurance.
- I confirm that the answers I have provided in this Personal Statement (and any other forms, questionnaires and information provided to TAL) are true, accurate and complete to the best of my knowledge.
- I acknowledge that TAL will rely on the answers and information I have provided in my application for insurance. I understand that, notwithstanding any Authorities which may be provided to TAL, TAL will not necessarily seek or obtain any further information in relation to my application.
- I understand that by signing this form, I consent to the collection, use and disclosure of my personal information (including financial and medical reports and tests) in accordance with TAL's and any other relevant privacy policy.

Signature  
of member

X

Date

DD / MM / YYYY

### SUBMITTING THIS FORM

Please return your completed form and any supporting documentation to:

TAL Life Limited  
GPO Box 5380  
Sydney NSW 2001

### CONTACTING TAL

- @ groupriskadmin@tal.com.au
- ☎ 1800 666 136
- 📄 +61 (0)2 9465 2065
- 🌐 tal.com.au

SAVE

PRINT