Personal Statement

CommInsure

Section A – Your details

Member number | Surname | Given name(s)

Name of superannuation fund | Employer

Salary or remuneration earned in the last 12 months | Occupation | Date of birth (DD/MM/YYYY)

1. What is your: **Height** cm **or** ft/in **Weight** kg **or** st/lb

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

No ☐ Yes ☐ ▸ If **'yes'**, please indicate what you smoke

What is your average? per day | per week **or** per year

3. Do you drink alcohol? No ☐ Yes ☐ ▸ If **'yes'**, please provide the average number of standard drinks consumed:

per day | per week **or** per year

Section B – Personal statement

1. Do you engage in any hazardous pastimes or pursuits such as, but not limited to, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than a fare paying passenger), scuba diving or any sport(s) in a professional capacity?	No ☐ Yes ☐	A
2. Have you: **a)** Recently applied for or do you have a policy for life, total and permanent disability, trauma or salary continuance (excluding this application)? **b)** Ever had an application for life, disability, trauma, accident or sickness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms? **c)** Ever claimed a lump sum or accident or sickness benefit from any insurance policy, including but not limited to superannuation, workers' compensation, disability pension or Veterans Affairs?	 No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐	 B B B
3. Have you ever experienced symptoms, received medical advice, been treated for or diagnosed with any back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, or an injury, complaint or disorder of any joint, bones or muscle, including arthritis, gout or repetitive strain injury (RSI)?	No ☐ Yes ☐	C
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental illness, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, attention deficit disorder or aspergers syndrome, myalgia or fibromyalgia or Chronic Fatigue Syndrome?	No ☐ Yes ☐	D
5. Have you received medical advice, undergone any treatment, investigation or operation for, or had: **a)** High blood pressure or raised cholesterol? **b)** Cyst, mole, sunspots, skin lesions, skin cancer or melanoma? **c)** Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint requiring hospitalisation? **d)** Chest pain, heart complaint, cardiomyopathy, stroke, neurological disorder, multiple sclerosis, muscular dystrophy or blood disorder? **e)** Cancer, leukaemia, diabetes or chronic kidney complaint?	 No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐	 E F G G G
6. Have you: **a)** Taken any illegal or non prescribed drugs (other than over the counter medications) in the last 10 years? **b)** Ever been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse? **c)** Ever been infected with or tested positive for HIV/AIDS, Hepatitis B and/or C or are you awaiting the results of such a test? **d)** In the last five years, ever engaged in unprotected anal intercourse (except in a relationship between you and one other person only where that person is not known or suspected to be HIV positive and/or injects non-prescribed drugs) or worked as or engaged the services of a prostitute?	 No ☐ Yes* ☐ No ☐ Yes* ☐ No ☐ Yes* ☐ No ☐ Yes* ☐	
7. Apart from anything already stated: **a)** Are you considering seeking medical advice, treatment, tests or surgery in the future? **b)** Have you, in the last five years, received any medical advice, any medical treatment, investigation or had any operation not mentioned above (apart from colds, flu, contraceptive advice)?	 No ☐ Yes ☐ No ☐ Yes ☐	 G G
8. To the best of your knowledge, have any of your natural parents, brothers or sisters suffered from or been diagnosed with: **a)** Heart or circulatory problems, stroke, high blood pressure, diabetes? **b)** Depression or any other mental illness? **c)** Cancer of any type? **d)** Huntington's disease, muscular dystrophy, multiple sclerosis, polycystic kidney disease or any other hereditary disease?	 No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐	 H H H H

Have you answered 'yes' to any questions (1 to 5) or (7 and 8) in Section B?

No ☐ ▸ **Go straight to Section E on page 8. Do not complete Section C or D.**

Yes ☐ ▸ **For each 'yes' answer you must complete a corresponding questionnaire, as noted in the column beside your 'yes' answer above. Proceed to relevant questionnaire in Section C.**

*If you have answered `yes' to question 6, a confidential questionnaire will be sent to you.

Section C – Questionnaire A – Pastimes questionnaire

Only complete if you answered **'yes'** to **question 1** of **Section B – Personal statement**

1. Do you engage in any of the following hazardous pastimes or pursuits?	
a) Flying? (other than as a fare paying passenger on a commercial airline)	No ☐ Yes ☐
b) Underwater diving (scuba)	
If **'yes'** (i) do you dive more than 40 metres in depth?	No ☐ Yes ☐
(ii) do you dive alone?	No ☐ Yes ☐
c) Football of any code (other than touch or Oztag)	No ☐ Yes ☐
d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing	No ☐ Yes ☐
e) Trail bike or quad bike riding (including off road and dirt bike)	No ☐ Yes ☐
f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports, horse riding or recreations involving heights?	No ☐ Yes ☐

If you have answered 'yes' to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

At what level do you participate? (**tick (✔) the appropriate box)**

Recreational only (non competition) ☐

Recreational with competition ☐

Semi-professional/professional ☐

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)?

No ☐ Yes ☐

Questionnaire B – Insurance history questionnaire

Only complete if you answered **'yes'** to any part of **question 2** of **Section B – Personal statement**

1. Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance on your life with CommInsure, or any other insurance company? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	Type of cover	Insurance benefit	To be replaced?	Date commenced
		$	No ☐ Yes ☐	DD/MM/YYYY
		$	No ☐ Yes ☐	DD/MM/YYYY
		$	No ☐ Yes ☐	DD/MM/YYYY

2. Has an application for life, total and permanent disability, trauma, or salary continuance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

3. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, from any superannuation fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits? No ☐ Yes ☐

If **'yes'**, please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
	DD/MM/YYYY	$	DD/MM/YYYY
	DD/MM/YYYY	$	DD/MM/YYYY
	DD/MM/YYYY	$	DD/MM/YYYY

Questionnaire C – Joint/musculoskeletal questionnaire

Only complete if you answered **'yes'** to **question 3** of **Section B – Personal statement**

1. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

5. Was an x-ray or scan taken?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Date of most recent test DD/MM/YYYY

Details of results of tests taken:

6. Is the nature of the condition degenerative or a disc problem?

No ☐ Yes ☐

7. Are you still undergoing treatment or experiencing symptoms?

No ☐ ▸ If **'no'**, please complete the details below:

Yes ☐

Date symptoms ceased DD/MM/YYYY

Date treatment ceased DD/MM/YYYY

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire D – Mental health questionnaire

Only complete if you answered **'yes'** to **question 4** of **Section B – Personal statement**

1. Please provide details of the condition (doctor's diagnosis):

2. Please indicate the reason or cause by ticking the appropriate box(es):

Bereavement/family illness ☐

Marital problems ☐

Post natal ☐

Work related ☐

Other (please specify) ☐

3. Date symptoms first commenced:

DD/MM/YYYY

4. Have the symptoms ceased?

No ☐ Yes ☐ ▸ If **'yes'**, please provide the date symptoms ceased:

DD/MM/YYYY

5. Have you taken or are you taking medication?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)
		DD/MM/YYYY
		DD/MM/YYYY
		DD/MM/YYYY

6. Have you attempted suicide or had suicidal thoughts?

No ☐ Yes ☐

7. Have you ever been hospitalised?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire E – High blood pressure/ Raised cholesterol questionnaire

Only complete if you answered **'yes'** to **question 5a** of **Section B – Personal statement**

1. Name of condition
High blood pressure ☐ Raised cholesterol ☐

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain?
No ☐ Yes ☐ If **'yes'**, please provide details:

4. Are you taking regular medication for this condition?
No ☐
Yes ☐ If **'yes'**, please provide details, including dosage:

5. Blood pressure

When was your last blood pressure reading?
DD/MM/YYYY

Was it considered to be well controlled, e.g. less than 140/90?
No ☐ Yes ☐
Don't know ☐

Cholesterol

When was your last cholesterol reading?
DD/MM/YYYY

What was the result of your last cholesterol reading?
2.0 to 6.5 mmol ☐
6.6 to 7.5 mmol ☐
7.6 or above ☐
Don't know ☐

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire F – Cysts, moles, sunspots or skin lesion questionnaire

Only complete if you answered **'yes'** to **question 5b** of **Section B – Personal statement**

1. Please provide type:
Cyst ☐ Mole ☐ Sunspot ☐ Skin lesion ☐
Melanoma ☐ Basal cell carcinoma ☐
Other ☐ please specify:

2. Location of growth(s)
Face/head ☐ Back/shoulder ☐ Chest/front ☐
Arm/leg ☐

3. When was this?

4. Was/were the growth(s) removed?
No ☐ Yes ☐ If **'yes'**, please complete below:
When was it removed?
DD/MM/YYYY
How many growths were removed?
Method of removal:
Frozen/burnt off ☐ Surgical/cut out ☐

5. Was/were the growth(s) reported as cancerous (malignant)?
No ☐ Yes ☐ If **'yes'**, were any further tests, investigations, treatments, follow up or re-excision required?
No ☐ Yes ☐ If **'yes'**, please provide dates and details of further tests, investigations, treatments, follow up or re-excision:

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Only complete if you answered **'yes'** to any part of **question 5 C, D & E and/or 7** of **Section B – Personal statement**

1. When did you last consult a doctor?

Within the last month ☐ 1 to 3 months ago ☐ 3 to 6 months ago ☐

6 to 12 months ago ☐ 12 months to 2 years ago ☐ Over 2 years ago ☐

a) What was the reason for this consultation?

b) What was the result/outcome from your last consultation? **(tick (✔) the appropriate box)**

Referral to specialist/health professional ☐ Tests conducted – results pending ☐

Ongoing treatment e.g. Ventolin inhaler ☐ Routine tests conducted – results all clear/normal ☐

All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication) ☐ Not fully recovered yet ☐

c) Was the doctor/medical centre consulted, your usual doctor/medical centre?

No ☐ Yes ☐

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

2. This question is for females only, otherwise please continue to question 3.

a) Are you currently pregnant?

No ☐ Yes ☐ ▸ If **'yes'**, what is the due date for your baby? DD/MM/YYYY

b) Will you be returning to work in the same capacity as your current occupation, e.g. back to the same or greater hours within or at the end of your 12 month maternity leave

No ☐ Yes ☐

c) Have you ever had any complications with pregnancy or childbirth? (e.g. diabetes, ectopic pregnancy, pre-eclampsia & excluding elective caesarian or miscarriage in the first 15 weeks)

No ☐ Yes ☐ ▸ If **'yes'**, please provide details and dates below

d) Have you ever had an abnormal result for any of the following tests?

i) Pap smear No ☐ Yes ☐

ii) Breast ultrasound No ☐ Yes ☐

iii) Mammogram No ☐ Yes ☐

If **'yes'**, please provide details and dates below

e) Have you ever had a breast lump or breast cyst or any other type of breast abnormality (even if you have not consulted a doctor)?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details including dates and results of treatments.

f) Have you ever sought treatment for any condition of the ovary, uterus, endometrium or perineum?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details including dates and results of treatments.

▸ Please continue to question 3 overpage...

Questionnaire G – Personal and medical details questionnaire (continued)

3. Have you ever had, or sought advice or treatment, experienced symptoms or suffered from any of the following:

a)	Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint requiring hospitalisation?	No ☐ Yes ☐
b)	Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever	No ☐ Yes ☐
c)	Stroke, paralysis, neurological disorder, multiple sclerosis , muscular dystrophy or blood vessel disorder	No ☐ Yes ☐
d)	Alzheimer's, Parkinson's dementia or any other disorder of the brain	No ☐ Yes ☐
e)	Cancer, tumour or melanoma	No ☐ Yes ☐
f)	Thyroid, glandular, pituitary or pancreatic disorder	No ☐ Yes ☐
g)	Gastric or duodenal ulcer, persistent indigestion, gastro oesophageal reflux disease, Barrett's oesophagitis irritable bowel or other bowel disorder (eg: polyps, ulcerative colitis and Crohn's disease)	No ☐ Yes ☐
h)	Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar	No ☐ Yes ☐
i)	Any disorder of the gall bladder or liver, including hepatitis B, C or fatty liver/raised liver function	No ☐ Yes ☐
j)	Varicose veins, haemorrhoids or hernia	No ☐ Yes ☐
k)	Disorder of the kidney, bladder or prostate (including raised PSA), blood in urine or kidney stones	No ☐ Yes ☐
l)	Epilepsy, fits of any kind, fainting episodes, dizziness or vertigo or recurring headaches or migraines	No ☐ Yes ☐
m)	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder including insomnia	No ☐ Yes ☐
n)	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome	No ☐ Yes ☐
o)	Eczema, dermatitis, psoriasis or any other skin disorder, embolism, thrombosis (DVT) or Factor V Leiden	No ☐ Yes ☐
p)	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder, embolism, thrombosis (DVT) or Factor V Leiden	No ☐ Yes ☐
q)	Any impairment of sight (other than corrected by glasses or lenses) or blurred vision	No ☐ Yes ☐
r)	Any impairment of hearing (including tinnitus, deafness, high frequency hearing loss) or speech	No ☐ Yes ☐
s)	Any sexually transmitted diseases	No ☐ Yes ☐
t)	Any other illness, injury, disease or disorder not mentioned above	No ☐ Yes ☐
u)	Other than those conditions mentioned above, are you taking any regular prescribed medication	No ☐ Yes ☐
v)	Have you undergone screening for diseases or conditions such as, but not limited to, bowel cancer or have you had a genetic test?	No ☐ Yes ☐
w)	Within the last three years, have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results, a genetic test or an ultrasound (other than for pregnancy)?	No ☐ Yes ☐
x)	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No ☐ Yes ☐

If you have answered **'yes'** to any **of the above questions**, please provide full details of each **'yes'** answer in **Section D – General health questionnaire on page 7.**

Questionnaire H – Family history questionnaire

Only complete if you answered **'yes'** to any part **question 8** of **Section B – Personal statement**

1. Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

2. Have you had or do you intend on having a genetic test?

No ☐ Yes ☐

3. What was the result of the genetic test? (please mark the appropriate box)?

Have not been tested yet ☐ Positive (I have the gene) ☐ Negative (I do not have the gene) ☐ Unsure ☐

Section D – General health questionnaire

If you have answered **'yes'** to any part of **question 3 a to x** in **questionnaire G**, please complete the table below:

Details for question number:	Question ( )	Question ( )	Question ( )
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started?	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
3. Date symptoms ceased (if applicable)?	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
4. Are these symptoms singular, recurrent or ongoing?			
5. How often do/did you have symptoms? Please choose one of the following: **daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).**			
6. Severity of symptoms? Please choose one of the following: **mild, moderate, severe, never had symptoms, symptoms ceased.**			
7. Did you take medication or have any other treatment for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'** please give details of the medication/treatment.			
8. Are you still on treatment, including medication?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
9. Have you ever been off work as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please indicate the total time off work.			
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
11. Have you ever had an x-ray, scan or blood test for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
12. Is your treating doctor different from your usual doctor?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please provide the doctor's name and contact details.			

Section E – Duty of disclosure

Your duty of disclosure

Before you enter into a contract of life insurance with an insurer you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your insurance.

Your duty, however, doesn't require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer wouldn't have issued the cover if the failure had not occurred, the insurer may avoid the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may avoid the cover at any time.

An insurer who is entitled to avoid cover may elect not to avoid it, but apply either of the following options:

- reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer
- vary the cover in such a way as to place the insurer in the position it would have been in had the failure to comply with the duty of disclosure not occurred.

If your cover is death cover, the insurer may only apply the first of the two options and it must do so within three years of issuing the cover.

Section F – Privacy of your personal information

Personal information we collect about you can include information such as your identity, contact details, gender, marital status, medical, life style and financial information. We collect information directly from you and from others such as, trustees, employers, service providers, family members or anyone that holds information relevant to your application or claim. We may be required by law to identify you or people who act on your behalf and we may verify the information provided. When we do so we may disclose your personal information. This collection and verification helps us to protect against fraud and other illegal activities. It's important you provide us with accurate and complete information. If you don't, we may not be able to provide you with the product or service that you are seeking such as processing your application or claim.

We collect, use and exchange your information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services
- administer our products and services, including managing your application, cover and claims
- manage our relationship with you and to contact you, including by electronic means
- manage our risks (including by reinsurance) and help identify and investigate illegal activity, such as fraud
- conduct and improve our businesses and improve the customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you.

We may also collect, use and exchange your information in other ways permitted by law.

We may exchange your information with other members of the Commonwealth Bank group (CBA), so that the group may adopt an integrated approach to its customers. CBA members may use this information in the same way we use your information. We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information. Third parties include:

- trustees of superannuation funds and their administrators, your employer and former employers
- brokers, agents, advisers, attorneys and persons acting on your behalf
- medical and healthcare practitioners, claims-related providers such as assessors and investigators, insurance reference agencies, reinsurers, auditors and other insurers
- organisations to whom we may outsource certain functions e.g. IT
- any one that we reasonably believe may hold information relevant to your application, cover or claim.

Where we exchange your personal information with our service providers or agents confidentiality arrangements apply and they can use this personal information in the same way as we do. We may be required to disclose information by law, e.g. under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to illegal activities, fraud, sanctions, anti-money laundering or counter terrorism financing.

We may send your information overseas. Overseas parties can include CBA companies or other parties who operate or hold data outside Australia. Where we send it to these parties, we make sure that appropriate data handling and security arrangements are in place. Information may be sent overseas to complete assessment or to manage your application or claim (such as when we are required to send information under reinsurance arrangements) or where this is required by law and regulation of Australia or another country. As well as reinsurers, overseas parties can include medical or rehabilitation practitioners or other parties. Australian law may not apply to some of these overseas parties. Information about what countries your information may be sent to by us is included in our Privacy Policy.

The law generally allows you to access your personal information and to have any inaccurate information corrected. Our information handling practices, information on how to make a complaint and how we deal with your complaint is described in our Privacy Policy which is available at **www.commbank.com.au** or upon request at any CBA branch.

These sections must be completed in all circumstances

Section G – Doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Section H – Declaration

I have read the duty of disclosure in this Personal statement and I am aware of the consequences of non-disclosure.

I understand that the duty of disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers).
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me.
- any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical reports.

I agree to provide further medical authorities if requested.

I declare that:

- the answers to all the questions and the declarations in this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance
- I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.
- I have read and understood the "Privacy of your personal information" in Section F. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.
- I have read and understand the obligations outlined in the "Duty of disclosure" in Section E.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Full name

Signature of life to be insured

X

Date of signature

DD/MM/YYYY

Please ensure that you initial any amendments or changes made throughout this form