

2. Type of insurance

Is this a new application for insurance or an application to increase insurance cover?

new increase

Type of insurance

Type of insurance	Cover	Premium
<input type="checkbox"/> death only	amount \$ <input type="text"/> (min. \$50,000)	or \$ <input type="text"/> per month
or		
<input type="checkbox"/> TPD only	amount \$ <input type="text"/> (min. \$50,000)	or \$ <input type="text"/> per month
or		
<input type="checkbox"/> death and TPD	death amount \$ <input type="text"/> (min. \$50,000)	or \$ <input type="text"/> per month
	TPD amount \$ <input type="text"/> (min. \$50,000)	or \$ <input type="text"/> per month
and/or		
<input type="checkbox"/> salary continuance	amount \$ <input type="text"/> per month (min. \$500 per month) (This cannot be greater than 85% of your monthly income, which includes a maximum 10% allowance for super contributions. That is your cover amount cannot be greater than 75% of your monthly income plus an additional 10% of your monthly income representing a super contribution component. For example if you have a monthly salary of \$4,000 the maximum monthly cover amount you have is 75% x \$4,000 plus 10% x \$4,000.)	
What percentage of your cover amount indicated above represents a Super contribution component? If this is left blank nil will be assumed.	<input type="text"/> %	(This is optional and is a maximum of 10% of your monthly income.)

Please apply indexing to my sum insured

yes (default) no This feature is not available if you have chosen to be insured for a premium amount per month

Salary continuance only

benefit period	<input type="checkbox"/> 2 years (to age 65 if earlier)	<input type="checkbox"/> 5 years (to age 65 if earlier)	<input type="checkbox"/> to age 65
waiting period	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days
type of cover	<input type="checkbox"/> agreed value*	<input type="checkbox"/> indemnity	

* If you are applying for agreed value salary continuance cover, the following additional financial information is also required:

If you are self employed

- Profit & Loss statements for your business or practice (including any trusts if applicable) for the last 2 years,
- your income tax returns and notice of assessments including any business entities for the last 2 years, and
- if you are applying for cover of \$15,000 per month or more, Statement of Assets and Liabilities (held personally or in trust) from your accountant.

If you are not self employed and you are applying for cover

- up to \$12,500 per month, income tax return and notice of assessment for the last year, or
- above \$12,500 per month, income tax returns and notice of assessments for the last 2 years, or
- above \$15,000 per month, income tax returns and notice of assessments for the last 2 years **plus** Statement of Assets and Liabilities (held personally or in trust), from your accountant.

Please pay my insurance premium:

proportionally according to my account balance from my Investment Option
 from my Investment Option with the highest balance**

**If no selection is made or if the balance in your nominated Investment Option is insufficient, we will deduct premiums from the Investment Option with the highest balance.

3a. Personal statement – Part 1

annual salary (\$) number of hours worked per week height (cm) weight (kg)

1. Do you permanently reside in Australia? no yes

2. Have you smoked tobacco or any other substance in the last 12 months? no yes

If yes, please state forms and quantities:

3. Do you drink more than 20 standard drinks of alcohol per week? no yes

If yes, please provide forms and quantities:

4. Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer?) no yes

If yes, please provide the policy details in the schedule below.

Commencement date	Insurer	Type of cover	Amount of cover	To be replaced	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	no <input type="checkbox"/>	yes <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	no <input type="checkbox"/>	yes <input type="checkbox"/>

At the date of application:

5. Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full time basis due to injury or illness (even if you are not currently working on a full time basis or are unemployed)? no yes

6. In the last three (3) years, have you had any medical advice or treatment, taken prescribed or illicit drugs or been hospitalised for any injury or illness (excluding for colds or flus)? no yes

7. Have you ever had back or neck pain for seven (7) or more consecutive days, or have you ever had mental/nervous/stress disorders, cancer, blindness or deafness? no yes

8. Are you under any treatment by diet, medication, or sedative drugs? no yes

9. Has any company ever refused or applied special or modified conditions or cancelled any proposal to insure you for a life or disablement policy? no yes

10. Have you ever engaged or are you ever likely to engage in any aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (eg motor car racing, professional football, scuba diving over 30m depth)? no yes

If you answered yes to any of the questions above, please provide full details:

3b. Personal statement – Part 2

Section A: Medical details

Have you ever had or received treatment for or had symptoms of:

a. High blood pressure or blood disorder eg leukemia, anaemia or haemophilia?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
b. Heart, vein or circulatory disorder, including chest pain, heart attack, heart murmur, raised cholesterol or rheumatic fever?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
c. Mental or nervous disorder (eg stress, depression, insomnia), fainting, epilepsy, paralysis, multiple sclerosis, migraines, brain disorder or any neurological disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
d. Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or hernia?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
e. Back or neck pain, whiplash, sciatica or any muscle or joint disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
f. Asthma, bronchitis or other respiratory disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
g. Stomach, intestinal or rectal disorder, bleeding from bowel, ulcer, gall bladder or liver disorder, including hepatitis?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
h. Diabetes, thyroid or prostate disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
i. Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
j. Impairment / disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
k. Dermatitis, psoriasis or any skin disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
l. Kidney, bladder, blood in urine or reproductive organ disorder?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
m. Sexually transmitted diseases?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
n. Drug or alcohol dependence?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
o. Any other medical conditions not mentioned above?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
p. Hepatitis B or C or have you ever been told you are a Hepatitis B or C carrier?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
Females only				
(i) Female organ disorder (including abnormal pap smear, breast ultrasound or mammogram)?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
(ii) Are you currently pregnant?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
If yes, date of expected delivery	<input type="text"/>	/	<input type="text"/>	/
AIDS statement				
(i) Have you suffered from Acquired Immune Deficiency Syndrome (AIDS) or been infected with the HIV virus or are you carrying antibodies to the HIV virus?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
(ii) Since 1980, have you used intravenous drugs, engaged in male to male anal sexual activity or worked as a prostitute?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
(iii) Have you had sexual intercourse with someone you know or suspect to be HIV positive?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>

If you answered 'YES' to any questions in the AIDS statement (i) – (iii) above, a 'Confidential Lifestyle' questionnaire will need to be completed.

Section B: Further medical background

1. Are you considering consulting a doctor, seeking a medical examination, advice treatment, tests or an operation?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
2. During the last five (5) years have you:				
a. Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professionals?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
b. Been in hospital, clinic or nursing home?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
c. Been advised to have an operation?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>
d. Had any tests, including blood tests, ECG, x-rays or genetic tests?	no	<input type="checkbox"/>	yes	<input type="checkbox"/>

e. Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers? No Yes

If you answered YES to any of the questions in Sections A or B, please complete remainder of form. Otherwise, go to Sections D, E and F.

Section C: Answers in detail

If you answered YES to ANY question in Sections A or B, please provide details in the schedule below. If there is insufficient space, please provide a signed and dated supplementary statement.

question reference	time off work	date of illness/injury	degree of % recovery
illness, injury or tests			
results of tests			
reason and type of treatment including date of last symptoms			
full name and address of doctor or hospital (if any)			

Section D: Family history

1. Have any of your parents, brothers or sisters (living or deceased) had Huntington’s disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder? no yes
2. Have any of your parents, brothers or sisters (living or deceased) been diagnosed prior to age 65 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? no yes

If YES, to 1 or 2 above, please provide details in the schedule below.

Relation	Condition/Illness (For cancer – specify type)	Age at onset (approximately)	Age at death (approximately)

Section E: Doctors details

name of doctor	name of doctor
address	address
suburb	suburb
state	state
postcode	postcode
telephone	telephone
date of last consultation	date of last consultation
how long have you been a patient?	how long have you been a patient?

Section F: Further salary details (for salary continuance only)

1a. Please state your monthly salary from your current occupation (net of business expenses but before tax). Please refer to the definition of salary on page 26 of the PDS for further information.

Principal occupation: Current year \$ _____ per month

Previous year \$ _____ per month

1b. How long have you been at your current occupation? _____ years _____ months

How much of the above income will continue if you are disabled? \$ _____

i. For how long? _____ years/months

ii. State source of income (eg. sick leave) _____

2. If you became disabled, would you receive income from other sources? no yes

If yes

a. How much: \$ _____ per month

b. For how long _____ years/months

c. State source of income _____

3. Do you also perform another occupation? no yes

If yes, describe the daily duties of this occupation (including manual work)

4. Do you receive any unearned income? (eg. from investments such as rental property or dividends) no yes

If yes, how much? \$ per month

5. What was your previous occupation?

6. Are you self-employed by your own company no yes
 If yes

a. Date your business started / /

b. How long have you been self-employed? years/months

c. What percentage of your work is: i. Freelance? % ii. Contract? %

d. If self-employed, did your business make a loss in the last financial year? no yes
 If yes, please provide copies of Profit and Loss Statements for the last two (2) years.

e. How many people do you employ?

7. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? no yes
 If yes, when / /
 Date of discharge / /

8. Do you work at home? no yes
 If yes, state percentage of the time %

9. Do you earn commission or bonuses? no yes
 If yes, state percentage of total income %

4. General declaration

- **Truth and Accuracy** – I hereby declare that to the best of my knowledge and belief all of the answers to questions on this application form are true and accurate and I have not deliberately withheld any information material to the proposed insurance.
 - **Changes to Contract** – I understand that I must advise the Insurer of any material change in my health during the period between the application date shown below and the cover commencement date. I understand that my failure to advise of such a change may make the contract of insurance voidable by the insurer.
 - **Acceptance of the application** – I note that this application is subject to acceptance by the Insurer and that the insurance cover does not commence until I have been advised by AIA Australia or the Plan about acceptance of my application.
 - **Duty of Disclosure** – I acknowledge that I have read and understood the Duty of Disclosure notice in accordance with the Insurance Contracts Act 1984 as detailed on page 23 of the Perpetual WealthFocus Super Plan PDS.
 Warning: You have a duty to disclose all information relevant to the insurer’s decision to accept your application.
 - **Privacy Statement** – I have read and understood the Privacy disclosure as detailed on page 35 of the Perpetual WealthFocus Super Plan PDS. I consent to my personal information being collected and used and disclosed in accordance with the Privacy disclosure.
 - **Consent to provide personal health information to my adviser** – I consent to allow Perpetual to provide my adviser with any personal health information to assist the Trustee and Insurer in assessing my application for insurance.
- I do not authorise my financial adviser to be provided with any personal health information submitted in relation to my application for insurance.

signature date / /

5. Consent

Consent to Disclose – I consent to AIA Australia and to the Trustee on behalf of AIA Australia, seeking medical information from any doctor who at any time I have consulted prior to the date below. While I am insured, I authorise the provision of such information to AIA Australia. I consent to the use of my personal information to be used as outlined on page 35. I agree to be bound by the provisions of the Policy Document between AIA Australia and the Trustee, which govern the terms of life insurance and conditions set out in this document.

signature <input style="width: 95%;" type="text"/>	date <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/>
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6. Medical authority

I,

authorise any Medical Practitioner, hospital, clinic or other person (including any life insurance company, underwriter or third party acting on behalf of AIA Australia), to disclose to AIA Australia full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

signature <input style="width: 95%;" type="text"/>	date <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/>
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Would you like an underwriter to contact you to clarify any information?

no yes

7. Adviser use only

Insurance commission

Please nominate how you would like your insurance commission paid. If you do not nominate we will pay you level commissions.

level

stepped (upfront)

Adviser details

adviser name	<input style="width: 100%;" type="text"/>				
phone (after hours)	<input style="width: 30%;" type="text"/>	phone (business hours)	<input style="width: 60%;" type="text"/>		
mobile	<input style="width: 30%;" type="text"/>	fax	<input style="width: 60%;" type="text"/>		
AFSL licensee name	<input style="width: 60%;" type="text"/>		AFSL number	<input style="width: 30%;" type="text"/>	
Perpetual adviser number	<input style="width: 100%;" type="text"/>				
dealer group	<input style="width: 60%;" type="text"/>		dealer branch	<input style="width: 30%;" type="text"/>	
adviser signature	<input style="width: 30%;" type="text"/>	date	<input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/>	<div style="border: 1px solid black; border-radius: 50%; width: 60px; height: 60px; margin: auto; display: flex; align-items: center; justify-content: center;"> ADVISER STAMP </div>	

IL GN / / (Group)

IL AN / / (Adviser)

IL CN / / (Client)