Zurich Personal Statement

Provide this form with your insurance application

right by your side

If you are applying for Insurance cover and are required to go through full underwriting please complete the Personal Statement and return with your completed Insurance Application form.

Important Notice

Zurich Australia Limited (Zurich) is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by Zurich
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by Zurich.

Zurich requires this application and other health information to assist in making a decision on your proposed insurance cover. This application is confidential. Please refer to the Brighter Super *Privacy policy* and the *Zurich Privacy Policy*.

You may wish to seal it in an envelope and send it to:
Brighter Super, GPO Box 264, Brisbane QLD 4001

Personal Details

Brighter Super respects your privacy. All personal information collected is protected in line with Brighter Super's Privacy policy.

Member number	Title	Given name/s

Surname	Date of birth	Gender
	/ /	

Email[1]	Phone number

Residential address

Suburb/town	State	Postcode

Postal address (if different to above)	State	Postcode

[1] The email address you provide may be used to send information of a sensitive and personal nature.

1 The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into. To meet this duty, each person whose life is to be insured must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth. This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

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

This document has been prepared and issued by LGIAsuper Trustee (ABN 94 085 088 484 AFS Licence No. 230511) (Trustee) as trustee for LGIAsuper (ABN 23 053 121 564) (Fund), trading as Brighter Super. Brighter Super may refer to the Trustee or LGIAsuper as the context requires. Brighter Super products are issued by the Trustee on behalf of Brighter Super.

ZURICH
Zurich Australia Limited (Zurich)
ABN 92 000 010 195 AFSL 232510

About this application

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

We will ask questions we need to know the answers to. These will be about personal circumstances, such as health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance of each life to be insured. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the fund trustee passes on your personal information to us. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Guidance for answering our questions

You are responsible for the information provided to us. Each person answering our questions should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume we will ask others such as your doctor
- review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

Notifying the insurer

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

Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

If you need help

It's important that you and every person answering our questions understands this information and the questions we ask. Ask us or your adviser for help if you have difficulty answering our questions or understanding the application process. If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If a person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

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

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

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

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

2 Residence and travel information

1. Are you currently residing in Australia? ☐ Yes ☐ No
   If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian or New Zealand citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No
   If **yes**, please proceed to question 3
   If **no**, please advise what type of visa you hold

3. Do you have any intention of traveling outside Australia within the next two years? ☐ Yes ☐ No
   If **yes**, please complete the following:

   Date of departure: / / Duration of stay / /

   Destination(s) (country/cities):

   Purpose of stay:

   ☐ Holiday ☐ Business ☐ Residing ☐ Other

   If **other**, please provide a description below

3 Your insurance and claim history

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including Zurich (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

   If **yes**, please complete the below table:

Name of Company	Cover Type	Sum Insured	Date Commenced (dd/mm/yyyy)	Will this policy be discontinued or replaced? (Y or N)	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No

   If **yes**, please provide name of company, alteration, date and reason (if known)

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans' Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

   If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc

4 Occupation and income details

4. Please confirm (✓) your current employment status and complete employment details below:

☐ Casual ☐ Contract (more than 12 months) ☐ Self-employed ☐ Full-time employee ☐ Part-time employee

Hours worked ____________ per week Weeks worked _______ per year

5. Occupation name:

____

6. Qualifications

Do you hold any qualifications related to your current occupation? ☐ Yes ☐ No
If 'yes' provide details below

____

7. Industry:

____

8. Annual income before tax or insurable income if you are self employed:

$☐☐☐,☐☐☐ (Please refer to the relevant Insurance guide for the definition of salary)

9. Duties performed in current position:

Duties (e.g. office, manual, site supervision, selling etc.)	Location (e.g. office, on site, at home, driving etc.)	Percentage of time %

10. Do you have more than one occupation? ☐ Yes ☐ No
If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s)

____

5 Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang-gliding etc? ☐ Yes ☐ No
3. aviation/flying, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered yes to any of the questions above, please complete the relevant section below:

Motorcycle/motor racing

Do you have a Motorcycling Australia (MA), FIM international or similar licence? ☐ Yes ☐ No

Vehicle Type: ______________ Number of races p.a: ______________

Engine Size: ______________ Max Speed (km/h): ______________

Class: ☐ Recreational ☐ Amateur ☐ Professional

Scuba/skin diving

Average depth (m): __________ Maximum depth (m): ______________ Dives p.a ______________

Do you dive in caves or potholes? ☐ Yes ☐ No

Do you use explosives? ☐ Yes ☐ No

If **yes**, please give details

____

Football/Soccer/Aussie Rules, etc

Code played: ____

Number of games p.a: __________ ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income participating in football/soccer/Aussie Rules etc? ☐ Yes ☐ No

If **yes**, please provide amount and details:

____

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes**, state type and period held:

____

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

Please complete the table below:

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

6 Pastimes (cont)

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? ☐ Yes ☐ No

If yes, please provide frequency and details:

Other sports or pastimes

Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc):

Activity 1:

On what basis do you partake in this activity : ☐ Recreational ☐ Amateur ☐ Professional

Activity 2:

On what basis do you partake in this activity : ☐ Recreational ☐ Amateur ☐ Professional

Activity 3:

On what basis do you partake in this activity : ☐ Recreational ☐ Amateur ☐ Professional

7 Personal statement

1. What is your current weight and height?

   Height: __________ cm Weight: ____________ kg

2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No

   If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance or used any form of electronic cigarette? ☐ Yes ☐ No

   If **yes**, state type and daily quantity.

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc) or anti-smoking medication (e.g. Zyban, Chantix, etc)? ☐ Yes ☐ No

   If **yes**, please state type(s), used and length of time you have been using this.

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No

   If **yes**, please state type, quantity per day and date ceased.

6. Do you consume alcohol? ☐ Yes ☐ No

   If **yes**, please state how many standard drinks you consume per day[2]

7. Have you ever been advised to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No

   If **yes**, please provide full details.

[2.] A standard drink is 125 ml wine, 250 ml beer or 30 ml spirits

If you are required to a have a full medical examination, go to Section 10 on page 10.

8 Family history

Please complete this section for your blood relatives only (if adopted and family history unknown, please state so)

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder?

   ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)?

   ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table:

Relation	Name of condition	Age diagnosed

Please note: You are only required to disclose family history information pertaining to first degree blood-related family members – living or deceased (mother, father, brothers, sisters).

9 Medical history

To the best of your knowledge, have you ever had any of the following:

Please select the appropriate box and circle the specific conditions that are applicable

1. Asthma? ☐ Yes ☐ No
2. High blood pressure? ☐ Yes ☐ No
3. High cholesterol? ☐ Yes ☐ No
4. Diabetes? ☐ Yes ☐ No
5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No
6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No
7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No
8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered yes to any above conditions, please complete the relevant questionnaire in sections 13 to 20

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness, fainting of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No

9 Medical history (cont)

16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No
19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No
20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment)? ☐ Yes ☐ No
22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No
23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No
24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No
25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No
26. Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)? ☐ Yes ☐ No
27. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No
28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future (e.g. X-ray, ECG, blood test, etc)? ☐ Yes ☐ No
29. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No
30. Have you ever used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No
31. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No
32. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS/AIDS-related condition? ☐ Yes ☐ No
33. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No
34. Is the combined total of your existing insurance(s) detailed above, and any new insurance you are applying for with Zurich, more than any one of the following; $500,000 Death; $500,000 TPD; $4,000 per month in total of any combination of Income Protection? ☐ Yes ☐ No

If you answered Yes to question 34 please proceed to 35, otherwise continue to question 36 (Females only)

35. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (Please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you) ☐ Yes ☐ No

You only need to complete the below questions if you are female

36. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No
37. Are you now pregnant? ☐ Yes ☐ No
    If **yes**, please advise due date (dd/mm/yyyy) / /
38. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No
39. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

Please Note: If you answered yes to any questions from 9 to 39, please complete the following table(s).

Should we require further medical information from your health providers we will seek your consent by requesting you to complete the '*Zurich Consent for accessing health information*'.

Medical Questionnaire

	Question number:		Question number:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)				
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First	Last	First	Last
Has further treatment, referral or investigation(s) been recommended?				
Time off work				
Have you completely recovered?				
Date of last symptoms (dd/mm/yyyy)				
Name and address of medical facility and attending doctor				

Medical Questionnaire

	Question number:		Question number:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)				
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First	Last	First	Last
Has further treatment, referral or investigation(s) been recommended?				
Time off work				
Have you completely recovered?				
Date of last symptoms (dd/mm/yyyy)				
Name and address of medical facility and attending doctor				

Medical Questionnaire

	Question number:		Question number:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)				
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First	Last	First	Last
Has further treatment, referral or investigation(s) been recommended?				
Time off work				
Have you completely recovered?				
Date of last symptoms (dd/mm/yyyy)				
Name and address of medical facility and attending doctor				

Medical Questionnaire

	Question number:		Question number:	
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)				
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First	Last	First	Last
Has further treatment, referral or investigation(s) been recommended?				
Time off work				
Have you completely recovered?				
Date of last symptoms (dd/mm/yyyy)				
Name and address of medical facility and attending doctor				

10 Details for your usual doctor or medical centre

1. Full name and address of usual doctor/medical centre:

   Doctor/Medical centre: ______________________

   Medical centre address: ______________________

   Phone number: ______________________

2. How many years have you been attending this doctor/medical centre? ______________________

   When was your last visit to this doctor/medical centre? ______________________

   Reason for check-up or consultation? ______________________

   Outcome including medication, treatment etc ______________________

   Degree of recovery? __________

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? ☐ Yes ☐ No
   If **yes**, please provide details

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc

11 Declaration

By submitting this application for insurance, I acknowledge that:

- I have read and understood the questions in this Personal Statement.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
- I have read the Privacy Statement in Section 12 of this form. (Zurich's Privacy Policy details is available at zurich.com.au/important-information/privacy)
- I acknowledge and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statement on this form (see Section 12).
- I accept that where the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to Zurich in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the *Product Disclosure Statement(s) (PDS)* for the type(s) of cover for which I am applying.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by Zurich.

Signature	**Date signed**
	/ /

Please sign in blue or black pen - Brighter Super does not accept digital signatures on this form.

12 Privacy statement

In this section 'we', 'us' and 'our' refers to Zurich Australia Limited (Zurich). 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information (including health and other sensitive information) from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information (including health and other sensitive information). Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from zurich.com.au/important-information/privacy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information (including health and other sensitive information) to certain third parties as outlined below.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information (including health and other sensitive information) include:

- an organisation that assists us to detect and protect against consumer fraud;
- any related company of Zurich which will use the information for the same purposes as Zurich and will act under Zurich's Privacy Policy;
- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner (or parties acting on behalf of the policy owner);
- regulatory bodies, government agencies, law enforcement bodies and courts;
- our related companies (members of the Zurich Insurance Group Ltd group), including for carrying out any group business functions;
- organisations, including those in alliance with us or our related companies, to distribute, manage and administer our products and services, carry out business functions and analytics activities.
- We will also disclose your personal information (including health and other sensitive information) in circumstances where we are required by law to do so. Examples of such laws are:
- the *Family Law Act 1975 (Cth)* enables certain persons to request information about your interest in a superannuation fund;
- there are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

Zurich may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at zurich.com.au/important-information/privacy

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at zurich.com.au/important-information/privacy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

12 Privacy statement (cont)

Our Privacy Policy contains information about:

- when we may collect information from a third party;
- how you may access and seek correction of the personal information (including health and other sensitive information) we hold about you; and
- how you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing:
GPO Box 75, Sydney NSW 2001

Email:
privacy.officer@zurich.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667. More information can be found in our Privacy Policy at zurich.com.au/important-information/privacy

Overseas recipients

We may disclose your personal information (including health and other sensitive information) to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in our Privacy Policy at zurich.com.au/important-information/privacy.

13 Supplementary questionnaires - Asthma

Only complete this questionnaire if you answered yes to question 1 in Section 9:

1. When did you have your first episode of asthma? / /
2. When was your most recent episode of asthma? / /
3. Approximately how many episodes have occurred in the last 12 months? ______
4. Have you ever suffered from nocturnal asthma attacks? ☐ Yes ☐ No
   If **yes**, please provide the frequency of these attacks and approximate date of last attack
   ______
5. Have you had any time off work due to this condition? ☐ Yes ☐ No
   If **yes**, please provide the dates and duration
   ______
6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ☐ Yes ☐ No
   If **yes**, please provide details
   ______
7. Have you sought medical treatment or advice for asthma? ☐ Yes ☐ No
   If **yes**, please provide details:
   ______
   Name of doctor/health professional: ______
   Address: ______
   Date of last consultation (dd/mm/yyyy): / /
8. How has your doctor described your asthma?
   ☐ Mild ☐ Moderate ☐ Severe

9. Have you ever used any medication, including steroids? ☐ Yes ☐ No
If **yes**, please provide details below:

Type	Date Commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation

10. Have you ever been hospitalised due to asthma? ☐ Yes ☐ No
If **yes**, please provide details

Date from (dd/mm/yyyy) Date to (dd/mm/yyyy): / /

Name of hospital: ____________________

Address: ____________________

11. Have you ever had lung function tests performed? ☐ Yes ☐ No
If **yes**, please provide details below:

Date (dd/mm/yyyy)	Test results

14 Supplementary questionnaires - Blood pressure

Only complete this questionnaire if you answered yes to question 2 in Section 9:

1. When was your high blood pressure first diagnosed? / /
2. What was your blood pressure reading at that time? ____________________

Systolic ____________________ Diastolic ____________________

3. Have you ever been treated by medication? ☐ Yes ☐ No
If **yes**, please provide details below:

Type	Date Commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation

4. Did you undergo any tests or investigations? ☐ Yes ☐ No
If **yes**, please provide details below:

Tests performed	Date (dd/mm/yyyy)	Results

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No
If **yes**, please provide details:

Name of doctor/health professional: ____________________

Address: ____________________

Date of last consultation (dd/mm/yyyy): / /

6. What was the date of your last blood pressure check? / /

7. What was your blood pressure reading at that time?

   Systolic ____________ Diastolic ____________

8. How has your doctor described your blood pressure control?

   ☐ Excellent ☐ Good ☐ Poor ☐ Other

   If other, please provide details

   ____

9. What is the date of your next blood pressure check-up? / /

15 Supplementary questionnaires - Cholesterol

Only complete this questionnaire if you answered yes to question 3 in Section 9:

1. When was your high cholesterol first diagnosed? / /

2. What were your cholesterol readings at that time?

   Cholesterol ____________ Triglycerides ____________

   HDL Cholesterol ____________ LDL Cholesterol ____________

3. Did you undergo any tests or investigations? ☐ Yes ☐ No

   If yes, please provide details below:

Tests performed	Date (dd/mm/yyyy)	Results

4. Have you ever used any medication? ☐ Yes ☐ No

   If yes, please provide details below:

Type	Date Commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation

5. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ☐ Yes ☐ No

   If yes, please provide date of when treatment changed and the reason(s) for change

   ____

6. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

   If **yes**, please provide details:

   Name of doctor/health professional: ____________

   Address: ____________

   Date of last consultation (dd/mm/yyyy): / /

7. What was the date of your last cholesterol check? / /

8. What were your cholesterol readings at that time?

Cholesterol ____________ Triglycerides ____________

HDL Cholesterol ____________ LDL Cholesterol ____________

9. How has your doctor described your cholesterol control?

☐ Excellent ☐ Good ☐ Poor ☐ Other

If other, please provide details

10. What is the date of your next cholesterol check-up? / /

16 Supplementary questionnaires - Diabetes

Only complete this questionnaire if you answered yes to question 4 in Section 9:

1. What type of diabetes were you diagnosed with? ____________

2. When was your diabetes first diagnosed? / /

3. How is your diabetes controlled?

☐ Insulin (go to question 4) ☐ Diet only (go to question 5) ☐ Oral (list medications below & go to question 5)

4. How many times a day do you administer insulin?

☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

5. How often do you monitor your sugar levels?

☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details

Condition	Date (dd/mm/yyyy)	Treatment

7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details:

Date (dd/mm/yyyy)	Test results

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details:

Date (dd/mm/yyyy)	Test results

8. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details:

Name of doctor/health professional: ____________

Address: ____________

Date of last consultation (dd/mm/yyyy): / /

17 Supplementary questionnaires - Mental health

Only complete this questionnaire if you answered yes to question 5 in Section 9:

1. Please select the conditions you have had (or currently have), or received treatment for:

☐ Anxiety including generalised anxiety, panic or phobia disorder
☐ Eating disorder including anorexia nervosa or bulimia
☐ Depression including major depression or dysthymia
☐ Manic depressive illness or bipolar disorder
☐ Alcohol or other substance abuse or addiction
☐ Post traumatic stress
☐ Schizophrenia or any other psychotic disorder
☐ Stress, sleeplessness or chronic tiredness
☐ Other*

*If other, please describe

2. Please complete the table below for all described conditions:

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No
If **yes**, please provide details including dates

4. Are you currently symptom free? ☐ Yes ☐ No

5. Date of last symptoms: / /

6. Have you ever attempted suicide or self harm? ☐ Yes ☐ No
If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital

7. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No
If **yes**, please provide details

8. Have you had any time off work due to this condition? ☐ Yes ☐ No
If **yes**, please provide the dates and duration

9. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No
If **yes**, please provide details below:

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc)	Date Commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation

17 Supplementary questionnaires - Mental health (cont)

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No
    If **yes**, please provide details

    ____

11. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No
    If **yes**, please provide details:

    Name of doctor/health professional: ______________________________

    Address: ______________________________

    Date of last consultation (dd/mm/yyyy): / /

12. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No
    If **yes**, please provide details

    Name of doctor/health professional: ______________________________

    Address: ______________________________

    Date of last consultation (dd/mm/yyyy): / /

    Doctor(s) consulted: ______________________________

Additional Information (if needed):

18 Supplementary questionnaires - Back/Neck

Only complete this questionnaire if you answered yes to question 6 in Section 9:

1. When did your back/neck condition first occur? / /
2. Which area(s) of your back/neck was affected (e.g. middle back)?
3. What was the cause or reason for the condition?
4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc)
5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No
   If **yes**, please provide details below:

Tests	Date (dd/mm/yyyy)	Results

6. Have you had recurrent or multiple episodes of the back/neck condition? ☐ Yes ☐ No
   If yes, please provide details including the number of episodes and the date of the most recent episode including duration
7. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor or health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)

8. Have you had any time off work due to this condition ☐ Yes ☐ No
   If **yes**, please provide the dates and duration
9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No
   If **yes**, please provide details below:
10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No
    If **yes**, please provide details below:
11. Overall do you feel that your condition is:
    ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating
12. What was the date of your last symptoms? / /

19 Supplementary questionnaires - Arthritis/Joint

Only complete this questionnaire if you answered yes to question 7 in Section 9:

1. Which joint is/was affected (please select relevant box/es)? If more than one box is selected, please copy this questionnaire and complete for each condition?

	Left	Right		Left	Right
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other*	☐	☐
Knee	☐	☐			

*If other, state which joint ______________________________

2. When did this condition first occur? / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known

5. Have you had recurrent or multiple episodes of the condition? ☐ Yes ☐ No
   If yes, please provide details including the number of episodes and the date of the most recent episode including duration

6. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor or health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)

7. Have you had any time off work due to this condition? ☐ Yes ☐ No
   If **yes**, please provide the dates and duration

8. Do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No
   If **yes**, please provide details below:

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No
   If **yes**, please provide details below:

10. Are you still undergoing treatment? ☐ Yes ☐ No
    If **yes**, please provide details below:

11. Overall do you feel that your condition is:
    ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? / /

20 Supplementary questionnaires - Cyst/Mole/Lesions

Only complete this questionnaire if you answered yes to question 8 in Section 9:

1. Please provide details in the table below:

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, Melanoma, Cyst, Mole)	Pathology results (e.g. malignant, benign, unknown)

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No
   If **yes**, please provide details for each:

   Date: / / By what method (e.g. surgically, frozen or burnt off)?

   If **no**, please provide details including date set for removal, if applicable:

3. Have you been or are you required to attend any further treatment or regular follow-up since the original removal? ☐ Yes ☐ No
   If **yes**, please provide details and advise how often follow-up is required

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No
   If **yes**, please provide details

Tests/Treatments/Investigations	Date (dd/mm/yyyy)	Results

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No
   If **yes**, please provide details:

   Name of doctor/health professional: ________

   Address: ________

   Date of last consultation (dd/mm/yyyy): / /

21 Additional Information

Complete this section if there is additional information you wish to provide the Insurer to support your application: