Accelerated Protection Application

SAVE PRINT

This form applies to insurance cover structured:

- outside of superannuation, and
- through superannuation (where the policy is owned by the trustee of the fund).

If you are applying for insurance cover through superannuation, references to 'the Fund' and 'the Trustee' in this form are to:

- TAL Super (the Fund) – a plan within the Retail Division in the Mercer Super Trust ABN 19 905 422 981, and
- Mercer Superannuation (Australia) Limited ABN 79 004 717 533, AFSL 235906 (the Trustee).

Reference number
(Please ensure the correct quote illustration is attached to this Application Form.)

Life to be insured 1 name

IMPORTANT INFORMATION

Product Disclosure Statement (PDS)

Before you apply for new insurance cover or change your existing policy, you should read the PDS relevant to your policy.

For new applications, TAL or a financial adviser must have provided you with an Accelerated Protection PDS dated 12 October 2018 prior to you submitting your application.

If you are requesting a change to an existing policy, you should refer to the PDS issued at the time you applied for your policy, and any updates to that PDS.

Completing this form

Please complete all relevant sections. If you do not provide the required information, we may not be able to process your application.

You can submit this form by mail, email or fax (see last page for details). Alternatively, your financial adviser may submit an electronic application to TAL.

Please complete in black ink, using BLOCK letters. Use X in boxes.

APPLICATION DETAILS

1. How many lives insured apply to this application? 1☐ 2☐ 3☐ 4☐ 5☐
   If there is more than one life to be insured, you will need to complete a Personal Statement form for each person.

Life 2 name

Life 3 name

Life 4 name

Life 5 name

2. How many policies apply to this application? 1☐ 2☐ 3☐ 4☐

DUTY OF DISCLOSURE

Before you enter into or become insured under an insurance contract with us, you and any life to be insured are required under the *Insurance Contracts Act 1984* to provide us with the information we need to decide whether we'll accept your application for insurance, what terms will apply and what your premium will be. For the purposes of this Duty of Disclosure section, 'You' includes both the Policy Owner and the Life Insured.

You have this duty until we agree to insure you. You have the same duty before you extend, vary or reinstate an insurance contract. You do not need to tell us anything that:

- reduces the risk we insure you for
- is common knowledge
- we know or should know as an insurer, or
- we waive your duty to tell us about.

If the insurance is for the life of another person and that person does not tell us everything they should have, this may be treated as a failure by you to tell us something that you must tell us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate contracts of life insurance. If they do, we may apply the following rights separately to each type of cover.

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within three years of entering into it. If we choose not to avoid the contract, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the contract has a surrender value, or provides cover on death, we may only exercise this right within three years of entering into the contract.

If we choose not to avoid the contract or reduce the amount you have been insured for, we may, at any time vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

If you have applied for your Accelerated Protection Policy via a financial adviser it is also your responsibility to ensure that the information provided to your financial adviser is accurate and complete and that the correct information is entered into the paper or electronic Application Form.

1. PERSONAL DETAILS

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Middle name

Last name

Previous last name

Date of birth DD / MM / YYYY

Gender ☐ Male ☐ Female

1. PERSONAL DETAILS (continued)

Tax file number

Only provide this if you are applying for cover through TAL Super.

Important Please refer to Section 34 for information about providing your tax file number.

If the life to be insured has been pre-assessed for this application and a Pre-assessment Reference Number provided, please enter below. Do not include phone call pre-assessments.

Pre-assessment Reference Number 1

Pre-assessment Reference Number 2

Residential address

Do not enter a PO Box in this field. If your mailing address is different to your residential address, please complete your residential address details and then provide your mailing address in Section 2.

Street address

Suburb State Postcode

Country

2. CONTACT DETAILS

Email

Preferred email

We will use email for some of the information we need to send you about your policy, rather than sending paper copies. However, if you'd prefer to receive information by post, please indicate by writing X in the box on the right. ☐

Phone

Preferred contact number 1 Home ☐ Business ☐ Mobile ☐

Preferred contact number 2 Home ☐ Business ☐ Mobile ☐

Mailing address

If your mailing address is different to the residential address provided in Section 1, please provide details.

Address

Suburb State Postcode

Country

3. OCCUPATION DETAILS

To be completed for all cover.

1. What is your occupation?

2. What industry do you work in?

3. OCCUPATION DETAILS (continued)

3. Please select the statement that describes your occupation.

	Occupation description	Occupation category
	Professional | Medical | Legal | Administration | White Collar	
☐	• I am a university qualified professional, and • I am registered and working with my qualification in a role that requires membership of a professional or government body, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment. OR	AAA
☐	• I am working in an office-based management role that I have held for 2 years or more, and • I earn $120,000 or more per annum, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment.	
☐	I am a university qualified medical practitioner, registered and practising in my field of qualification.	AA+
☐	• I am working in an office-based management or clerical role, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment. OR	AA
☐	• I am a qualified health professional providing medical advice and/or light physical therapy. OR	
☐	• I am a classroom teacher, not teaching manual arts or physical education.	
	Supervisory | Trades | Light Manual | Heavy Manual | Driving	
☐	I work in an occupation that requires me to undertake some light physical work, supervise manual work or work in an environment that is not office-based.	A
☐	• I spend more than 10% of my time performing or supervising light manual work in an occupation for which I hold trade certification. OR	BBB
☐	• I spend more than 10% of my time performing or supervising light manual work in a skilled occupation that is not office-based.	
☐	I perform moderate to heavy manual work including using machinery, driving or lifting. I do not undertake work at heights over 10 metres.	BB
☐	I perform heavy manual work including using machinery, driving or lifting. I do not undertake work at heights over 20 metres.	B
☐	I perform heavy manual work including using machinery, driving or lifting.	SRA
	House Person | Unemployed	
☐	My occupation is Home Duties.	Home Duties
☐	I am not working in paid employment – I am a retiree, a pensioner, a student or unemployed.	Not working
☐	**Other**	

To be completed when applying for:

- **TPD (except for Home Duties)**
- **Income Protection benefits**
- **Life cover that exceeds $6 million.**

4. Please select the term that best describes your occupation status.

☐ Permanent full-time ☐ Permanent part-time ☐ Casual ☐ Contractor

- Permanent full-time means you are employed on a permanent basis and work a minimum of 30 hours and five days per week.
- Permanent part-time means you are employed on a permanent basis and work less than 30 hours and/or five days per week.
- Casual means you are not employed on a permanent basis and do not have an employment contract.
- Contractor means you have a contractual agreement to provide services for a specific period of time or task.

5. How many hours do you work per week? hours

6. How many days do you work per week? days

3. OCCUPATION DETAILS (continued)

7. How many weeks do you work per year? weeks

8. Do you have any professional or trade qualifications?

☐ No → Go to Question 11. ☐ Yes → Complete Questions 9 and 10.

9. What type of qualification do you have? If more than one, please select the highest level achieved.

☐ Certificate I – II
☐ Certificate III – IV (Trade Certificate)
☐ Diploma, Advanced Diploma or Associate Degree
☐ Bachelor Degree or Honours Degree
☐ Graduate Certificate or Graduate Diploma
☐ Master's Degree
☐ Doctoral Degree or Higher Doctoral Degree

10. Did you become registered or licensed within the last three years? ☐ Yes ☐ No

If yes and Income Protection application, are you applying for the New Professionals Package? ☐ Yes ☐ No

Adviser note To be eligible for this offer, the applicant must:

- have become registered or licensed in the last three years
- have applied for more than 75% of income
- be working full-time, and
- be one of the selected AAA, AA+ and AA occupations (see Adviser Guide for full details).

11. What is your current employer's or your business name and street address?

Employer/Business name

Street address

Suburb State Postcode

Contact number Contact type ☐ Business ☐ Mobile

Email

4. EMPLOYMENT DETAILS

To be completed for:

- **TPD (except Home Duties)**
- **Income Protection benefits**
- **Life cover that exceeds $6 million.**

Questions 1 to 3 must be completed when:

- **Critical Illness cover exceeds $1 million and**
- **Life cover is between $2,500,001 and $6 million.**

Questions 4 to 11 are required for Income Protection applications only.
For other insurance go to Question 12.

1. Are you self-employed?

☐ No → Go to Question 12. ☐ Yes → Go to Question 2.

'Self-employed' means you are either:

- a business owner
- a sole trader
- an employee of a company you have a shareholding in either directly or indirectly
- a beneficiary or trustee or unit holder of a trust, or
- in a partnership.

2. What is your share of the business? %

3. How many other owners/shareholders are there in the business?

4. If there is only one other business owner, is this your spouse? ☐ Yes ☐ No

☐ Yes → Go to Question 5. ☐ No → Go to Question 9.

4. EMPLOYMENT DETAILS (continued)

5. Does your spouse work in the business?

☐ Yes → Go to Question 6. ☐ No → Go to Question 9.

6. Does your spouse perform administration tasks only for the business?

☐ Yes → Go to Question 7. ☐ No → Go to Question 9.

7. Is your spouse being paid a wage consistent with the hours and work they perform (that is, a market rate)?

☐ Yes → Go to Question 8. ☐ No → Go to Question 9.

8. Please advise your spouse's role in the business, their duties, wage, working hours and whether they are applying for insurance cover.

9. How many employees do you have? Please include any contractors or sub-contractors.

10. What percentage of your work is done from home? %

11. If more than 50% of work is done from home, what percentage of your work requires face to face meetings with clients (coming to your residence or you visiting theirs)? %

12. How long have you been working in your current occupation? years months

If less than two years, please go to Question 13. Otherwise, go to Question 17.

13. In the last two years, have you had any period of unemployment longer than two months?

☐ No ☐ Yes → Please provide an employment history for the last three years.

PREVIOUS OCCUPATION	PREVIOUS EMPLOYER	DATE FROM	DATE TO
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

14. If **self-employed**, have you commenced in your business within the last 12 months? ☐ Yes ☐ No

a) **If yes,** are you contracting back to your previous employer? ☐ Yes ☐ No

b) **If no,** please advise the date you became self-employed or commenced in this business, whether you have purchased an existing business or franchise, how you source business, the terms and conditions of any contracts in place and any other information that will assist us in underwriting this application.

15. If not self-employed, how long have you been working for your current employer?

years months

16. Are you working in the same occupation and industry as your previous occupation?

☐ Yes → Go to Question 17. ☐ No → Please provide your employment history for the last three years.

PREVIOUS OCCUPATION	PREVIOUS EMPLOYER	DATE FROM	DATE TO
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

4. EMPLOYMENT DETAILS (continued)

17. In the next 12 months, do you have plans to change your occupation or work duties, work hours, take a redundancy, become self-employed, take extended leave (eg parental or study leave) or make other changes (including leaving your current employer) to your work circumstances?

☐ No → Go to Question 18. ☐ Yes → Please provide details including dates.

18. Do you have any other occupation?

☐ No → Go to Section 5. ☐ Yes → Go to Question 19.

19. Do you work in the same occupation and industry as your main occupation?

☐ Yes ☐ No → Please provide details.

a) What is your other occupation?

b) Name of your employer.

c) How many hours per week do you work in this other occupation? hours

d) How long have you been doing this other occupation? years months

e) What is your annual income from this other occupation? $

Note Do not include this income in upcoming income questions.

5. INCOME DETAILS

1. If applying for Life, TPD or Critical Illness insurance, what is the purpose of the cover being applied for?

☐ Key person ☐ Partnership/Share purchase ☐ Loan cover ☐ Personal ☐ Combination

2. What is your current annual income before tax? $

'Current annual income' means your gross income including superannuation (less any business expenses if you are self-employed) before tax is deducted, earned for the current tax year. It does not include investment income.

3. In the last five years, have you been either declared bankrupt or put under any form of personal insolvency administration or if you've been a business owner, has your business ever been insolvent or placed into any form of insolvency or external administration (such as liquidation, receivership or administration)?

☐ No ☐ Yes → Please answer a) and b).

a) Has your bankruptcy been discharged or company liquidation, receivership or administration been finalised?

☐ No ☐ Yes

If yes, how long ago did the discharge or finalisation occur? years months

b) Have any of the above events occurred more than once? ☐ Yes ☐ No

You will need to complete the questions relevant to your application and employment status.

Your application	Employed	Self employed
More than $2.5m Life or $2m TPD	Questions 4 and 5	Questions 4, 5, 9 and 10
Income Protection with a monthly benefit under $20,000	Questions 6 (if Agreed Value), 7 and 11	Questions 6 (if Agreed Value), 8, 9, 10 and 11
Income Protection with a monthly benefit of $20,000 or more	Questions 6 (if Agreed Value), 7, 11 and 12	Questions 6 (if Agreed Value), 8, 9, 10, 11 and 12
Business Expenses option	Not applicable	Question 13

5. INCOME DETAILS (contined)

4. Assets and liabilities

Please provide full and complete information about the assets and liabilities that you own or have control of directly or otherwise, including the value of any shares in private (Pty Ltd) or public (Limited) companies. Please attach a separate sheet if insufficient space below.

Assets		**Liabilities**	
Description	**Value**	**Description**	**Value**
Personal residence and furniture etc	$	Mortgage	$
Motor vehicles, boats etc	$	Motor vehicles, boats etc – loan(s)	$
Investment properties	$	Investment properties – mortgage(s)	$
Investment shares	$	Investment shares – loan(s)	$
Business	$	Business loan(s)	$
Other (please specify)		Other (please specify)	
1.	$	1.	$
2.	$	2.	$
Total	**$**	**Total**	**$**

5. Do you have any dependants?

☐ No ☐ Yes → Please provide the age of each dependant and their relationship to you.

6. Are you applying for the Proof of Income endorsement? ☐ Yes ☐ No

If you are an arms-length employee, answer Question 7.

7. Does your remuneration include a bonus or commission component? ☐ Yes ☐ No

If yes, what percentage is this of your total remuneration package? %

8. If self-employed, how many entities do you have an ownership interest in or are entitled to profit share from either directly or indirectly?

9. Please complete income details here if you are a business owner, sole trader, an employee of a company you have a shareholding in either directly or indirectly, a beneficiary or trustee or unit holder of a trust, or are in a partnership. If newly self-employed refer to the Adviser Guide for instructions to assist completing this section.

	Last tax year	**Previous tax year**
A. Gross business income (turnover) This is the total revenue figure for your business excluding any passive income (eg interest, rent, dividends).	$	$
B. Business expenses This is the total expenses figure for your business, including all add back and non-add back items.	$	$
C. Total net business income before tax (net profit) This figure is derived by deducting business expenses from gross business income.	$	$
D. Share of net business income? This figure is derived by multiplying net business income by your share of the business as stated in the Occupation Details section.	$	$

Please enter the following income items that were paid to you (as shown in your Profit and Loss account):

Add back items	**Last tax year**	**Previous tax year**
E. Salary/Wages	$	$
F. Superannuation	$	$
G. Other benefits	$	$
Total income (D+E+F+G)	$	$

5. INCOME DETAILS (contined)

10. If a figure is entered at Question 9G (Other benefits), please advise what has been included.

Do not add back drawings, dividends or any salary/wage paid from the business if you are a sole trader or in partnership.

11. In the event of your disablement, would your income continue for more than 60 days? ☐ Yes ☐ No

Do not include other insurance, workers compensation, annual or long service leave entitlements, rental or other investment income.

a) **If yes,** is this due to accrued sick leave only? ☐ Yes ☐ No

b) **If sick leave,** how many days do you have accrued? days

c) **If not sick leave,** is there a written or verbal agreement in place regarding your ongoing income entitlements and when they might cease (eg a partnership agreement)?

☐ Yes → Please provide details below or a copy of the agreement.

☐ No → Please advise the nature of the ongoing income entitlements, the amount of income and its duration.

To be completed for Income Protection only, if the monthly benefit is over $20,000 total cover.

12. Do you have net assets (excluding the personal residence/family home and superannuation) exceeding $5 million and/or net investment or unearned annual income exceeding $250,000?

This includes assets and investments you have either an ownership interest in or control over (directly or indirectly) including those held in your spouse's name, in trusts or other entities owned by trusts or any other entity that you have control over.

☐ No ☐ Yes → Please provide details here. If you answer yes to this question, cover may be restricted.

To be completed for Business Expense option only.

13. What are your monthly Business Expenses less any amounts for depreciation, salary and superannuation paid to yourself or an associated person (eg spouse) where that associated person does not work in the business?

$

14. I understand that a Benefit under the Business Expense option is payable only in the event of an Operating Loss caused solely as a result of my disability, in accordance with the terms and conditions of the Accelerated Protection Policy Document. Any benefits payable under the Business Expense option will be the lesser of the Business Expense option monthly benefit and the Operating Loss. If my business income continues to cover my Business Expenses when disabled, no benefits will be payable.

☐ I agree.

6. OTHER INSURANCE DETAILS

To be completed for Life, TPD and Critical Illness insurance applications.

1. Apart from this application, do you have or are you applying for any other Life, TPD or Critical Illness insurance (including cover held under superannuation)?

☐ Yes → Is this other insurance being completely replaced by this application? ☐ Yes ☐ No

☐ No → What will be the total amount of cover in force on your life (including this application)?

Note Please include any TPD benefits under Critical Illness type contracts. Financial evidence may be required if total combined cover exceeds our financial underwriting limits.

Life $ TPD $ Critical Illness $

Please go to Section 29 if you would like to nominate a preferred risk commencement date when replacing existing cover with this application.

To be completed for Income Protection and Business Expense insurance applications.

2. Apart from this application, do you have or are you applying for any other Income Protection or Business Expense insurance (including cover held under superannuation)?

☐ No → Go to Section 7. ☐ Yes → Complete Question 3.

3. Is this other insurance being completely replaced by this application? ☐ Yes ☐ No

   a) **If no and you are applying for Income Protection,** does your existing insurance have a maximum benefit period of two years?

   ☐ Yes ☐ No → Please provide full details of cover being retained including benefit amount, waiting period and benefit period. **Note** An existing insurance offset may apply to Income Protection.

   b) Is the waiting period 30 days or less? ☐ Yes ☐ No

Please go to Section 29 if you would like to nominate a preferred risk commencement date when replacing existing cover with this application.

Adviser note If you are using TAL's tele-interviewing service for online applications, please skip to Section 25. If you provide an email address for the Life Insured in Section 2, we can collect a voice signature during the tele-interview eliminating the need to collect an original signature.

7. HEALTH AND LIFESTYLE DETAILS

1. Height and weight

Height cm or feet inches

Weight kg or stone pounds

2. Have you smoked tobacco or any other substance in the last 12 months?

☐ No → Go to Question 3.

☐ Yes → Complete the following questions.

   a) Smoked cigarettes?

   ☐ No ☐ Yes → What daily quantity is consumed?

   b) Smoked cigars or pipe? ☐ Yes ☐ No

   c) Smoked another substance? ☐ Yes ☐ No

3. On average how many standard drinks of alcohol do you typically consume per day?
   A 'standard drink' is approximately 285ml full strength beer, 100ml wine or 30ml spirits.

8. RESIDENCY

1. Are you an Australian citizen or permanent resident or a New Zealand citizen residing in Australia?

☐ Yes → Go to Section 9. ☐ No → Complete Questions 2 to 6.

2. How long have you lived in Australia? years ☐ months ☐

3. What are your plans for obtaining permanent residency and when is this likely to be granted?

4. Visa

   a) What type of visa do you have?

   b) When does it expire? DD / MM / YYYY

5. In what country were you born?

6. What is your nationality or what other countries do you have residency/citizenship rights in?

9. TRAVEL PLANS

1. In the next 12 months do you have definite plans to travel or live overseas or are you required to travel overseas on a regular basis for business?

☐ No → Go to Section 10. ☐ Yes → Complete Questions 2 to 5.

2. Please select the term that best describes your travel plans.

☐ Personal and/or business travel ☐ Living or moving overseas (even temporarily)

3. Please advise the destinations (city and country) you will be travelling to or visit most frequently (if regular businesses travel).

4. Please advise departure date, the frequency of travel, the duration of visit and the purpose of each trip.

5. If you live, or are planning to live overseas, please provide full details of where, the length of time and purpose of being there.

10. PURSUITS AND ACTIVITIES

Do you currently participate in, or do you have any intention of participating in, any sports or hazardous activities including aviation (except as a fare paying passenger on a commercial airline), football, scuba diving, motor racing, rock climbing?

☐ No ☐ Yes → Complete the relevant questionnaire(s) in Sections 11 to 14.

11. AVIATION QUESTIONNAIRE

If you work for a major commercial (non-charter or private company) airline, please do not complete this questionnaire. Refer to the TAL Occupation List for eligibility guidelines.

1. Do you hold a current pilot's licence? ☐ Yes ☐ No
2. Do you intend to change the scope of your present licence? ☐ Yes ☐ No
3. Do your occupation duties include flying? ☐ Yes ☐ No
4. If you fly as part of your occupation, do you fly charter flights or private company aircraft or participate in aerial photography and surveys? ☐ Yes ☐ No ☐ Not applicable
5. Are you a flying instructor? ☐ Yes ☐ No
6. Does your flying incorporate any special risks such as agricultural flying, flying to oil rigs, record attempts, display flights, aerobatics, or flying outside Australia? ☐ Yes ☐ No
7. Do you fly microlights, ultralights or powered hang-gliders? ☐ Yes ☐ No
8. Have you ever had an accident or been charged with a violation of Department of Transport regulations? ☐ Yes ☐ No
9. Do you land at unauthorised aerodromes, airports or landing areas? ☐ Yes ☐ No
10. How many hours do you fly per annum? hours
11. If you have answered yes to any of the questions above, please describe the scope of your aviation activities including the type and purpose of flying, and aircraft and specific information in relation to the question.

12. SCUBA QUESTIONNAIRE

1. Are you a current certified diver? ☐ Yes ☐ No
2. Do you work as a diving instructor? ☐ Yes ☐ No
3. What are the maximum depths of your dives? ☐ Up to 30 metres ☐ 31 – 40 metres ☐ More than 40 metres
4. Do you participate in mixed gas or decompression diving and/or use explosives while diving? ☐ Yes ☐ No
5. Do you dive in wrecks, pits, caves or potholes or participate in night or abalone diving? ☐ Yes ☐ No
6. Do you intend to change the scope of your diving activities? ☐ Yes ☐ No
7. If you answered yes to any of the questions above, please provide any further information you think may assist in underwriting your application.

13. MOTORSPORTS QUESTIONNAIRE (car, bike, boat)

1. Please specify the type of motorsport activity, and type of vehicle and licence held.

a) Engine size

b) Times per annum

c) Maximum speed

d) Years participated in sport

e) Type ☐ Social (non-competition) ☐ Racing (competition) ☐ Professional

13. MOTORSPORTS QUESTIONNAIRE (car, bike, boat) (contined)

2. Please specify the type of events and categories of racing.

3. Do you take part in international events?

☐ No ☐ Yes → Please provide any further information you think may assist in underwriting your application.

14. OTHER ACTIVITIES (eg football, rock climbing, abseiling, caving, bungee jumping)

1. Please specify the type of activity and events participated in.

2. If relevant please specify:

   a) Times participated in per year

   b) Location (eg indoor, outdoor, overseas)

   c) Contact or non-contact (eg please specify for martial arts or touch football)

   d) Type of competition

   ☐ Social/Amateur ☐ Competition (match payments) ☐ Competition (semi/professional)

3. Please specify:

   a) Equipment used

   b) Heights or depths involved

4. Please provide any other information you think may assist in underwriting your application.

15. FAMILY HISTORY

1. Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 60? If family history is unknown, answer no.

☐ No ☐ Yes → Please indicate against the following list.

Note Information is only required for first degree blood related family members, living or deceased.

☐ Heart disease (eg angina or heart attack) or stroke

☐ Cardiomyopathy

☐ Breast, cervical and/or ovarian cancer

☐ Bowel cancer or polyposis of the colon

☐ Any other type of cancer

☐ Diabetes Please specify type ☐ Type 1 (early onset, insulin dependent) ☐ Type 2

☐ Alzheimer's disease

☐ Multiple sclerosis

☐ Motor neurone disease, Parkinson's disease, Polycystic kidney disease, Huntington's disease, mental illness and/or any other hereditary disorder not previously listed in this section.

2. If you indicated a condition above, please advise relevant condition, number of relatives and age(s) affected.

RELATIONSHIP	MEDICAL CONDITION (eg breast cancer, heart attack)	AGE WHEN DIAGNOSED	AGE AT DEATH (if applicable)

Please provide details and results of any investigations performed on you as a result of this history.

16. HEALTH DETAILS

Please indicate below if you have ever had or received medical advice or treatment (including surgery) for any of the listed conditions.

For all yes answers, please provide details using the Additional Medical Statement in Section 17.

If you answer yes to a question marked with an asterisk, please complete the relevant questionnaire in Sections 20 to 24.

1. Any disease, disorder or condition relating to the heart and circulatory system including high blood pressure, raised cholesterol, heart murmur, stroke, brain haemorrhage, or embolism, chest pain or palpitations?* ☐ Yes ☐ No
2. Diabetes or raised blood sugar levels? ☐ Yes ☐ No
3. Any disorder of the kidney, bladder or genitourinary system including prostate disorders, urinary tract infections, kidney stones, blood or protein in the urine? ☐ Yes ☐ No
4. Any disorder of the digestive system (liver, oesophagus, stomach, gall bladder, pancreas or bowel) including reflux, hernia, ulcers, haemochromatosis, colitis or Crohn's disease? ☐ Yes ☐ No
5. Any cancer, leukaemia or tumour, lump, cyst or growth either malignant or benign (non-malignant)? ☐ Yes ☐ No
6. Asthma, sleep apnoea, or any other respiratory, lung or breathing disorder?* ☐ Yes ☐ No
7. Head injury, epilepsy, fits, convulsions, or chronic headaches? ☐ Yes ☐ No
8. Numbness, tingling, altered sensation, tremor, fainting attacks, problems with balance or co-ordination, any form of paralysis or multiple sclerosis? ☐ Yes ☐ No
9. Any disorder of the eyes or ears, including blindness, blurred or double vision (other than sight problems corrected by glasses, contact lenses or laser surgery) or impaired hearing or tinnitus? ☐ Yes ☐ No
10. Eczema, dermatitis, psoriasis or any other skin condition (other than acne)? ☐ Yes ☐ No
11. Rheumatoid arthritis, other forms of arthritis, osteoporosis or gout? ☐ Yes ☐ No
12. Back or neck pain including muscular pain, strain, whiplash and sciatica?* ☐ Yes ☐ No
13. Any joint (eg wrist, elbow, shoulder, ankle, knee, hip), bone or muscle pain or disorder including RSI? ☐ Yes ☐ No
14. Any blood disorder including anaemia? ☐ Yes ☐ No
15. Any thyroid disorder or lupus? ☐ Yes ☐ No
16. Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, chronic fatigue, post natal depression, or any other mental or nervous condition?* ☐ Yes ☐ No

Note Questions 17 and 18 relate to females only. Males go to Question 19.

17. Any disorder of the cervix (including abnormal Pap smear), ovary, uterus, breast or endometrium, or are you currently pregnant?

☐ No ☐ Yes → If pregnant, please advise expected delivery date. DD / MM / YYYY

18. Any complications of pregnancy or childbirth or a child with congenital abnormalities? ☐ Yes ☐ No
19. Have you ever injected, smoked or otherwise taken recreational or non-prescription drugs, taken any drug other than as medically directed or received advice and/or counselling for excess alcohol consumption from any health professional? ☐ Yes ☐ No
20. Have you ever tested positive for HIV/AIDS, Hepatitis B or C, or are you awaiting the results of such a test (other than for this application)? ☐ Yes ☐ No
21. In the last five years have you engaged in any activity reasonably expected to having an increased risk of exposure to the HIV/AIDS virus? (This includes unprotected anal sex, sex with a sex worker or sex with someone you know to be HIV positive or suspect to be HIV positive.) ☐ Yes ☐ No
22. Have you in the last five years been absent from work or your usual duties for a period of more than five days through any illness or injury not previously disclosed in this application? ☐ Yes ☐ No
23. Apart from any condition already disclosed, do you have any symptoms of illness, any physical defect, or any condition for which you receive medical advice or treatment? ☐ Yes ☐ No
24. Apart from treating any condition already disclosed, have you in the last two years had medication prescribed (except contraceptives or antibiotics)? ☐ Yes ☐ No
25. Apart from investigating any condition already disclosed, have you had any medical test (eg ECG, X-Ray, colonoscopy, endoscopy, gastroscopy or ultrasound)? ☐ Yes ☐ No
26. Apart from investigating any condition already disclosed, have you ever had a genetic test where you received (or are currently awaiting) an individual result or are you considering having a genetic test (excluding genetic screening of a child during pregnancy)? ☐ Yes ☐ No
27. 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? ☐ Yes ☐ No

17. ADDITIONAL MEDICAL STATEMENT

For any questions to which you answered yes in Section 16 (Health details), please complete the relevant questionnaire or add details here.

	QUESTION NUMBER _____	QUESTION NUMBER _____	QUESTION NUMBER _____
1. What was the condition and which part of the body was affected?			
2. What was the date symptoms first started including a description of the symptoms?	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
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 the duration of attacks or symptoms?			
6. For how long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide the date and duration of your stay.	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
8. What advice/ treatment did you receive?			
9. Are you still receiving treatment? If so, please advise the nature and the frequency of treatment.			
10. When did you last suffer from any symptoms?	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
11. What is your degree of recovery (%)?			
12. Please supply the name and address of all doctors or hospitals consulted for this specific condition.			
13. Does your current general practitioner have records for this condition?			
14. Please provide any further information you think may assist in underwriting your application.			

18. INSURANCE DECLINED OR MODIFIED

If more than once, please provide details for all circumstances.

1. Have you ever had any application for Life, TPD, Critical Illness, Income Protection or Business Expense insurance refused, modified or offered on non-standard terms?

☐ No → Go to Section 19. ☐ Yes → Complete Questions 2 to 5.

2. How long ago were these modified terms offered? (select all that apply)

☐ Within the last 3 years ☐ Between 3 and 5 years ago ☐ More than 5 years ago

3. Please advise the type of modified terms offered (if known). (select all that apply)

☐ Declined ☐ Loading/Extra premium ☐ Benefits reduced

☐ Deferred/Postponed ☐ Exclusion(s) ☐ Term of plan reduced

☐ None of the above ☐ More than one of the above ☐ Unknown

4. The modified terms were due to which of the following? (select all that apply)

☐ Medical reasons ☐ Occupation ☐ Pastime(s)

☐ Other ☐ Unknown

5. Do you confirm that if terms have been modified or declined, that all reasons for modifying or declining are disclosed in this application? ☐ Yes ☐ No

19. CLAIMS

If more than once, please provide details for all circumstances.

1. Have you ever received claim payments, including but not limited to workers compensation or other insurance payments for an accident, sickness or disability or are you currently making a claim (including by TAL)?

☐ No → Go to Section 20. ☐ Yes → Complete Questions 2 to 6.

Please ensure full medical disclosure has been made of the condition being claimed for.

2. Has the claim been finalised?

☐ Yes ☐ No→ Please advise the details of the claim including when it was, who it is/was made against (eg workers compensation, an insurance company), the amount of money claimed, the condition claimed for, current status of this condition and total time off work.

3. Have you made a full and complete recovery from the condition for which you claimed?

☐ No ☐ Yes→ How long have you been fully recovered?

☐ Less than 1 year ☐ Between 1 and 2 years ☐ Between 2 and 5 years ☐ More than 5 years

4. How much time did you take off work and/or your usual daily activities due to this condition?

☐ Less than 1 month ☐ Between 1 and 3 months ☐ Between 3 and 6 months ☐ More than 6 months

5. If you haven't made a full recovery, please provide further details including the name of the condition and the nature of the ongoing impairments/symptoms.

6. Do you confirm that the condition is disclosed in this application? ☐ Yes ☐ No

20. MENTAL HEALTH CONDITION QUESTIONNAIRE

To be completed if you have had depression, anxiety, stress, fatigue or any other mental health condition.

1. Did you first experience symptoms within the last six months?

☐ No ☐ Yes→ Please advise the underlying cause, number and frequency of episodes, date symptoms last experienced, treatment received, time off work required and name and address of treating doctor.

2. Have you ever considered or attempted to commit suicide?

☐ No ☐ Yes→ Please advise the underlying cause, the number and frequency of episodes, the date symptoms were last experienced, treatment received, time off work required and the name and address of the treating doctor.

3. In the last five years, have you required hospitalisation due to this condition?

☐ No ☐ Yes→ Please advise the underlying cause, the number and frequency of episodes, the date symptoms were last experienced, treatment received, time off work required and the name and address of the treating doctor.

4. Have you required more than 12 weeks off work in total or been unable to perform your normal activities due to your mental health condition?

☐ No ☐ Yes→ Please advise the underlying cause, the number and frequency of episodes, the date symptoms were last experienced, treatment received, time off work required and the name and address of the treating doctor.

5. In the last five years:

   a) How many days have you had off work or been unable to perform your normal activities due to your condition? days

   b) Please advise the underlying cause, the number and frequency of episodes, the date symptoms were last experienced, treatment received, time off work required and the name and address of the treating doctor.

6. Are you under the care of a psychiatrist?

☐ No ☐ Yes→ Please describe the type and frequency of treatment, including any medications taken and the dosage.
If medication, please advise when this commenced and the dates of any changes to the treatment type or dosage.
If counselling, please advise how regularly this occurs.

20. MENTAL HEALTH CONDITION QUESTIONNAIRE (continued)

7. When did you last experience symptoms of this condition? DD / MM / YYYY

8. Please provide any other information you think may assist in underwriting your application, including the names and addresses of doctors or other health care professionals consulted, and the date first and last consulted.

21. BACK/NECK CONDITION QUESTIONNAIRE

To be completed if you have had a back or neck condition.

1. Do you plan to have surgery for your back/neck condition or have you had surgery in the past?

☐ No ☐ Yes→ Please advise the cause of the condition, the date symptoms were first and last experienced, the type of treatment you are receiving, the type of surgery you've had or which is to be undertaken, the section of the back affected, time off work and the degree of recovery.

2. Have you ever been diagnosed as having a bulging disc, prolapsed disc, slipped disc, disc protrusion, herniated disc or any other disc condition?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

3. Do you require regular (that is, once a week or more frequently) painkillers/anti-inflammatories or cortisone injections (quarterly or more frequently)?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

4. Have you had to modify your work duties or change your occupation as a result of this condition?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

21. BACK/NECK CONDITION QUESTIONNAIRE (continued)

5. Have you had any time off work due to this condition?

☐ No ☐ Yes→ Please advise the amount of time you've taken off work in total, and the amount of time you've taken off work in in the last five years specifically (in days).

6. How many episodes of back/neck pain have you had?

7. How long ago did you last experience symptoms?

☐ Within the last year ☐ 1 to 4 years ☐ 4 to 5 years ☐ More than 5 years

8. Have you required any form of treatment for your back/neck condition? ☐ Yes ☐ No

9. How long ago did you last require treatment?

☐ Within the last year ☐ 1 to 4 years ☐ 4 to 5 years ☐ More than 5 years

10. On average, do/did your symptoms last more than one month? ☐ Yes ☐ No

11. Please indicate which sections of your spine were affected.

☐ Upper spine only (including neck) ☐ Lower spine only ☐ Middle spine only ☐ More than one section

☐ Not sure

12. Please provide any other information you think may assist us in underwriting your application, including the name and address of medical practitioners attended.

22. ASTHMA/BRONCHITIS QUESTIONNAIRE

To be completed if you have had asthma.

1. Was this childhood asthma only, with no further symptoms or treatment?

☐ Yes → No further details need to be provided in this section.

☐ No → Complete Questions 2 to 6.

2. Within the last two years, have you been admitted to hospital for more than 24 hours for treatment of this condition?

☐ No ☐ Yes→ Please provide full details including name and frequency of treatment, time off work or restriction to usual duties, whether you have an Asthma Action Plan in place and the name and address of the doctor who has records.

3. Within the last 12 months, have you required more than two courses of steroid tablets (not inhalers)?

☐ No ☐ Yes→ Please provide full details of asthma treatment, time off work or restriction to usual duties, whether you have an Asthma Action plan in place and the name and address of the doctor who has records.

4. How often would you experience symptoms (eg coughing, wheezing, shortness of breath or chest tightness)?

☐ Infrequently ☐ Weekly, not daily ☐ Daily

22. ASTHMA/BRONCHITIS QUESTIONNAIRE (continued)

5. Do you experience symptoms at night?

☐ No ☐ Yes→ Please provide full details of this condition including date of first and last symptoms, frequency and severity of episodes, any types of treatment required, and the name and address of your treating doctor.

6. Within the last 12 months, have you had more than five consecutive days off work or been unable to carry out your normal daily activities due to asthma only?

☐ No ☐ Yes→ Please provide full details of asthma treatment, time off work or restriction to usual duties, whether you have an Asthma Action plan in place and the name and address of your treating doctor.

23. CHOLESTEROL QUESTIONNAIRE

To be completed if you have had raised cholesterol.

1. When was your raised cholesterol diagnosed? DD / MM / YYYY

2. What type of treatment are you taking for your raised cholesterol?

3. What was your latest reading?

4. Apart from the regular blood tests for your cholesterol, have you been advised to have any further cardiovascular investigations?

☐ No ☐ Yes→ Please provide information to assist in underwriting your application including details and date of latest readings (including HDL/LDL if known), details of medication, investigations and follow up and the name and address of the doctor consulted.

5. Are you currently on medication for this condition?

☐ Yes ☐ No→ Please provide details.

a) Did you cease medication for raised cholesterol on the advice of your doctor? ☐ Yes ☐ No

b) Has your cholesterol been checked since ceasing medication? ☐ Yes ☐ No

c) What was your latest reading?

6. Please provide any further information you think may assist in underwriting your application, including the name and address of the doctor who treats this condition.

24. HIGH BLOOD PRESSURE QUESTIONNAIRE

To be completed if you have had high blood pressure.

1. When was your high blood pressure diagnosed? DD / MM / YYYY
2. Have you had your blood pressure taken since being told you had high blood pressure? ☐ Yes ☐ No
3. What was your latest reading?
4. If latest reading unknown, what did your doctor advise in relation to your blood pressure reading?
5. What type of treatment are you currently undertaking?
6. If you are taking medication, how many types do you take per day to control your blood pressure?
7. How often do you attend your GP to have your prescription for blood pressure tablets renewed?
8. Apart from the initial investigations when first diagnosed, have you been advised to have or have you undergone any further cardiovascular (eg ECG) or urinary investigations in the last 12 months?

☐ No ☐ Yes→ Please provide any other information to assist us in underwriting your application such as medications (including previous medications and dates changed), results of tests and the names and addresses of health professionals consulted.

9. For females, was your high blood pressure diagnosed during pregnancy? ☐ Yes ☐ No ☐ Not applicable

If yes, please advise if your blood pressure has returned to normal, whether any treatment was required and whether this treatment has ceased or is required on an ongoing basis.

10. Please provide any other information you think may assist in underwriting your application including the name and address of the doctor who treats this condition.

25. MEDICAL EXAMINATION

Would you like TAL to arrange any medical exams or blood tests that may be required to complete this application?

☐ Yes ☐ No

26. DOCTOR/CLINIC DETAILS

1. Do you have a general practitioner (GP) or medical practice that you usually attend?

☐ No ☐ Yes→ Complete the following.

Name

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

2. How long ago was your last consultation with this GP or medical practice?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

3. How long have you been attending this GP or medical practice?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

4. If less than two years, or you don't currently have a GP or medical practice that you usually attend, please provide the name and contact details of your previous GP or medical practice attended.

Name

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

27. POLICY OWNER

Policy Owner 1

All correspondence in relation to this policy will be sent to the Policy Owner(s).

Owner type

☐ Life Insured ☐ Trustee of a TAL superannuation fund* ☐ Other trustee

☐ SMSF ☐ Platform superannuation fund ☐ Company ☐ Other

*TAL Super

Only complete the details below if the Policy Owner is NOT the Life Insured or the Trustee of a TAL superannuation fund.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Last name

Trustee/Company name

ABN/ACN

27. POLICY OWNER (continued)

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

We will use email for some of the information we need to send you about your policy, rather than sending paper copies. However, if you'd prefer to receive information by post, please indicate by writing X in the box on the right. ☐

Policy Owner 2

Owner type

☐ Life Insured ☐ Company ☐ Other

Only complete the details below if the Policy Owner is NOT the Life Insured or the Trustee of a TAL superannuation fund.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Last name

Trustee/Company name

ABN/ACN

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

We will use email for some of the information we need to send you about your policy, rather than sending paper copies. However, if you'd prefer to receive information by post, please indicate by writing X in the box on the right. ☐

28. DEATH BENEFIT NOMINATION – NON-SUPERANNUATION (optional)

Section 48A of the *Insurance Contracts Act 1984* allows you to nominate a person or certain legal entities to receive benefits under this policy. The following restrictions apply to such a nomination under this policy:

- you may only nominate up to five beneficiaries to receive the benefit payable as a result of a death claim (but not Terminal Illness claim) under the Life Insurance Plan
- you must be both the only Policy Owner and the only Life Insured in order to make a valid nomination
- you may change a nominated beneficiary or revoke a previous nomination at any time prior to a claim event, but the change does not take effect until TAL receives the new nomination form
- payment of Death Benefits will be made on the basis of the latest nomination received, unless it has been revoked
- if a nominated beneficiary predeceases you, the portion of the Death Benefit nominated in respect of that beneficiary will be paid to your personal representative
- your nomination will be automatically revoked on the assignment (transfer) of the policy, and
- a nominated beneficiary has no rights under the policy, other than to receive the Death Benefit after the claim has been admitted by TAL. The nominated beneficiary cannot authorise or initiate any policy transaction.

28. DEATH BENEFIT NOMINATION – NON-SUPERANNUATION (optional) (continued)

Would you like to make a Death Benefit nomination?

☐ No ☐ Yes→ Please provide details below.

You can nominate up to five beneficiaries to receive a portion of the Death Benefit.

Please ensure that percentages are entered as whole numbers, and that the total adds up to 100%.

NAME OF BENEFICIARY	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO POLICY OWNER	% OF DEATH BENEFIT (whole numbers only)
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		

Legal Personal Representative (your estate)

Total (must add up to 100%) 100%

29. PREFERRED RISK COMMENCEMENT DATE (optional)

Please indicate a preferred risk commencement date if you are replacing cover that is held elsewhere.

DD / MM / YYYY

Note You may select a future date between 1 and 60 days from the current date. If TAL is not able to issue the policy by the nominated date, a revised commencement date may apply. If this happens, we will contact your financial adviser to confirm the revised commencement date. Your Duty of Disclosure applies even after this application is completed and until TAL advises acceptance of insurance and issues a Policy Schedule.

30. METHOD OF PAYMENT

Payment method ☐ Direct debit ☐ Credit card ☐ Cheque* ☐ Platform ☐ SuperStream* ☐ Rollover** ☐ BPay*

Frequency ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

* Not available monthly

** Only available yearly. If selected please complete an Enduring Rollover Authority form.

31. DIRECT DEBIT PAYMENT AUTHORITY BY CREDIT CARD

I authorise the debit of my premiums from my ☐ Visa ☐ MasterCard

Account name

Card number

Expiry date DD / MM / YYYY

Signature of cardholder* ✗

Date DD / MM / YYYY

* Signature only required when the payer is not the Life Insured or Policy Owner.

32. DIRECT DEBIT AUTHORITY

I request and authorise TAL Life Limited (Direct Debit System User Identification Number 245397) to directly debit my premiums, from my account detailed below, using the Bulk Electronic Clearing System (BECS). I confirm that I have read the Direct Debit Request Service Agreement in the PDS and that I have the authority to make these payments.

Account name

Name of bank

BSB number

Account number

Signature of account holder 1* ✗ Date DD / MM / YYYY

Signature of account holder 2* ✗ Date DD / MM / YYYY

* Signature(s) only required when the payer is not the Life Insured or Policy Owner.

33. DIRECT DEBIT FROM A PLATFORM ACCOUNT

Important Direct debit from a superannuation or investment platform account is only available where TAL has an agreement with the platform provider.

Platform name

Account/Member number

Account name

34. PROVIDING YOUR TAX FILE NUMBER

The *Superannuation Industry (Supervision) Act 1993* allows the trustee of a superannuation fund to collect your tax file number (TFN).

Your TFN will be used for authorised purposes only. This includes finding and identifying your superannuation benefits, calculating tax on any benefit payments and providing information to the Australian Taxation Office (ATO) or other prescribed authority. These purposes may change in the future. It is not an offence if you do not provide your TFN but if we do not hold your TFN, the following may apply:

- we may not be able to process your application
- your insurance cover could lapse, as we are unable to accept personal contributions to pay for insurance and/or your contributions may not be enough to cover premiums due to the extra tax being applied to the contributions
- you will not be able to make personal or spouse contributions to your superannuation
- employer and salary sacrifice contributions will be taxed at the highest marginal tax rate plus the Medicare levy. Please refer to www.ato.gov.au for more information on income tax rates
- for pre 1 July 2007 members, concessional contributions of up to $1,000 will be taxed at 15%. For concessional contributions in excess of $1,000, the whole amount will be taxed at the highest marginal tax rate plus the Medicare levy.
- locating all your superannuation benefits when you retire may be harder, and
- lump sum withdrawals will not be concessionally taxed.

We may also provide your TFN to another superannuation provider if your benefits are being transferred to that superannuation provider, unless you request in writing that it not be disclosed.

By completing and returning this form, you agree to provide your TFN to the Trustee of TAL Super.

35. PRIVACY

In this section, the words 'we' and 'our' refer to both TAL and the Trustee.

The way in which we collect, secure, hold, use and disclose personal and sensitive information (your information) is explained in the 'Your Privacy' section of the PDS and in our privacy policies. These policies can be obtained online at www.tal.com.au/privacy-policy (all policies) and www.mercer.com.au/privacy.html (TAL Super policies only) or by contacting us.

If you have any questions about the way in which your information is managed, or would like a paper copy of our privacy policies, please contact us by phone on 1300 209 088 or by email to customerservice@tal.com.au.

36. DECLARATION

I/We declare that I/we have read the following statements, and I/we agree and acknowledge that:

- I/we have received a copy of the Accelerated Protection or Accelerated Protection for Investment Platforms PDS, dated 12 October 2018
- I/we have read and understand the Duty of Disclosure as set out in the PDS and this Application Form and understand the Duty of Disclosure also applies to Interim Cover and that the Duty of Disclosure continues to apply until TAL accepts this application and issues a Policy Schedule
- I/we have provided TAL with true, accurate and complete answers in my/our application (including this Application Form, quotes and all other forms, questionnaires and information provided to TAL), whether answered by me/us or my/ our financial adviser, to the best of my/our knowledge
- I/we acknowledge that TAL will rely on the answers and information provided by me/us in my/our application to date. I understand that, notwithstanding any Authorities which may be provided to TAL by me/us, TAL will not necessarily seek or obtain any further information in relation to my/our application, and that the decision whether to seek further information is solely within TAL's discretion
- where my/our application has been submitted electronically to TAL, I/we will review
  - a printout of the application submitted and will notify my/our financial adviser of any answers which are incorrect, incomplete or inaccurate, or
  - a summary received by email (if I/we have provided TAL with an email address for the purpose of receiving a summary of the application by email) and will notify TAL of any answers which are incorrect, incomplete or inaccurate within five business days
- I/we will cooperate with TAL if modifications to the Policy conditions are required because of any changes to the answers TAL are notified of
- I/we understand that by signing this form, I/we consent to the collection, use and disclosure of my/our personal information in accordance with the section in the PDS headed 'Your Privacy'
- I/we understand that my/our financial adviser is my/our agent and not the agent of TAL
- I/we understand that TAL may accept information from my/our financial adviser or their representative, and that TAL will rely on any such information in deciding whether or not to accept my/our application and in relation to all matters of administration
- in relation to any tax returns submitted in support of this application, I/we confirm that these are the tax returns submitted to the Australian Taxation Office and no subsequent adjustments have been made or are expected
- in the event that TAL determines to not accept my/our application on standard terms
  - I/we authorise TAL to inform my/our financial adviser or their representative, of the reasons for that decision
  - I/we understand that TAL will not provide copies of medical or other reports to my financial adviser or their business without first obtaining my/our consent, and
  - I/we authorise my/our financial adviser or their representative to communicate to TAL my/our acceptance of any alternative terms on my/our behalf, and
- I/we have authorised TAL to debit my/our premiums if credit card or bank account details are provided with my/our application.

Signature of life to be insured ✗ Date DD / MM / YYYY

Signature of Policy Owner 1 ✗ Date DD / MM / YYYY
(if different to the life to be insured)

Signature of Policy Owner 2 ✗ Date DD / MM / YYYY
(if different to the life to be insured)

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37. MEDICAL EVIDENCE AUTHORITY

Reference number

Date of birth DD / MM / YYYY

Name of life to be insured

Dear Doctor

I have applied to TAL Life Limited (TAL) for insurance and a medical report from your practice may be required. If TAL seeks a report from you, TAL may not be able to finalise my application for insurance until it receives your report.

I have agreed that any Medical Practitioner or any other person who has been or may be consulted by me at any time in the future whether named by me or not shall be and is hereby authorised and directed by me to divulge to TAL, any legal tribunal or any third party engaged by TAL all medical or surgical information acquired with regard to myself. A copy of this authority shall be considered as valid as the original. I would be grateful if you could attend to this matter as soon as possible.

Signature of life to be insured ✗

Date DD / MM / YYYY

38. APPLICATION TO JOIN TAL SUPER

Fund: TAL Super – a plan within the Retail Division in the Mercer Super Trust ABN 19 905 422 981

Trustee: Mercer Superannuation (Australia) Limited ABN 79 004 717 533 AFSL 235906

1. Personal details

This should only be completed where the policy is to be owned by the Trustee of TAL Super.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Last name

Date of birth DD / MM / YYYY

Residential address

Street address

Suburb State Postcode

Country

OR

Business address

Street address

Suburb State Postcode

Country

2. Eligibility to contribute

Please tick any of the following statements that apply:

☐ I am under age 65.

☐ The contributions to meet the premiums are employer award or superannuation guarantee contributions.

☐ I am over 65 and I am gainfully employed on at least a part-time basis (I have worked for at least 40 hours in a period of not more than 30 consecutive days in the financial year in which the contribution is made).

☐ None of the previous apply to me but I am still eligible to make or receive superannuation contributions for the following reason:

Please refer to the information about superannuation contribution rules provided in the PDS for details.

3. Contributions to meet premiums

☐ Employer contributions ☐ Rollover

Personal contributions: I intend to apply for a tax deduction for the contributions. ☐ Yes ☐ No

4. Death Benefit nomination

Understanding who receives your superannuation benefit, including any insurance, in the event of your death is important. Under the rules of the Fund, the Trustee has the discretion to determine to whom and in what proportions any Death Benefit is payable. You may, however, nominate your legal personal representative and/or dependants as your preferred beneficiaries and the Trustee will consider your wishes in the event of your death.

If you wish to make your nomination binding, this application must be signed in the presence of two witnesses. Both of these witnesses need to be over the age of 18 and cannot be beneficiaries under the binding nomination.

Please note that your binding Death Benefit nomination remains valid for three years and should be reviewed regularly particularly if circumstances change, as in the case of marriage or divorce.

More information about beneficiary nominations is provided in the PDS.

Important An incomplete or incorrectly completed binding nomination is not binding on the Trustee of TAL Super, and would be invalid in the event of a claim.

☐ I wish to make a **binding** nomination ☐ I wish to make a **non-binding** nomination

Please ensure that percentages are entered as whole numbers, and that the total adds up to 100%.

NAME OF DEPENDANT	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO LIFE INSURED	% OF DEATH BENEFIT (whole numbers only)
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		
		DD / MM / YYYY		
			Legal Personal Representative	
			Total (must add up to 100%)	100%

5. Declaration

- I wish to apply to become a member of TAL Super. (**Note** If a binding Death Benefit nomination has been made in Question 4, you must sign this application in the presence of two adult witnesses who are not the nominated beneficiaries listed above.)
- I will be bound by the provisions of the governing rules of TAL Super.
- I acknowledge that where the Trustee is unable to accept certain contributions made by me, or on my behalf, then those contributions will be returned to me or the person or organisation (including my employer) who made the contribution on my behalf and any such contributions will not be added to my super account.
- I agree to Mercer (Australia) Pty Ltd (Mercer) paying the Trustee's costs of running TAL Super and to TAL making payments to Mercer towards those costs of running TAL Super. I understand that these costs are not an additional cost to me.
- Where my policy is to be held through TAL Super, I am making a written direction with respect to the investment of my super in TAL Super, to the extent applicable.

Applicant signature ✗ Date DD / MM / YYYY

Signed by the applicant in the presence of:

Witness 1 signature ✗ Date DD / MM / YYYY

Witness 1 name

Witness 2 signature ✗ Date DD / MM / YYYY

Witness 2 name

39. ADVISER DETAILS

Principal authorised representative

TAL adviser number

Authorised representative name

Dealer group

Commission split (whole numbers) New business % Servicing %

Contact number Contact type Business ☐ Mobile ☐

Email

Shared authorised representative

TAL adviser number

Authorised representative name

Dealer group

Commission split (whole numbers) New business % Servicing %

Contact number Contact type Business ☐ Mobile ☐

Email

Note If splitting commission, new business and servicing commission must each total 100%.

40.ADVISER NOTES

SUBMITTING THIS FORM

Please return your completed form and any supporting documentation to:

TAL Life Limited
GPO Box 5380
Sydney NSW 2001

CONTACTING TAL

customerservice@tal.com.au
1300 209 088
1300 351 133
tal.com.au

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