Perpetual Select Super Plan
Product Disclosure Statement issue number 12 dated 1 March 2025
Insurance in your super dated 1 March 2025
Equity Trustees Superannuation Limited ABN 50 055 641 757 AFSL 229757 RSE L0001458

Insurance application

Please complete all pages of this form in black ink, using BLOCK letters.

This form should be used if you:

- are aged 55 or older, or
- require more than $1 million of death only cover, or
- require more than $1 million of TPD only cover, or
- require more than $1 million death and total permanent disablement cover, or
- earn over $128,000 per annum and therefore require more than $8,000 monthly benefit of salary continuance cover, or
- require agreed value salary continuance cover, or
- have answered 'yes' to any of the questions in the 'Insurance cover' section of the Super Plan application form.

Are you an existing Super Plan member?

yes ☐ account number

1. Member details

title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ other

first name(s)

last name

date of birth / / current age gender ☐ male ☐ female

unit number street number

street name

suburb (if relevant) OR city

state postcode

country

email address

phone (business hours) phone (after hours)

occupation

industry

daily duties (including % time spent performing each duty)

2. Type of insurance

Type of insurance (for an increase in cover, the amount nominated will be added to any existing cover)

Type(s) of cover			New		Increase	
death only or	☐	amount	$	(min. $50,000)	$	
TPD only or	☐	amount	$	(min. $50,000)	$	
death and TPD	☐	death amount	$	(min. $50,000)	$	
		TPD amount	$	(min. $50,000)	$	
and/or salary continuance	☐	amount	$	per month (min. $500 per month)	$	per month

(The amount of salary continuance cover cannot be greater than 85% of your monthly income, which includes a maximum 10% allowance for super contributions. That is your cover amount cannot be greater than 75% of your monthly income plus an optional 10% of your monthly income representing a super contribution component. For example if you have a monthly salary of $4,000 the maximum monthly cover amount you can have is 75% x $4,000 plus 10% x $4,000.)

What percentage of your cover amount indicated above represents a super contribution component? ☐ (This is optional and is a maximum of 10% of your monthly income.)

If this is left blank nil will be assumed.

Please apply indexing to my sum insured:

yes (default) ☐ no ☐

Salary continuance only

benefit period	2 years (to age 65 if earlier) ☐		5 years (to age 65 if earlier) ☐	to age 65 ☐	
waiting period	30 days ☐		60 days ☐	90 days ☐	
type of cover	agreed value* ☐		indemnity ☐		

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

If you are self employed

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

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

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

Please pay my insurance fees

☐ from my investment option with the highest balance (default) - including where the balance in a nominated investment option is insufficient to pay an insurance fee

☐ proportionally across my investment options

☐ from my _____ investment option

3. Personal statement – Part 1

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

1. Are you:

(a) an Australian citizen or holder of an Australian permanent resident visa? no yes

(b) a New Zealand citizen holding a current special category visa who is residing in Australia indefinitely? no yes

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

If yes, please state forms and quantities:

3. Do you drink alcohol? no yes

If yes, state how many standard drinks you consume per week:
(One standard drink = 30 ml spirits (one nip), 100 ml wine, 10 oz/285 ml beer)

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

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

Commencement date	Insurer	Type of cover	Amount of cover	To be replaced
				no yes
				no yes

At the date of application:

5. Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full time basis due to injury or illness (even if you are not currently working on a full time basis or are unemployed)? no yes
6. In the last three (3) years, have you had any advice or treatment, taken prescribed drugs or been hospitalised for any injury or illness (excluding for colds or flus)? no yes
7. Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? no yes
8. Are you under any treatment by diet, medication, prescribed drugs or other therapy? no yes
9. Has any company ever refused or applied special or modified conditions or cancelled any application to insure you for a life or disability policy? no yes
10. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? no yes

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

11. Do you have definite plans to travel or reside overseas? no yes

If 'yes', please state:

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure

Family history

12. (a) Have any of your immediate family (father, mother, brother, sister), prior to the age of 60 (living or dead), ever suffered from:
    - Heart disease or stroke? no yes

- Breast cancer, ovarian cancer, prostate cancer or colon (bowel) cancer? no yes
- Polycystic kidney disease or diabetes? no yes
- Mental disorder? no yes
- Huntington's chorea, Alzheimer's disease, Dementia, Motor neurone disease, Multiple sclerosis, Muscular dystrophy or Parkinson's disease? no yes
- Any other hereditary disease? no yes

If 'yes', please provide details in the table below:

	Condition/illness (for heart disease or cancer please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

(b) Are you required to undergo any regular screening as a result of your family history? no yes

If 'yes', please provide details.

3. Personal statement – Part 2

Section A: Medical details

1. Have you ever experienced any symptoms of or received treatment:
   - (a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke? no yes
   - (b) Asthma, chronic lung disease, sleep apnoea or other respiratory disorder? no yes
   - (c) Indigestion, gastric or duodenal ulcer, hernia/s or any bowel disorder? no yes
   - (d) Diabetes, abnormal blood sugar, gout or thyroid disorder? no yes
   - (e) Depression, anxiety/stress state, fatigue, panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder? no yes
   - (f) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness, tremor or recurrent headaches or any neurological disorder including multiple sclerosis? no yes
   - (g) Arthritis, repetitive strain injury (RSI), chronic fatigue syndrome, fibromyalgia? no yes
   - (h) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles? no yes
   - (i) Psoriasis or eczema, skin disorder or abnormality with hearing, eyesight or speech? no yes
   - (j) Cancer, cyst, lump, tumour or growth of any kind? no yes
   - (k) Liver, pancreas, prostate, kidney or bladder disorder, renal colic or stone? no yes
   - (l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia? no yes
   - (m) Hepatitis B or C or are a Hepatitis B or C carrier. Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus? no yes

3. Personal statement – Part 2 (continued)

Females only

Have you ever experienced any symptoms of or been advised to have treatment for:

(n) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? no ☐ yes ☐

(o) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries? no ☐ yes ☐

(p) Abnormal vaginal bleeding within the last 12 months or endometriosis? no ☐ yes ☐

(q) Are you currently pregnant?

If yes, please state expected delivery date ☐☐ / ☐☐ / ☐☐☐☐ no ☐ yes ☐

2. Have you ever experienced symptoms of or had any other illness, disease or disorder? no ☐ yes ☐

3. In the last 5 years have you:

(a) Had any medical examinations, consultations, X-rays, pathology tests or procedures? no ☐ yes ☐

(b) Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? no ☐ yes ☐

4. Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? no ☐ yes ☐

5. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? no ☐ yes ☐

(Only if you are applying for TPD or salary continuance cover)

(a) Have you ever been involved in an accident that has caused you to be off work or reduce your working capacity for greater than 10 consecutive days? no ☐ yes ☐

(b) Have you consulted a chiropractor, osteopath, physiotherapist or acupuncturist? no ☐ yes ☐

Lifestyle statement

6. (a) Have you ever used any illicit drugs not prescribed by a medical practitioner? no ☐ yes ☐

If 'yes', a 'Drugs Questionnaire' is required.

(b) In the last 5 years, have you been diagnosed with or experienced symptoms of Sexually Transmitted Infections (STIs) (examples include chlamydia, gonorrhoea, syphilis)? no ☐ yes ☐

If 'yes', a 'Confidential Supplementary Personal Statement' is required.

If you answered YES to ANY of the questions in Section A, please complete Section B. Otherwise, go to Sections C and D.

Section B: Answers in detail

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

question reference		time off work		date of illness/injury		degree of % recovery	

illness, injury or tests

results of tests

reason and type of treatment including date of last symptoms

full name and address of doctor or hospital (if any)

3. Personal statement – Part 2 (continued)

Section C: Doctor's details

name of doctor

address

suburb (if relevant) OR city

state postcode

telephone

date of last consultation

/ /

how long have you been a patient?

name of doctor

address

suburb (if relevant) OR city

state postcode

telephone

date of last consultation

/ /

how long have you been a patient?

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

1. (a) Please state your monthly salary from your current occupation (if self-employed, net of business expenses but before tax). Include income from personal exertion only. (Do not include non-personal exertion income such as dividends, interest, rental income or royalties).

   Principal occupation — Current year — per month

   Previous year — per month

   (b) How long have you been at your current occupation? — years — months

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

   (i) For how long? — years/months

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

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

   If yes

   (a) How much? — per month

   (b) For how long? — years/months

   (c) State source of income

3. Do you also perform another occupation? no ☐ yes ☐

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

3. Personal statement – Part 2 (continued)

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

   If yes, how much? ☐ per month

5. What was your previous occupation? ☐

6. Are you self-employed? (sole trader, business partner, employee of own company/trust) no ☐ yes ☐

   If yes

   (a) Date your business started ☐☐ / ☐☐ / ☐☐☐☐

   (b) How long have you been self-employed? ☐ years/months

   (c) What percentage of your work is: (i) Freelance? ☐ % (ii) Contract? ☐ %

   (d) If self-employed, did your business make a loss in the last financial year? no ☐ yes ☐

   If yes, please provide copies of Profit and Loss Statements for the last two (2) years.

   (e) How many people do you employ? ☐

7. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? no ☐ yes ☐

   If yes, when ☐☐ / ☐☐ / ☐☐☐☐

   Date of discharge ☐☐ / ☐☐ / ☐☐☐☐

8. Do you work at home? no ☐ yes ☐

   If yes, state percentage of the time ☐ %

9. Do you earn commission or bonuses? no ☐ yes ☐

   If yes, state percentage of total income ☐ %

4. General declaration

- **Truth and Accuracy** – I hereby declare that to the best of my knowledge and belief and where applicable:
  - all of the answers to questions on this application form are true and accurate and I have not deliberately withheld any information material to the proposed insurance
  - if I am transferring my existing insurance cover from another provider and this information is being provided directly to the insurer, this information is true and accurate at the time of transfer and I have not deliberately withheld any information material to the insurance cover that is being transferred and
  - all information I have provided to the insurer directly is true and accurate and I have not deliberately withheld any information material to the proposed insurance cover.
- **Changes to Contract** – I understand that I must advise the trustee and insurer of any material change in my health during the period between the application date shown below and the cover commencement date. I understand that my failure to advise of such a change may make the contract of insurance voidable by the insurer.
- **Acceptance of the application** – I note that this application is subject to acceptance by the insurer and that the insurance cover does not commence until I have been advised by the trustee about acceptance of my application and (where applicable) I have provided written acceptance of any special acceptance terms.
- **Duty to take reasonable care** – I acknowledge that I have read and understood the 'Duty to take reasonable care' in accordance with the Insurance Contracts Act 1984, as detailed in the 'Insurance in your super' document.
  Warning: You have a duty to disclose all information relevant to the insurer's decision to accept your application.
- **Privacy Statement** – I have read and understood the Privacy disclosure as detailed in the separate 'Your Super Plan account' document. I consent to my personal information being collected and used and disclosed in accordance with the privacy disclosure.
- **Consent to provide personal health information to my financial adviser** – I consent to allow the Trustee to provide my financial adviser with any personal health information to assist the trustee and insurer in assessing my application for insurance.

☐ I do not authorise my financial adviser to be provided with any personal health information submitted in relation to my application for insurance.

Election to maintain cover (optional)

☐ I wish to opt-in to maintain my insurance cover in the event that my account becomes inactive for a continuous period of 16 months (where my insurance cover would otherwise be required to be cancelled). I understand and acknowledge that the ongoing insurance fees being charged to my account will likely reduce my account balance.

signature _____ date ☐☐/☐☐/☐☐☐☐

5. Authority to release medical information

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

Consent to Disclose – I consent to AIA Australia and to the Trustee on behalf of AIA Australia, to collect and use my health information to assess my application for cover, to assess and manage my claim, or to confirm the information I gave when I applied for cover or made a claim. AIA Australia will respect your privacy by only asking for the information AIA Australia reasonably need, and will tell you each time your consent is used.

Even if AIA Australia collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell AIA Australia every matter (including about your health) that is relevant to AIA Australia decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

Authority 1

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **AIA Australia**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **AIA Australia** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

name

signature

date / /

Authority 2

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks;
  or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.
If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **AIA Australia**, or to third parties they engage, only if **AIA Australia** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

name

signature

date / /

☐ I authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my health and medical history.

6. Financial adviser use only

Financial adviser details

financial adviser name

phone

mobile

fax

postal address

email

AFSL licensee name

AFSL number

adviser number

or dealer group

dealer branch

financial adviser signature

date / /

IL GN / / (Group)

IL AN / / (Adviser)

IL CN / / (Client)

ADVISER STAMP