Insurance Application Form
& Personal Health Statement

max
very friendly super

Use this form if you want Death only or Death and TPD cover greater than $350,000 (Steps 1-3) or if you want an existing **max Super** member and want to add Insurance Cover (see note before completing Step 3).

Please use a **dark pen** and CAPITAL letters (except for your email address), print it and send it to us. Use (**X**) to mark boxes. Forms are located on our website at maxsuper.com.au/member/forms-docs. If you have any questions, call us on 1300 629 787.

Step 1: Your details

Member number

Date of birth

M F

Title

Last name

Given name(s)

Occupation

Industry

Daily duties

Step 2: Insurance application

max Super offers either **Death Only** OR **Death and Total & Permanent Disablement (TPD)** insurance to its Members. Your application for insurance cover will be assessed by **max's** insurer, AIA Australia Limited (ABN 79 004 837 861 AFSL 230043), and you will need to satisfy its underwriting criteria to obtain cover. Please refer to the **max Super** PDS for more information regarding your Insurance options. You don't have to take out insurance if you don't want insurance.

Death and Total & Permanent Disablement (TPD)

☐ I would like **Death Only** cover

Amount $,

(in multiples of $50,000)

OR

☐ I would like **Death and TPD** cover

Amount $,

(in multiples of $50,000)

Reply Paid 3528
TINGALPA DC QLD 4173
Email: maxteam@maxsuper.com.au

Issued by Tidswell Financial Services Ltd
ABN 55 010 810 607 AFSL 237628 as Trustee for
max Super ABN 22 508 720 840

Step 2: Insurance application cont'd

	Agree	Disagree
1. I'm actively working and able to perform my usual duties.		
2. I've never had back/neck pain for 7 or more consecutive days, and never had mental/nervous/stress disorders, cancer, blindness or deafness.		
3. I've never had any company refuse or apply special or modified conditions or cancel any proposal to insure me for a life or disablement policy.		
4. I'm not, as far as I'm aware, suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the HIV virus and I am not carrying antibodies to the HIV virus.		

Have you smoked any tobacco or any other substance in the last 12 months? **Yes** ☐ **No** ☐

If YES, please state forms and quantities

General insurance declaration

- **Truth and Accuracy** – I hereby declare that to the best of my knowledge and belief all of the answers to questions and personal statements on this Insurance Application 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 this 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 Limited (AIA) or max Super about acceptance of my application.
- **Duty of Disclosure** – I acknowledge that I have read and understand the Duty of Disclosure notice in accordance with the Insurance Contracts Act 1984 as detailed in the 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 understand the Privacy Statement as detailed in the PDS. I consent to my personal information being collected and used in accordance with the Privacy Statement.
- **Election to maintain insurance** - By applying for underwritten cover, I agree to opt-in to maintain my insurance in the event my account becomes inactive for a continuous period of 16 months where it would otherwise be turned off.

Signature of person to be insured

Date (DD-MM-YYYY)

Only Complete Step 3 if:

- You want **Death Only**, OR **Death & TPD** cover **greater than $350,000**.
- You **Disagreed** to **any** of the four **Basic Personal Statements** above.

Step 3: Personal health statement

i) Please state your height cm ☐☐☐

ii) Please state your weight kg ☐☐☐

iii) Do you permanently reside in Australia or New Zealand? **Yes** ☐ **No** ☐

iv) Do you intend to work, live or travel overseas? **Yes** ☐ **No** ☐

If YES, please state the destination, duration, frequency and purpose

SECTION A - Medical Details

1. Have you ever had or received treatment for, or had symptoms of:	Yes	No
(a) High blood pressure or blood disorder e.g. leukaemia, anaemia or haemophilia?	☐	☐
(b) Heart, vein or circulatory disorder, including chest pain, heart attack, heart murmur, raised cholesterol or rheumatic fever?	☐	☐
(c) Mental or nervous disorder (e.g. stress, depression, insomnia), fainting, epilepsy, paralysis, multiple sclerosis, migraines, brain disorder or any neurological disorder?	☐	☐
(d) Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or hernia?	☐	☐
(e) Back or neck pain, whiplash, sciatica or any muscle or joint disorder?	☐	☐
(f) Asthma, bronchitis or other respiratory disorder?	☐	☐
(g) Stomach, intestinal or rectal disorder, ulcer, bleeding from bowel, gall bladder or liver disorder, including hepatitis?	☐	☐
(h) Diabetes, thyroid or prostate disorder?	☐	☐
(i) Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?	☐	☐
(j) Impairment/disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?	☐	☐
(k) Dermatitis, psoriasis or any skin disorder?	☐	☐
(l) Kidney, bladder, blood in urine or reproductive organ disorder?	☐	☐
(m) Sexually transmitted diseases?	☐	☐

SECTION A - Medical Details cont'd

	Yes	No
(n) Drug or alcohol dependence?	☐	☐
(o) Any other medical condition not mentioned above?	☐	☐
(p) Females only i) Female organ disorder? (including abnormal pap smear, breast ultrasound or mammogram)	☐	☐
ii) Are you currently pregnant?	☐	☐

If YES, date of expected delivery: ☐☐ – ☐☐ – ☐☐☐☐

SECTION B - Medical Background

		Yes	No
1.	Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?	☐	☐
2.	During the last five (5) years have you:	☐	☐
	(a) Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?	☐	☐
	(b) Been in hospital, clinic or nursing home?	☐	☐
	(c) Been advised to have an operation?	☐	☐
	(d) Had any tests, including blood tests, ECG, or x-rays?	☐	☐
	(e) Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquilisers?	☐	☐

If you answered YES to ANY of the questions in Sections A or B, please complete all Sections below. Otherwise, complete Sections D, E, and F.

SECTION C - Answers in Detail

1. 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 (include (Section A or B)	Test, or nature address of doctor or complaint	treatment and Date	Full name and Reference of condition Duration work	Commencement Recovery (%)	Full details of Time off type of operations)	Degree of results or hospital (if any)

SECTION D - Other Details

1. Do you drink alcohol? — Yes ☐ No ☐

   If YES, what type of alcohol

   How much (daily intake)?

2. Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)? — Yes ☐ No ☐
   If YES, please provide the policy details in the schedule below.

Commencement Date	Insurer	Type of Cover	Amount of Cover	*To be Replaced 'Y' or 'N"

* For policies to be replaced, please attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

SECTION E - 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? — Yes ☐ No ☐
   If YES, please provide details in the schedule below.

Relation	Condition/Illness	Age at Onset (Approximately)	Age at Death (If Applicable)

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? — Yes ☐ No ☐

   If YES, please provide details in the schedule below.

Relation	Condition/Illness For Cancer – Specify Type	Age at Onset (Approximately)	Age at Death (If Applicable)

SECTION F - Doctor's Details (please provide current details)

Date of last consultation

How long have you been a patient?

Title

Last name

Given name(s)

Residential address

Suburb

State

Postcode

Contact phone number

Email address or fax number

Declaration and consent

- **Duty of Disclosure** – I acknowledge that I have read and understand the Duty of Disclosure notice in accordance with the Insurance Contracts Act 1984 as detailed in the 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 understand the Privacy Statement in the PDS. I consent to my personal information being collected and used in accordance with the Privacy Statement.
- **Consent to Disclose** – I consent to AIA Australia Limited (AIA) and to max Super on behalf of AIA, 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. I agree to be bound by the provisions of the policy document between AIA and the Trustee, which govern the terms of life insurance and conditions set out in this document.

Signature of person to be insured

Date (DD-MM-YYYY)

Medical authority

Full name of person to be insured I,

1. Doctor(s)/ Hospital/Clinic

2. Doctor(s)/ Hospital/Clinic

authorise ______ and ______

to disclose to AIA Australia Limited full details of my health and medical history. A photocopy of this authorisation is as valid as the original.

Signature of person to be insured

Date (DD-MM-YYYY)

Would you like an underwriter to contact you to clarify any information? **Yes** ☐ **No** ☐

When you've completed the application, sign where indicated and send to:

max Super
P.O. Box 3528
Tingalpa DC QLD 4173