Application Form
(alteration, increase, continuation option and transfer only)

OneCare

March 2023

Zurich Australia Limited (Zurich, OnePath)
ABN 92 000 010 195 AFSL 232510
OnePath Custodians Pty Limited (OnePath Custodians)
ABN 12 008 508 496 AFSL 238346 RSE L0000673
Retirement Portfolio Service (the Fund)
ABN 61 808 189 263 RSE R1000986

Customer Care
Phone 133 667
Email client.onepath@zurich.com.au
Website onepath.com.au

Risk Adviser Services
For use by advisers only
Phone 1800 222 066
Email adviser.onepath@zurich.com.au

Before you sign this Application Form, be aware that OnePath, OnePath Custodians or your adviser will provide you with a Product Disclosure Statement (PDS) containing important information about the product(s) you are applying for. This information will help you to understand the product(s) and it is appropriate for your needs.

Duty to take reasonable care not to make a misrepresentation

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.

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.

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
- 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).

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you and each person who answered our questions would now answer differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please contact 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.

Residency status

In most cases, the life insured must be either an Australian citizen, New Zealand citizen or permanent resident of Australia and currently residing in Australia in order to qualify for cover with OnePath. Your financial adviser will confirm if you qualify.

Cover details

☐ Tick this box to confirm that a **signed copy** of the quote has been attached to this Application Form. **It forms part of the Application Form and your application cannot be assessed without it.**

Application details – adviser to complete

Please note a separate Application Form must be completed for each life insured.
Please tick the boxes relating to the policy(ies) being applied for and/or amended:

Modified underwriting/Transfer ☐

Existing OnePath policy

☐ Increase to OneCare policy
☐ Addition of new cover to OneCare policy
☐ Replace OnePath policy
☐ Alteration to OneCare policy

Existing policy number

☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐

☐ Continuation Option

Name of fund and policy number

Exit date (dd/mm/yyyy) / /

Packaging

Please tick the boxes that apply:

☐ Packaging discount
☐ Business Debt Protector (Increases only)

Existing policy/group number

☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐

or

List other lives and include dates of birth

If a packaging discount is being applied for, what is the relationship between the lives eligible for this discount?

☐ Family members ☐ Business partners ☐ Extended business

Purpose of cover:

☐ Personal ☐ Key person ☐ Buy/Sell agreement
☐ Business loan ☐ Share purchase agreement

Income Secure Cover guaranteed benefit payment type (increase to an existing policy only)

If the life insured is applying to increase an existing Income Secure Cover with a guaranteed benefit payment type, the financial evidence must be provided as part of this application.

Trauma Cover, Income Secure Cover and/or TPD Cover, under a SuperLink arrangement

If your application relates to Income Secure, Trauma and/or Total and Permanent Disability Cover, will this be under a SuperLink arrangement?

☐ Yes. If **yes,** please ensure you complete the policy details for each policy in Section A.

☐ No

Pre-assessment

Did you apply for an underwriting pre-assessment number? ☐ Yes ☐ No

If **yes**, please provide the underwriting pre-assessment number

Name of underwriter

Sections to complete

The table below indicates which sections need to be completed, depending on what you are applying for.

	Section A–B	Section C1	Section C2	Section C3	Section C4	Section C5	Section C6	Section C7	Section C8	Section C9	Section C10	Section C11	Section C12	Section C13	Section C14	Section D (1–2)	Section E	Section F	Section G*
Increase to existing/Addition of new/Transfer from World of Protection to																			
Life Cover	✓	✓	✓	Q1-12			✓	✓	✓	✓	✓					✓	✓	✓	✓
Trauma Cover	✓	✓	✓	Q1-12			✓	✓	✓	✓	✓					✓	✓	✓	✓
TPD Cover (all except non-working)	✓	✓	✓	✓			✓	✓	✓	✓	✓					✓	✓	✓	✓
TPD Cover (non-working)	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓				✓	✓	✓	✓
Income Secure Cover (all types)	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓					✓	✓	✓	✓
Business Expense Cover	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					✓	✓	✓	✓
Living Expense Cover	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓				✓	✓	✓	✓
Child Cover	✓												✓			✓		✓	
Extra Care Cover	✓	✓	✓	Q1-12			✓	✓	✓	✓	✓					✓	✓	✓	✓
Alterations																			
Decrease to existing Covers	✓															✓	✓	✓	
Continuation Options																			
Life Cover	✓	✓	Q1	Q1 a–d			✓	Q3–5								✓		✓	
Life & TPD Cover†	✓	✓	Q1	✓			✓	Q3–5								✓		✓	
Income Secure Cover	✓	✓	Q1	✓	✓		✓	Q3–5								✓		✓	
Transfers‡§																			
OneAnswer (OnePath) or OptiMix to OneCare Super (Life Cover)	✓	✓	✓	Q1-12											✓	✓	✓	✓	
OneAnswer (OnePath) or OptiMix to OneCare Super (Life and TPD Cover)	✓	✓	✓	✓											✓	✓	✓	✓	
Oasis Group^ to OneCare (Life and TPD Cover)	✓			✓											✓	✓	✓	✓	
Oasis Group^ to OneCare Super (Life Cover)	✓			Q1-12											✓	✓	✓	✓	
Modified underwriting																			
Life or Trauma Cover	✓	✓	✓	Q1-12			✓	✓	✓	✓	✓					✓	✓	✓	✓
TPD Cover	✓	✓	✓	✓			✓	✓	✓	✓	✓					✓	✓	✓	✓
Income Secure Cover (all types)	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓					✓	✓	✓	✓
Business Expense Cover	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					✓	✓	✓	✓

* Section G to be completed as required (refer to Section C9).

† Continuation of TPD Cover is not available from all Group policies. Please check the Policy Terms of the Group scheme from which the cover is being transferred prior to submission.

‡ Transfer of Life and TPD Cover only. All other cover types, and transfers from Integra Super or Zurich Group Risk require full underwriting as per 'Increase to existing/Addition of new'.

§ If more than $500,000 is required, a full underwriting assessment as per 'Increase to existing/Addition of new' will be necessary.

^ Oasis Group refers to the Group Insurance cover provided under the Zurich Group Insurance policies issued to members under the Oasis Superannuation Master Trust.

Authority to arrange blood tests, medical examinations or other tests

If required, OnePath or an authorised representative may arrange, on my behalf, any blood test, medical examinations or any other tests for this application, with an independent service provider ..... ☐ Yes ☐ No

Applicant to complete – Life insured and policy owner details

Use Section A to provide details for the life insured and for each policy owner including contact details. If your application relates to multiple policies, please provide separate policy ownership details for each policy.

A1 Details of life insured

If there is more than one life insured, a separate Application Form should be completed for each life insured (with the exception of children to be insured under Child Cover – see table below).

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname First name

Maiden name (if applicable) Date of birth (dd/mm/yyyy) / /

No. and street (home)

Suburb/Town State Postcode

Phone Home Business Mobile

Email

Gender ☐ Male ☐ Female **Smoker** ☐ Yes ☐ No

Marital status ☐ Single ☐ De facto ☐ Married ☐ Widow/Widower

May one of our underwriting staff or OnePath authorised service providers contact you by phone if we require more information? ..... ☐ Yes ☐ No

If **yes**, when is the most convenient time and on which phone number? (Weekdays from 8:30am to 6:00pm AEST)

Days Time From : to : Phone (h) ☐ (w) ☐ (m) ☐

Please complete the table below if your application relates to Child Cover.

Children to be insured

Surname	First name	Male/ Female	Date of birth (dd/mm/yyyy)	Relationship to life insured
1.			/ /	
2.			/ /	
3.			/ /	

Sections A2–A6 relate to policy owner details.
If there is more than one policy for the life insured, for example under a TPD or Trauma SuperLink arrangement, please complete policy details for each policy type.

Non-superannuation policy details

A2 Complete this section if your application relates to a non-superannuation policy (including SuperLink arrangements). Otherwise, continue to A3.

☐ Please tick here if the life insured is also a policy owner. If the life insured is the sole policy owner, continue to Contact details for correspondence and complete the preferred correspondence method.

If the policy owner is different to the life insured, or there are additional policy owners, please complete their details below. If there is more than one policy owner, they are applying as joint tenants.

First Policy Owner:

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname/Company name First name

Maiden name (if applicable) Date of birth (dd/mm/yyyy) / /

No. and street

Suburb/Town State Postcode

Phone Home Business Mobile

Email Relationship to life insured

Second Policy Owner:

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname/Company name First name

Maiden name (if applicable) Date of birth (dd/mm/yyyy) / /

No. and street

Suburb/Town State Postcode

Phone Home Business Mobile

Email Relationship to life insured

Contact details for correspondence

Please indicate if you wish to be notified by SMS for service messages, such as when premiums are dishonoured or become overdue..... ☐ Yes ☐ No

Please specify the contact details below. The contact details should not be the details of your financial adviser.

No. and street/PO Box

Suburb/Town State Postcode

Email address Mobile

A3 OneCare Super policy details – issued to OnePath Custodians

Complete this section if your application relates to a OneCare Super policy and the Retirement Portfolio Service (the Fund). Otherwise, continue to A4. Do not complete this section if your application relates to an External Master Trust policy (for which you should complete details at A6).

Contact details for correspondence

Please indicate if you wish to be notified by SMS for service messages, such as when premiums are dishonoured or become overdue..... ☐ Yes ☐ No

Please specify the contact details below. The contact details should not be the details of your financial adviser.

No. and street/PO Box

Suburb/Town State Postcode

Email address Mobile

1. How will premiums be paid? ☐ Contribution ☐ Internal rollover ☐ External rollover

2. Tax File Number

Before providing this information, please refer to 'Tax File Number' in the 'OneCare Super' section of the PDS.

☐☐☐ - ☐☐☐ - ☐☐☐

3. **Do not complete this question if paying premiums via rollover.** For information on eligibility to contribute to superannuation please refer to 'Who can contribute to the Fund' in the 'OneCare Super' section of the PDS.

Are you eligible to make contributions to the Fund? ..... ☐ Yes ☐ No

What type of contributions are being made by you or on your behalf

☐ Personal ☐ Spouse ☐ Employer

Select only one.

A4 Self Managed Super Funds (SMSF) with individuals as trustees policy details – issued to the trustees of an SMSF.

Complete this section if your application relates to an external superannuation policy, the fund is an SMSF with individual trustees and the life insured is a member of that fund.
Otherwise, continue to A5 or A6.

Name of superannuation fund

Australian Business Number (ABN) ☐☐–☐☐☐–☐☐☐–☐☐☐

No. and street

Suburb/Town State Postcode

Member Number ☐☐☐☐☐☐☐☐☐☐

Single member fund

Trustee names^
1.
2.

^ Two trustee names can be captured, one of these being the member. This section is not to capture the name of the SMSF.

Two to Four member fund

Trustee names*
1.
2.
3.
4.

* All trustee names must be captured. This section is not to capture the name of the SMSF.

Contact details for correspondence

Please indicate if you wish to be notified by SMS for service messages, such as when premiums are dishonoured or become overdue..... ☐ Yes ☐ No

Please specify the contact details below. The contact details should not be the details of your financial adviser.

No. and street/PO Box

Suburb/Town State Postcode

Email address Mobile

I/We hereby declare that there is an executed trust deed in existence for the fund and all members admitted to the fund will be bound by the provisions contained therein and that the fund is regulated under the *Superannuation Industry (Supervision) Act 1993*.

I/We have read and understood the 'How to apply' section of the OneCare PDS.

Trustee name

Trustee signature ✗ Date (dd/mm/yyyy) / /

Trustee name

Trustee signature ✗ Date (dd/mm/yyyy) / /

Trustee name

Trustee signature ✗ Date (dd/mm/yyyy) / /

Trustee name

Trustee signature ✗ Date (dd/mm/yyyy) / /

A5 SMSF and Small APRA funds (SAF) – issued to the corporate trustee of an SMSF or SAF.

Complete this section if your application relates to an external superannuation policy, the fund is an SMSF or SAF with a corporate trustee and the life insured is a member of that fund.
Otherwise, continue to A6.

Corporate trustee

Name of Corporate entity (e.g. ABC Pty Ltd)

Australian Business Number (ABN) of corporate entity

Name of superannuation fund

Australian Business Number (ABN) of superannuation fund

No. and street

Suburb/Town State Postcode

Member Number

Single member fund

Director's name^

1.

2.

^ When applying under a corporate trustee, member's name and signature is required, an additional director's name and signature is optional.

Two to Four member fund

Director's name

1.

2.

3.

4.

Contact details for correspondence

Please indicate if you wish to be notified by SMS for service messages, such as when premiums are dishonoured or become overdue..... Yes No

Please specify the contact details below. The contact details should not be the details of your financial adviser.

No. and street/PO Box

Suburb/Town State Postcode

Email address Mobile

I/We hereby declare that there is an executed trust deed in existence for the fund and all members admitted to the fund will be bound by the provisions contained therein and that the fund is regulated under the *Superannuation Industry (Supervision) Act 1993*.

I/We have read and understood the 'How to apply' section of the OneCare PDS.

Director/Trustee name

Director/Trustee signature ✗ Date (dd/mm/yyyy) / /

Director/Trustee/Secretary name

Director/Trustee/Secretary signature ✗ Date (dd/mm/yyyy) / /

A6 Details of External Superannuation policy – issued to the trustee of an external superannuation master trust

Complete this section if your application relates to an External Master Trust policy owned by the trustee of an external superannuation master trust and the life insured is a member of that fund.

Trustee

Product name

Member number

Please note: A member number is required for all external superannuation funds or master trusts. The member number must be received by OnePath before Interim cover or a policy can be issued.

Contact details for correspondence

Please indicate if you wish to be notified by SMS for service messages, such as when premiums are dishonoured or become overdue..... ☐ Yes ☐ No

Please specify the contact details below. The contact details should not be the details of your financial adviser.

No. and street/PO Box

Suburb/Town State Postcode

Email address Mobile

Beneficiary details

Please complete this section if you are nominating beneficiaries for death benefits under your policy(ies).

B1 Nomination of beneficiaries – OneCare non-superannuation

Please complete the table below to nominate the beneficiaries to whom death benefits under any cover will be paid and in what proportion.

I/We, the policy owner(s), nominate the following beneficiary(ies) to receive the specified proportion of the amount insured payable in the event of the life insured's death. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I/We understand that I/we reserve the right to alter this nomination at any time and that subsequent valid nominations supercede previous nominations. If the ownership of this policy is transferred at any time any existing nomination shall become void. OnePath may discharge its obligations to any minor beneficiary by paying monies due to a duly appointed legal guardian of any minor beneficiary or to the duly appointed trustee of any appropriate fund created for the purpose of receiving any monies so due, among other things.

Surname/Company name of nominated beneficiary	First name (including title, e.g. Mr or Mrs)	Address	Relationship to life insured	Date of birth (dd/mm/yyyy)	Proportion of the amount insured (%)*
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	
Estate/Policy owner			N/A	N/A	
				Total (must add up to 100%)	100%

* Proportion of the benefit should be whole numbers only.

B2 Nomination of beneficiaries – OneCare Super

For information on nominating a beneficiary please refer to 'Death Benefit' in the 'OneCare Super' section of the PDS. 'Trustee' in this section refers to OnePath Custodians as the trustee of the Retirement Portfolio Service (the Fund).

As a member of the Fund, you have two options in relation to your Death Benefit. You can either make:

- a lapsing nomination, which must be confirmed or updated within three years of the date of the initial nomination or any subsequent nomination, or
- a non-lapsing nomination, which does not have to be confirmed or updated every three years.

If you provide us with a nomination (whether lapsing or non-lapsing) the Trustee must pay your Death Benefit to the beneficiaries you have nominated and in such proportions as you have specified, provided it satisfies all legal requirements, and has not become defective. The circumstances in which a nomination may become defective, and how the Trustee will pay your death benefit in these circumstances, are explained in the PDS.

A nominated beneficiary (whether a lapsing or a non-lapsing nomination) must be your dependant under superannuation law (including financial dependant) or your Legal Personal Representative (estate).

Tick one of the boxes below to indicate whether you are choosing to make a lapsing or non-lapsing nomination:

☐ **Lapsing nomination**

I hereby advise the Trustee of my lapsing nomination as to who should receive the benefit payable on my death and in what proportions. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I reserve the right to alter my nomination at any time.

☐ **Non-lapsing nomination**

I hereby advise the Trustee of my non-lapsing nomination as to who should receive the benefit payable on my death, how to pay the benefit, and in what proportions. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I reserve the right to alter my nomination at any time.

Please make your nomination(s) in the space provided on the next page, up to a maximum of five nominations. You should update your nominations as personal circumstances change, e.g. you marry, divorce or have a child/children. You may indicate how you would like your benefit to be paid, i.e. a lump sum or an income stream or a combination of both. Please note that the Trustee has the discretion as to how the benefit is to be paid. Superannuation rules restrict who can receive, and how much can be paid as, an income stream. Eligibility is determined at the time the income stream is proposed to commence and not at the time the nomination is made. Speak to your financial adviser for more information. Any amount paid to an estate is paid as a lump sum.

Surname	First name (including title, e.g. Mr or Mrs)	Address	Relationship to member	Date of birth (dd/mm/yyyy)	Proportion of the death benefit (%)*			Preference how the death benefit is to be paid	
								Lump Sum	Income Stream
1.				/ /					
2.				/ /					
3.				/ /					
4.				/ /					
5				/ /					
Estate			N/A	N/A				Lump sum only	
				Total (must add up to 100%)	100%				

* Proportion of the benefit should be whole numbers only.

Declaration for OneCare Super beneficiary nominations

1. I have read and understood the 'Death Benefit' in the 'OneCare Super' section of the PDS which accompanies this Application Form and have provided my nomination to OnePath Custodians, the Trustee.

2. I understand that the Trustee will pay my death benefit to the beneficiaries I have nominated and in such proportions as I have specified, provided certain requirements as set out in the trust deed for the Fund are met.

3. I understand my death benefit will not be payable in accordance with my nomination if it is cancelled or becomes defective and will instead be payable as set out in the PDS.

4. I understand that if I choose to make a lapsing nomination, my nomination will also become defective if I do not confirm or amend my nomination, or make no fresh nomination within either three years of the date I make the initial nomination or three years after any subsequent nomination.

5. I understand and acknowledge that a non-lapsing nomination will not override a previous valid lapsing nomination. The previous lapsing nomination must first be revoked before making a new non-lapsing nomination.

6. I understand that any nomination I make on this form will only apply to the benefits payable under the OneCare Super policy, issued by OnePath to the Trustee in respect of my life.

7. By completing this form, I acknowledge that it is my responsibility to ensure that each person I have nominated as a beneficiary is made aware that:

- they have been nominated as a beneficiary
- OnePath and the Trustee hold a record of their personal information for this purpose
- they may contact OnePath or request access to their information by calling Customer Care on 133 667.

Full name of member

Signature (for lapsing nominations, only sign in the presence of the two witnesses named below) ✗

Date (dd/mm/yyyy) / /

Signature of two witnesses (required for all lapsing nominations)

I am aged 18 years or over, and am not named as a beneficiary on this form. The member signed and dated this form (above) in the presence of us both.

Witness name

Witness signature ✗ Date (dd/mm/yyyy) / /

Witness name

Witness signature ✗ Date (dd/mm/yyyy) / /

Life Insured's Personal Statement

All questions in Section C must be completed by the person whose life is to be insured. If there is more than one life insured, a separate Application Form must be completed for each life insured.

Duty to take reasonable care not to make a misrepresentation

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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.

C1 Residence and travel details

1. Are you an Australian or New Zealand citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No

2. How long have you lived in Australia? Years ☐☐ Months ☐☐

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

If **yes**, please complete the following:

Date of departure (dd/mm/yyyy) / / Duration of stay

Destination(s)

Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other Please specify if **other**

C2 Insurance details

1a. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance, business expenses, living expenses, accidental death, terminal illness, needle stick, extended needle stick or cover for pregnancy and/or infancy, with any company, including OnePath (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

1b. Apart from this application do you have, or will you be replacing cover with either, OnePath or any other life insurance company (this includes insurance through your superannuation fund and employer)? ☐ Yes ☐ No

1c. If you have answered **yes** to either question 1a or 1b, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below.

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)
		$ ☐☐☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐☐☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐☐☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐☐☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐☐☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /

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

If **yes**, please provide name of company, alteration, type of cover, 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

Please note that questions continue on the next page.

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

C3 Occupation details

1a. Occupation

b. How many hours per week do you work in total in your principal occupation (include any hours worked at home)?

c. In which industry do you work?

d. Years in this industry

2. Which of the following best describes your employment situation?

☐ Employed by family company/trust ☐ Employed by my own company ☐ Partnership ☐ Casual

☐ Sole trader ☐ Employed by an independent employer ☐ Employed under terms of a contract

3. When did your present job/employment situation start? (dd/mm/yyyy) / /

4. What is your current annual income earned through personal exertion, before tax, but after deduction of business expenses?

Annual income (excluding superannuation guarantee (SG) contributions) $,

Superannuation guarantee (SG) contributions $,

5. Are any of your duties hazardous (e.g. working from heights, working underground, handling dangerous substances/explosives/chemicals, handling needles, sharps or biohazardous materials)? ☐ Yes ☐ No

If **yes**, please provide details.

Hazardous activity	Maximum height/depth (metres)	Average height/depth (metres)	Average hours per week
Heights			
Underground			

Other hazardous duties/hazardous chemical use

6. Are you familiar with all applicable safe-work procedures relating to your occupation? ☐ Yes ☐ No

If **no**, please indicate the reason you gave this response.

If **yes**, do you practice these at all times when performing your work? ☐ Yes ☐ No

If **no**, please provide details of when safe-work procedures are not practiced in your occupation.

7. Do you hold all appropriate work-safety certification, where required? ☐ Yes ☐ No ☐ Not required

If **no**, please provide details of certification not currently held and of future plans to obtain this.

8. Are you considering a change in your current occupation(s), duties, working hours, employment situation(s) or financial situation (including income)? ☐ Yes ☐ No

If **yes**, please provide details (e.g. 'concluding contract in three weeks', 'moving to new permanent job in 25 days', 'retiring permanently from the workforce in 12 months').

Please complete the following section if your application relates to TPD, Income Secure, Business Expense or Living Expense Cover. Otherwise, please Go to C6.

9. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases).

Type of work	% of time	Please describe your specific duties and where they are performed.
Sedentary/Administration (e.g. filing, computer work, answering telephone, reception duties)		
Manual work – supervising (specify where, e.g. factory, building construction site)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5kg)		
Manual work – heavy (e.g. bricklaying, lifting, painting, carpentry, mechanic, driving heavy plant/machinery)		
Site visits/inspections (e.g. real estate sales, building industry inspector, contractor, underground)		
Other (please specify)		
Total	100%	

10. Do you possess any trade or tertiary qualifications relevant to your occupation? ☐ Yes ☐ No

If **yes**, please provide details.

Qualifications, degree, licence number, etc.

When and where was the qualification received?

11a. Do you have a second occupation? ☐ Yes ☐ No

If **yes**, please specify occupation.

b. Please provide details of duties and earnings of second occupation.

Duties

c. Current annual income earned through personal exertion, before tax, including superannuation contributions, but after deduction of business expenses from second occupation..... $ ☐☐☐,☐☐☐

d. Hours worked per week in second occupation..... ☐☐

C4 Further occupation details – Income Secure Cover/Business Expense Cover only

If your application does not relate to Income Secure Cover or Business Expense Cover Go to C6.

1. Employer's name or name of business or practice

Business address no. and street

Suburb/Town State Postcode

2. Are any of your occupational duties performed at home? ☐ Yes ☐ No

If **yes**, advise how many hours you work at home and describe duties performed at home.

3. Please give details of your previous employment situation.

Previous employment situation

Industry Number of years in industry ☐☐

Please note that questions continue on the next page.

4. If your present employment situation started within the last 12 months, please describe the circumstances under which you changed to your current occupation e.g. promotion, commenced/ceased self-employment, started/purchased a business/practice.

5. What was your annual income earned through personal exertion from your principal occupation, before tax, but after deduction of business expenses for the two previous financial years?

Period ending	(dd/mm/yyyy) 30/06/	(dd/mm/yyyy) 30/06/
Annual income (excluding superannuation guarantee (SG) contributions)	$, ,	$, ,
Superannuation guarantee (SG) contributions	$, ,	$, ,

If the variance between the two years is greater than 20% please advise reason(s).

6. Is any of your income likely to continue if you become disabled, e.g. sick pay, investment income, company profit share, income generated by your business while you are unable to work? ☐ Yes ☐ No

If **yes**, what is the source of this income?

How long will the income continue if you become totally disabled?

How much income will be received (annual figure) $, ,

7. Have you or any entities owned or controlled by you ever been declared bankrupt or insolvent, or are you or any entities owned or controlled by you currently being declared bankrupt or insolvent? ☐ Yes ☐ No

If **yes**, please provide date, date of discharge and circumstances (if applicable).....Date declared bankrupt (dd/mm/yyyy) / /

Date discharged (dd/mm/yyyy) / /

Circumstances of bankruptcy

Please complete the following for all employment situations other than 'Employed by an Independent Employer' (i.e. complete if you are a sole trader, work for your own/family company or are in a partnership)

8. Please provide the following with respect to your business:

a. Including yourself, how many people have an ownership stake in your business?

b. What percentage of the business do you own?

c. What percentage of the business does your spouse own?

d. How many registered business entities (including trusts) does your business structure include?

9. Excluding yourself, your spouse and any other partners, how many people do you/does your business employ?

Full-time ..... Part-time/Casual .....

10. In the event of your total disability, would you expect the business to continue to generate income for at least 3 months afterward? ☐ Yes ☐ No

If yes:

a. Approximately what percentage of your pre-disability income would you reasonably expect to continue to receive from the business (through salary, net profit share, etc.)

1% to 75% of pre-disability income %

76% to 100% of pre-disability income %

b. For approximately how long would you expect this income to continue?

11. Is your business currently trading profitably? ☐ Yes ☐ No

If no, please give full details:

Please complete if your application relates to Priority Income Option including Mortgage Maintenance and/or Superannuation Maintenance.

12. If your application relates to Mortgage Maintenance, what was the average of your share of the minimum monthly mortgage repayments made over the previous 12 months? $ ☐☐,☐☐☐ per month

13. If your application relates to Superannuation Maintenance, what were the average monthly superannuation contributions made by you or your employer over the previous 12 months? $ ☐☐,☐☐☐ per month

C5 Business Expense Cover Only

If your application does not relate to Business Expense Cover **Go to C6** **.**

1. What percentage of:

a. business income is derived from your personal exertion? ☐☐☐ %

b. total business expenses are you responsible for? ☐☐☐ %

c. business income can be attributed to other income-producing employees? ☐☐☐ %

2. Please state the number of employees and briefly describe their duties.

3. If working in a partnership, please specify how many partners you have: ☐☐☐

4. Eligible expenses – please provide details in the table below of any average monthly expenses for which you are responsible and which will continue during your absence.

	Annual amount
If income splitting exists, please indicate the annual amount paid to your spouse (please do not include this amount in the expenses below)	$ ☐☐☐,☐☐☐
Details of expenses (excluding recoverable GST)	Monthly amount
Accounting and audit fees	$ ☐☐☐,☐☐☐
Bank fees and charges	$ ☐☐☐,☐☐☐
Office cleaning costs	$ ☐☐☐,☐☐☐
Electricity, gas, water and property rates	$ ☐☐☐,☐☐☐
Equipment hire and motor vehicle leases	$ ☐☐☐,☐☐☐
Business related insurance premiums (not including premiums for this Business Expense Cover)	$ ☐☐☐,☐☐☐
Minimum monthly loan repayments, as per the relevant loan agreement, on:	
• business loans (short-term and long-term bank debt that relates to the operations and capitalisation of the business) including mortgage repayments on the business premises	$ ☐☐☐,☐☐☐
• finance lease payments relating to plant and equipment loans	$ ☐☐☐,☐☐☐
Office rent or leasing fees	$ ☐☐☐,☐☐☐
Salaries and superannuation contributions for employees not directly involved in the generation of revenue	$ ☐☐☐,☐☐☐
Payroll tax for the above salaries	$ ☐☐☐,☐☐☐
Regular advertising costs	$ ☐☐☐,☐☐☐
Telephone costs	$ ☐☐☐,☐☐☐
Subscriptions/fees/dues to professional associations	$ ☐☐☐,☐☐☐
Net cost of a locum (a person from outside your business who is a direct replacement for you in your business), less any business earnings generated by the locum	$ ☐☐☐,☐☐☐
Other expenses*	$ ☐☐☐,☐☐☐
Total	$ ☐,☐☐☐,☐☐☐,☐☐0

* Other expenses cannot include personal remuneration, salary, fees or drawings, payments to related entities or businesses also owned or controlled by you or an immediate family member, cost of goods or merchandise, cost of implements to the life insured's profession, salaries and superannuation contributions for employees directly involved in the generation of income, depreciation and the purchase cost of any assets, tools or other capital items.

Please fully describe other expenses.

Please note that questions continue on the next page.

C6 Pastimes

1. Have you any intention of engaging in:

a. motorcycle riding other than as a means of transportation to and from work (e.g. offroad, racing)? ☐ Yes ☐ No

b. any hazardous activities, sports or pastimes e.g. motor or water sports (such as canoeing), football, parachuting, gliding, recreations involving heights, underwater sports, caving, body contact sports, hang gliding? ☐ Yes ☐ No

c. aviation, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered yes to any of questions 1a, b or c above, please complete the relevant questionnaire(s) on page 40.

C7 Personal health statement

1. What is your current height and weight? Height (cm) ☐ Weight (kg) ☐

2. Has your weight varied by more than 10kg 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**, please state **type** and **quantity** per day.

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 (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

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

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

8. Have you within the past five years suffered a needle stick injury? ☐ Yes ☐ No

If **yes**, please provide date of incident, dates and results of all follow up blood tests.

9. Have you had or are you awaiting a test for coronavirus (COVID-19)? ☐ Yes ☐ No

If **yes**, what was the result?

C8 Family history

To be completed 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	Condition/Disorder	Age diagnosed

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).

C9 Medical history

To the best of your knowledge, have you ever had any of the following (please tick 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 of the conditions in bold above, please complete the relevant questionnaire on pages 31 to 39.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No

10. Heart trouble or 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, hydrocephalus, 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

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 (including carcinoma in situ of any organ), 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

Please note that questions continue on the next page.

32. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any 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 infection including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

34a. Is the combined total of your existing insurance(s) detailed in section C2 question 1c, and any new insurance you are applying for with OnePath, more than any one of the following; $500,000 Life; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? ☐ Yes ☐ No

If you answered **yes** to question 34a, please proceed to 34b, otherwise continue to question 35.

34b. 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 a medical research study where the result of the test has not been or will not be, provided to you) ☐ Yes ☐ No

35. Females only

a. Have you ever had any complications with pregnancy or childbirth (e.g. gestational diabetes)? Please do not include an elective caesarean section or miscarriage within the first 15 weeks of pregnancy as complications ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date (dd/mm/yyyy) / / ☐ Yes ☐ No

c. Are you currently on maternity leave or intending to take maternity leave? If **yes**, please advise date due to return to work. (dd/mm/yyyy) / / ☐ Yes ☐ No

d. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

e. 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

If you answered **yes** to any questions from 9 to 35, please complete the following table.

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): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

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): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

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): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

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): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

C10 Usual doctor or medical centre details

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

Doctor/Medical centre

Phone Fax

No. and street

Suburb/Town State Postcode

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

3. Please advise the approximate date of your last consultation with your usual doctor.

4. Please advise the reason for your last consultation with your usual doctor.

*Note: If **"check up"** please advise the outcome below

5. Please indicate the outcome of the consultation, including the results of any tests, any treatment or medication prescribed and the nature of any planned investigations or recommended referrals.

Outcome	Degree of recovery

6. Have you had any consultations with your doctor or any other medical professional regarding any illness, injury, prescription medication or any other medical issue within the last five years that you have not already indicated in sections above in C9 or C10.

☐ Yes ☐ No

If **yes,** please provide details below

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

C11 TPD Cover (non-working) or Living Expense Cover

If your application does not relate to TPD Cover (non-working) or Living Expense Cover **Go to C12** **.**

1. What is your annual household income?

☐ $0 to $30,000
☐ $30,001 to $50,000
☐ $50,001 to $65,000
☐ $65,001 to $80,000
☐ $80,001 and over

Please continue to complete this section only if you are age 65 or over.

2. Do you have children? ☐ Yes ☐ No

If **yes**, how many?

3. Are you involved in social activities (e.g. bowls, golf, trips, volunteer work)? ☐ Yes ☐ No

If **yes**, describe what type.

4. Do you have family that lives close by, with whom you have regular contact? ☐ Yes ☐ No

5. Are there any duties you are unable to perform as part of your normal daily activities due to physical, mental, emotional or memory problems?

Bathing and showering ☐ Yes ☐ No
Using the toilet, including getting up and down ☐ Yes ☐ No
Dressing and undressing, including putting on shoes and socks ☐ Yes ☐ No
Doing work around the house or garden ☐ Yes ☐ No
Eating and drinking, including cutting up food ☐ Yes ☐ No
Managing money such as paying bills and keeping track of expenses ☐ Yes ☐ No
Shopping for groceries ☐ Yes ☐ No
Making telephone calls ☐ Yes ☐ No
Taking medications ☐ Yes ☐ No
Walking across a room ☐ Yes ☐ No
Getting in and out of bed ☐ Yes ☐ No

If you answered **yes** to any part of question 5, please give details.

6. Do you need assistance with walking? ☐ Yes ☐ No

If **yes**, please give details (e.g. walking stick, zimmer frame, wheelchair).

7. If you have answered **yes** to questions 5 or 6 above, does anyone help you with these activities? ☐ Yes ☐ No

If **yes**, what relationship does the person providing assistance have to you (e.g. husband, daughter, friend, health worker, etc.)?

C12 Child Cover only

For any children listed under A1, please complete questions 1–4.

If your application does not relate to Child Cover **Go to C13** **.**

1. Do any of the children have any Life, TPD or Trauma Cover with OnePath or any other company? ☐ Yes ☐ No

If **yes**, please provide details.

Name of child	Gender	Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?
1.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No
2.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No
3.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No

	Child 1		Child 2		Child 3	
2. Has this child ever had:						
• high blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• rheumatic fever or any heart complaint?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• asthma, tuberculosis or any other lung disease?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• cancer, cyst, lesion or tumour of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• diabetes?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• indigestion, or gastric or duodenal ulcer?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• epilepsy, fainting attacks or fits of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• a physical or neurological defect, impaired sight or hearing?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• anaemia, leukaemia, haemophilia or any other blood disorder?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• kidney, liver or gall bladder problems, including hepatitis of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• or been diagnosed with, investigated for or displayed symptoms of any form of mental underdevelopment, incapacity or retardation?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
3. Has this child ever:						
• been advised to have an operation or surgery in the future?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• been infected with the virus which causes AIDS (the Human Immunodeficiency Virus) or are they carrying antibodies to that virus?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• been injected with or used any drug not prescribed by a medical practitioner?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• received a blood transfusion or treatment with human blood products?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
4. Has the child's mother, father, brother or sister:						
• suffered from diabetes, heart disease, cancer, stroke, mental disorder or breakdown, kidney disorder, Huntington's disease, multiple sclerosis, muscular dystrophy, motor neurone disease or any hereditary disease?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

For any **yes** answer for questions 2, 3, or 4, please advise the name of condition, dates of treatment, name and address of doctors or hospitals consulted and the relationship of the person who had the condition to the child.

Child 1

Child 2

Child 3

C13 Declaration of continued good health and circumstances – for transfers from Oasis or FSP Master Trust, OptiMix and OneAnswer with amounts insured of $500,000 or less, otherwise full personal statement required.

Since the date of the Application for the cover that is to be transferred, has any of the following occurred:

1. Any symptoms of ill health, illness or injury? ☐ Yes ☐ No

2. Consulted or received medical advice from any doctor, undergone any medical examination, tests or treatment, been in hospital or suffered any physical disability? ☐ Yes ☐ No

3. A change in occupation, duties performed or employment situation? (e.g. commenced self-employment) ☐ Yes ☐ No

4. A change in smoking status? ☐ Yes ☐ No

5. Either engaging or intending to engage in aviation other than as a fare paying passenger, any hazardous activities, pastimes or motorcycle riding/motor racing other than as a means of transport to and from work? ☐ Yes ☐ No

6. Any insurance declined, withdrawn or modified in any way? ☐ Yes ☐ No

Give details of all **yes** answers and if medical in nature include date, names and addresses of any doctors consulted, details of treatment and outcome. Show question number when giving details.

Question number	Details

Declarations

Information about OnePath's other products and services

D1

- I/We have received the OneCare Product Disclosure Statement (PDS) which accompanies this Application Form and have read and understood the duty to take reasonable care not to make a misrepresentation on pages 1 and 12 of this Application Form.
- Where making changes to existing Guaranteed benefit payment type, Income Secure Cover, I/we have read the 'Guaranteed benefit payment type' section under Income Secure Cover in the PDS dated 13 April 2019 available at onepath.com.au/public/pdfs/L8133-OneCare-Product-Disclosure-Statement.pdf
- Where making changes to existing Guaranteed benefit payment type, Business Expense Cover, I/we have read the 'Guaranteed benefit payment type' section under Business Expense Cover in the PDS dated 13 April 2019 available at onepath.com.au/public/pdfs/L8133-OneCare-Product-Disclosure-Statement.pdf
- I/We consent to the collection, use, storage and disclosure of my/our personal information as described in the Privacy Policies and the Privacy Statement(s) contained in the PDS (including discussing any information obtained from me/us and any doctors or accountants with the financial adviser associated with this application). OnePath's Privacy Policy is available at onepath.com.au/about-us/privacy-policy and OnePath Custodians' Privacy Policy is available at onepathsuperinvest.com.au/about-us/privacy-policy
- If I/we have provided personal information about any identified person, I/we declare that I/we have their permission to do so and I/we have informed them of the Privacy Policies and the Privacy Statement(s).
- I/We consent to (and request where required) OnePath contacting me/us in relation to this application, to administer any policy that is issued, and for any other purpose consistent with the Privacy Policies and Privacy Statement(s).
- I/We authorise OnePath and OnePath Custodians to use my/our personal information to send me/us information about other products and services that may be of interest to me/us. I/We understand that I/we may phone Customer Care on 133 667 to advise that I/we do not want OnePath or OnePath Custodians to use my/our information for marketing purposes
- I/We understand that if I/we fail to attend any medical appointments required by OnePath, I/we could be liable for any associated costs.
- I/We have read and understood my/our 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/We understand that if this application is to replace another life insurance policy (the 'other policy'), that I/we must cancel the other policy upon acceptance of this life insurance policy. In any event, if I/we do not cancel the other policy, the benefits paid under this policy will be offset or reduced to the extent of any of the benefits the policy owner is entitled to under the other policy.
- I/We understand that the insurance I/we have applied for will not become effective until my/our application is accepted by the insurer in writing.
- Where the proposed owner of this policy is a trust/company, I/we confirm that I/we have the capacity and authority to sign this application as authorised by the governing rules of the trust/company.
- I/We acknowledge that at the time of completing this application I/we am/are not currently receiving benefits, eligible or entitled to receive benefits under any life insurance policy or compensation scheme.

Please note that the declarations continue on the next page.

- Where there is a new adviser for any increase or alteration to an existing policy, I/we consent to the appointment of the adviser named in this Application Form.
- Where I/we have nominated to receive information from OnePath by email or SMS, I/we consent to the sending of policy information to my nominated email address and mobile number. I/We understand that any legal requirement for OnePath to provide written notice of certain information is satisfied by the sending of the information to either the nominated mailing address or email address. I/We understand that it is my/our responsibility to maintain ongoing access to both the email address and the mobile number, or to advise OnePath of new contact details when necessary, or OnePath will revert the correspondence preference to mail.
- I/We acknowledge that Zurich is a company within the Zurich Financial Services Australia Group. OnePath Custodians is a company within the Insignia Financial Group of Companies comprising Insignia Financial Ltd ABN 49 100 103 722 and its related bodies corporate (Insignia Financial Group). Zurich and OnePath Custodians are not related bodies corporate.
- If this application relates to an existing or new OneCare Super policy, and subject to meeting the policy terms including premium requirements, I continuously elect for OnePath Custodians or any successor holding this policy insuring me to take out and maintain insurance under the policy even if:
  - they receive no amount in respect of the policy for a continuous period of 16 months or longer;
  - the amount that they hold in respect of the policy is less than $6,000; or
  - I am under the age of 25 years.

  I acknowledge that by making this declaration, under superannuation law I have elected for the benefits to continue regardless of the factors above and that I can cease the policy on request.
- If this application relates to an existing or new OneCare External Master Trust policy, and subject to meeting the policy terms including premium requirements, I continuously elect for the trustee of the external master trust or any successor holding this policy insuring me to take out and maintain insurance under the policy even if:
  - the balance of my external master trust account is less than $6,000; or
  - I am under the age of 25 years.

  I acknowledge that by making this declaration, under superannuation law I have elected for the benefits to continue regardless of the factors above and that I can cease the policy on request.

Signature of life insured	✗	Date (dd/mm/yyyy) / /
Signature(s) of policy owner(s) if different to life insured (OneCare non-superannuation, SMSF or SAF only).	✗	Date (dd/mm/yyyy) / /
Signature(s) of policy owner(s) if different to life insured (OneCare non-superannuation, SMSF or SAF only).	✗	Date (dd/mm/yyyy) / /
Signature(s) of policy owner(s) if different to life insured (OneCare non-superannuation, SMSF or SAF only).	✗	Date (dd/mm/yyyy) / /
Signature(s) of policy owner(s) if different to life insured (OneCare non-superannuation, SMSF or SAF only).	✗	Date (dd/mm/yyyy) / /

E Doctor's Authorisation

Notes on releasing information about your health

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.

We, Zurich Australia Limited (Zurich, OnePath) ABN 92 000 010 195, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

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 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 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice	**Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances**
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 OnePath, or to third parties they engage. I agree to all the following: • My health information can be released in the form OnePath 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. • OnePath 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 OnePath 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.	I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to OnePath, or to third parties they engage, only if OnePath 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: • OnePath 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 OnePath 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 e□ective, and this Authority should be accepted as valid and e□ective where I have signed electronically or consented verbally.
Name	Name
Signature ✗	Signature ✗
Date (dd/mm/yyyy) / /	Date (dd/mm/yyyy) / /

F Payment Authority and Loyalty Details

Please select and complete only one of the following payment options; Direct Debit Authority; Credit Card Authority; OneCare Super Internal Rollover Authority or OneCare Enduring Rollover Request (see page 29).

Note: There may be tax implications due to the premiums being paid from a personal account. Speak to your financial or tax adviser on how this may affect you.

If you have selected SuperLink Trauma, SuperLink Income Secure or SuperLink TPD Cover please select up to two of the following payment options. Direct Debit Authority; Credit Card Authority; OneCare Super Internal Rollover Authority or OneCare Super Enduring Rollover Request (see page 29).

Make further copies of this page if you wish to pay premiums for each of the several policies using the same payment method. Note that it is not possible to pay premiums for OneCare Super from a bank account held in the name of the trustees of a self-managed super fund.

Members of an External Master Trust who have an agreement with OnePath are not required to complete this section as the premium will be deducted from their Superannuation Account and paid to OnePath.

Direct Debit Authority

Direct debit is not available from all account types. If in doubt please check with your financial institution.

By signing this Direct Debit Authority I/we acknowledge that I/we have read and understood 'Direct Debit Request Service Agreement' in the 'Key information you should know' section of the PDS and are bound by the terms and conditions contained in this authorisation.

I/We request and authorise Zurich Australia Limited (Zurich, OnePath) ABN 92 000 010 195 AFSL 232510 (user number 219313) to arrange for any amount OnePath may debit or charge me to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement.

Details of the account to be debited

Name of account holder

Name of financial institution

BSB number ☐☐☐ – ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

☐ Initial payment only or ☐ All payments

Signature (if direct debit is from a joint account, provide all signatures)

Signature of account holder ✗ Date (dd/mm/yyyy) / /

Signature of account holder ✗ Date (dd/mm/yyyy) / /

Credit Card Authority

I/We understand my/our bank or financial institution may charge a processing fee to my/our credit card for each payment that is made under this authorisation.

I/We acknowledge it is my/our responsibility to notify OnePath of any material change in credit card details, including a new expiry date.

I authorise OnePath to charge my: ☐ Visa ☐ Mastercard

Cardholder's name

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry date (mm/yyyy) /

☐ Initial payment only or ☐ All payments

Cardholder's signature ✗ Date (dd/mm/yyyy) / /

OneCare Super Internal Rollover Authority

This Internal Rollover Authority allows you to pay your OneCare Super policy premiums from an eligible OnePath superannuation product held in the Retirement Portfolio Service (the Fund). To use this Authority:

- the member of the Fund (the 'Member') must have or be applying for **OneAnswer Frontier Personal Super**; **OneAnswer Personal Super; ANZ OneAnswer Personal Super,** or have an **OptiMix Superannuation account**
- the Member must be the same as the account holder of the relevant OnePath superannuation product.

Only one Internal Rollover Authority can apply for each OnePath superannuation account. Choosing to pay premiums by internal rollover may also have implications for tax payable on benefits at time of claim. Please contact your financial adviser or taxation adviser for additional guidance prior to rolling over.

Fund Details

Member number		Product name	
Institution	**OnePath Custodians Pty Ltd**	Fund name	**Retirement Portfolio Service**

Please note: A member number is required in all cases and must be received before a policy can be issued.

OneCare Super premiums will be deducted proportionately from all your investment options (except Term Deposit options) unless you have requested to have premiums deducted from a single investment option in the OneAnswer application form or Change of Details form.

Internal Rollover Authorisation

I authorise Zurich Australia Limited (Zurich, OnePath) ABN 92 000 010 195 AFSL 232510 to arrange for my OneCare Super premium payments to be deducted from and if applicable refunded to my nominated account. These amounts may include current and ongoing premium payments, and any adjustments that may occur from time to time.

The Fund is a regulated and complying superannuation fund under the *Superannuation Industry (Supervision) Act 1993*.

I authorise OnePath Custodians as trustee of the Fund to provide all relevant information and any other documentation to OnePath for the purposes of administering my OneCare Super policy.

I understand that I may cancel this Internal Rollover Authority at any time by providing written notice to OnePath. To prevent additional rollovers, such notice should be received by OnePath at least 14 days before the next rollover is due.

I understand OnePath Custodians as trustee of the Fund may cancel a rollover request if I am no longer eligible to maintain some or all of my OneCare cover.

Name of Member			
Signature	✗	Date (dd/mm/yyyy)	/ /

Loyalty Details (if applicable)

Loyalty program **Qantas Frequent Flyer**	Member number
Member first name	Member surname

I understand that I must be a participating Qantas Frequent Flyer member and provide valid membership details to earn Qantas Points. Membership and Qantas Points are subject to Qantas Frequent Flyer program Terms and Conditions available at qantas.com/frequentflyer

I have read and accept the OnePath Terms and Conditions available at onepath.com.au/qantasfrequentflyer. Please refer to 'Eligible OnePath Insurance Policy' in onepath.com.au/qff-terms-conditions to check eligibility for your policy.

I consent to OnePath and OnePath Custodians collecting my personal information (including health and other sensitive information) from and exchanging my personal information with Qantas Frequent Flyer and understand that my personal information will be handled by Qantas in accordance with its privacy policy.

Member's signature	✗	Date (dd/mm/yyyy)	/ /

Enduring Rollover Request Form

OneCare Super

March 2023

Zurich Australia Limited (Zurich, OnePath)
ABN 92 000 010 195 AFSL 232510
OnePath Custodians Pty Limited (OnePath Custodians)
ABN 12 008 508 496 AFSL 238346 RSE L0000673
Retirement Portfolio Service (the Fund)
ABN 61 808 189 263 RSE R1000986 SFN 4571 159 75

Customer Care
Phone 133 667
Email client.onepath@zurich.com.au
Website onepath.com.au

Important Information

You may be requested by your existing super fund to forward details or sign additional documents. Please action this as soon as possible. Please be aware that other financial institutions may impose a fee when you withdraw from their super fund. There may also be delays in having your money transferred from your existing super fund.

If you intend to lodge a notification that you will be claiming a tax deduction for the superannuation product from which you are transferring, you may need to do so before you transfer to OneCare Super. Choosing to pay premiums by rollover may also have implications for tax payable on benefits at time of claim.

Please contact your financial adviser or taxation adviser for additional guidance prior to rolling over.

OnePath will rely on this authority to request the exact rollover amount required to fund the insurance premium for your policy at policy commencement and at each policy renewal date. We will notify you of the amount of annual premium required prior to requesting the rollover from the nominated super fund.

1. Applicant details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Surname

Given name(s)

Date of birth (dd/mm/yyyy) / /

Residential address (this cannot be a PO Box)

Suburb/Town State Postcode

Country Contact phone

Tax file number ☐☐☐ – ☐☐☐ – ☐☐☐

Please refer to 'Providing your Tax File Number' in the OneCare Super section of the OneCare PDS.

2. Request for partial rollover of funds: From-Fund details (paying institution)

Institution

Fund name

Unique Superannuation Identifier (USI)

Member/Policy number

Address of paying institution

Suburb/Town State Postcode

3. Request for partial rollover of funds: To-Fund details (receiving institution)

Institution **ZURICH AUSTRALIA LIMITED**

Fund name **RETIREMENT PORTFOLIO SERVICE**

Unique Superannuation Identifier (USI) **61808189263001**

Address of receiving institution **LOCKED BAG 994, NORTH SYDNEY NSW 2059**

Phone number of receiving institution **133667**

4. Approval to transfer

- I declare I have read this form and the information completed is true and correct.
- I request and consent to the transfer of superannuation benefits as described above and authorise the superannuation provider of each fund to give effect to this transfer.
- I authorise OnePath to arrange for the rollover of funds as and when required, and for the amount required, to meet OneCare premium payments due for insurance held in respect of my life. These amounts may include current and ongoing premium payments, and any adjustments which may occur from time to time.
- I acknowledge this enduring authority allows for subsequent rollovers to be requested, as required, for the purpose of paying insurance premiums, and I understand the authority will remain effective until such time as I revoke it in writing.
- To the best of my knowledge, my other superannuation fund(s) is a complying superannuation fund under the *Superannuation Industry (Supervision) Act 1993* (Cth).
- The Retirement Portfolio Service (the Fund) is a regulated and complying superannuation fund under the *Superannuation Industry (Supervision) Act 1993* (Cth).
- I consent to change my premium frequency to an annual frequency (if applicable).
- I understand I may be eligible for a rollover rebate, which will reduce the amount of the rollover required to meet the premium amount due, and that the availability of the rollover rebate may be withdrawn in the future.
- I am aware I may ask my superannuation provider for information about any fees or charges that may apply, or any other information about the effect this transfer may have on my benefits, and do not require any further information.
- I approve the deduction of any applicable transfer fees, exit fees and taxes from my account with the nominated super fund in addition to the benefit being transferred (subject to legislative restrictions).
- I understand conditions apply to the transfers the Trustee can accept, and if a transfer is rejected because the conditions are not met, I will make alternative arrangements to pay the premium for OneCare Super. The conditions that apply to transfers include the following:
  - the rollover amount, plus any rollover rebate, must equal the premium due.
  - only rollovers on which any applicable fund tax has already been paid can be accepted. The rollover will be rejected if it contains, in whole or in part, an Untaxed Element of a Taxable Component.
  - rollovers which contain foreign transfer amounts (including UK transfers) or KiwiSaver amounts cannot be accepted.
- I understand that if I cancel or change my policy, any pro-rata premium refund or reimbursement will not be paid to me but will be paid into my nominated superannuation fund accumulation account unless I nominate a different fund at the time the refund is processed, and the Trustee will retain a corresponding pro-rata amount of any rollover rebate applied.
- I understand that I am transferring an amount from my superannuation accumulation account to pay OneCare Super life insurance premiums and therefore my superannuation account balance and retirement savings may be reduced.
- I understand that each superannuation fund has differing rules such as imposing a minimum rollover amount, and I am aware of all possible member entitlements that I will lose by transferring an amount from my superannuation accumulation account, such as the cancellation of any life insurance cover I have attached to that accumulation account.
- I acknowledge that my superannuation fund may have particular processing requirements that if not satisfied may prevent or delay the processing of rollovers, and it is my responsibility to ensure any requirements of which I am notified are provided.
- I understand that where I intend to claim a tax deduction for any contributions I have made to the super fund nominated in this form, it is my responsibility to lodge the required notice of intention with the fund's trustee, before any rollovers are processed, otherwise I may be prevented from claiming the deduction on the full amount of the contributions.
- I understand that I may seek advice regarding the implications of rolling over amounts from a super fund with a service period start date earlier than the start date of my OneCare Super membership for tax payable on death and disability benefits payable from OneCare Super, and do not require further information.
- I consent to the collection, use, storage and disclosure of my personal information as described in the Privacy Policies and the Privacy Statement(s) contained in the PDS (including discussing any information obtained from me and any doctors or accountants with the financial adviser associated with this application). OnePath's Privacy Policy is available at onepath.com.au/about-us/privacy-policy and OnePath Custodians' Privacy Policy is available at onepath.com.au/superandinvestments/privacy-policy
- If I have provided personal information about any identified person, I declare that I have their permission to do so and I have informed them of the Privacy Policies and the Privacy Statement(s).
- I acknowledge that Zurich is a company within the Zurich Financial Services Australia Group. OnePath Custodians is a company within the Insignia Financial Group of Companies comprising Insignia Financial Ltd ABN 49 100 103 722 and its related bodies corporate (Insignia Financial Group). Zurich and OnePath Custodians are not related bodies corporate.

Signature of member ✗ Date (dd/mm/yyyy) / /

Postal address
OnePath
Locked Bag 994
North Sydney NSW 2059

G Questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in C9.

1. When did you have your first episode of asthma? ..... (dd/mm/yyyy) / /

2. When was your most recent episode of asthma? ..... (dd/mm/yyyy) / /

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.

(dd/mm/yyyy) / /

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

Suburb/Town State Postcode

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.

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 ..... From (dd/mm/yyyy) / / to (dd/mm/yyyy) / /

Name and address of hospital

11. Have you ever had lung function tests performed? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in C9.

1. When was your high blood pressure first diagnosed? ..... (dd/mm/yyyy) / /

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.

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.

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 ☐

Address ☐

Suburb/Town ☐ State ☐ Postcode ☐

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

6. What was the date of your last blood pressure check? ..... (dd/mm/yyyy) / /

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? ..... (dd/mm/yyyy) / /

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in C9.

1. When was your high cholesterol first diagnosed? ..... (dd/mm/yyyy) / /

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.

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

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

If **yes**, please provide details.

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

4b. 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.

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

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

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

6. What was the date of your last cholesterol check? ..... (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol ☐ Triglycerides ☐
HDL Cholesterol ☐ LDL Cholesterol ☐

8. How has your doctor described your cholesterol control? ..... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? ..... (dd/mm/yyyy) / /

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in C9.

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed? (dd/mm/yyyy) / /

3. How is your diabetes controlled?

☐ Insulin – go to question 4

☐ Diet only – go to question 5

☐ Oral – list medications below and then 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

Address

Suburb/Town State Postcode

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

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in C9.

1. Please tick 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 bi-polar 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)
		/ /	
		/ /	
		/ /	
		/ /	

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

Date (dd/mm/yyyy)	Details
/ /	
/ /	

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

5. Date of last symptoms (dd/mm/yyyy) / /

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 ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

Please note that questions continue on the next page.

9. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details.

Treatment (e.g. tranquilisers, sedatives, ECT, counselling)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

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.

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

Name of consultant

Address

Suburb/Town State Postcode

12. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details.

Date last admitted (dd/mm/yyyy) / /

Name of institution

Address

Suburb/Town State Postcode

Doctor(s) consulted

13. Does your usual doctor, as advised in section C10, have details of this condition(s)? ☐ Yes ☐ No

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

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

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

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in C9.

1. When did your back/neck condition first occur? (dd/mm/yyyy) / /

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).

5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No

If **yes**, please provide details.

Tests	Results	Date of tests (dd/mm/yyyy)
		/ /
		/ /

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/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

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.

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.

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

12. What was the date of your last symptoms? (dd/mm/yyyy) / /

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in C9.

1. Which joint is/was affected (please tick relevant box(es))? If more than one box is ticked, 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? (dd/mm/yyyy) / /

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/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.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? ☐ Yes ☐ No

If **yes**, please provide details.

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

12. What was the date of your last symptoms? (dd/mm/yyyy) / /

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in C9.

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 of removal (dd/mm/yyyy) / /

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

Address

Suburb/Town State Postcode

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

Pastime questionnaire

Only complete this questionnaire if you answered **yes** to question 1a, b or c in C6

Motorcycle/Motor racing

Vehicle type including the class or formula and engine capacity (cc)

Races p.a. Max. speed (km/h)

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

If **yes**, please advise which licence you hold and when you obtained.

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

Scuba/Skin diving

Average depth (m) Maximum depth (m) Dives p.a

Do you use explosives? ☐ Yes ☐ No

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

If **yes**, to either of the above please give details.

Football/Soccer/Australian Rules, etc.

Code played and grade Games p.a.

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

Do you receive any income for participating in Football/Soccer/Australian 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				

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

Do you participate in any other hazardous activities or sports (e.g. competitive riding, mountain climbing, body contact sports)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

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

Adviser to complete

Checklist for advisers

Attachments

- ☐ Quote
- ☐ Financial evidence
- ☐ Premium cheque(s) $☐☐☐,☐☐☐.☐☐

Have the following been completed or arranged?

- ☐ MediQuick
- ☐ Medical examination
- ☐ Non-fasting MBA-20
- ☐ HIV Test and Hepatitis B & C Serology
- ☐ Direct Debit, Credit Card Request or Enduring Rollover Authority
- ☐ Appropriate medical questionnaires
- ☐ Financial evidence
- ☐ Other tests

Additional information/comments

Reminder: For quicker processing, please make sure all applicable questions are answered in full.

Adviser details

To be completed by the authorised adviser who advised the applicant on the policies which are being applied for.

First adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature

✗

Commission: split/share ☐☐☐ %

Only complete if different from your default

Second adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature

✗

Commission: split/share ☐☐☐ %

Only complete if different from your default

OnePath use only

Seller 2

Seller 3

Postal address
OnePath
Locked Bag 994
North Sydney NSW 2059

Interim Cover Certificate

OneCare

March 2023

Zurich Australia Limited (Zurich, OnePath)
ABN 92 000 010 195 AFSL 232510
OnePath Custodians Pty Limited (OnePath Custodians)
ABN 12 008 508 496 AFSL 238346 RSE L0000673
Retirement Portfolio Service (the Fund)
ABN 61 808 189 263 RSE R1000986

Customer Care
Phone 133 667
Email client.onepath@zurich.com.au
Website onepath.com.au

Interim Cover for policy owner _____ on the life insured _____

Thank you for applying for OneCare. While we assess your application for insurance, we will provide you with Interim Cover subject to the terms as set out in the OneCare Product Disclosure Statement (PDS) and in this certificate. Please refer to 'Interim Cover' in the 'Key information you should know' section of the PDS for further information including the age requirements to be eligible for Interim Cover.

Interim Cover does not apply if the cover applied for:

- is to replace existing insurance which is still in force (active), whether with OnePath or another insurer; or
- would normally be declined or deferred under OnePath's current underwriting rules.

Interim Cover claims

Claims under Interim Cover will be denied if, under our appropriate underwriting guidelines, your application for insurance:

- would have been rejected; or
- if issued, would be issued with an exclusion which would have excluded the relevant claim.

Please also note that the cover provided under Interim Cover in some circumstances will be more limited than the cover described by the same name in the PDS.

Exclusions on Interim Cover

Interim Cover is subject to a number of exclusions, which include:

- self-inflicted injuries;
- conditions that the life insured knew about or for which the insured consulted a medical practitioner before the Interim Cover commences.

Please refer to 'Exclusions on Interim Cover' in the 'Interim Cover' section of the PDS under 'Key information you should know' for details on these and other exclusions.

When Interim Cover commences and ends

Please refer to the 'Commencement of Interim Cover' and 'Duration of Interim Cover' in the 'Interim Cover' section of the PDS under 'Key information you should know' for details of when Interim Cover starts and ends.

Please note that the Interim Cover Certificate continues on the next page.

Amount covered

Depending on the type of covers you have applied for, for each type of cover the Interim Cover Benefit we will pay will be the lesser of the:

- amount insured applied for
- maximum amount payable under Interim Cover for each type of cover, as specified below:
  - Life Cover – $1 million lump sum*
  - TPD and Trauma Covers – $500,000 lump sum*
  - Income Secure and Business Expense Covers – $5,000 per month^
  - Living Expense Cover – $2,000 per month
  - Child Cover – $200,000 lump sum
  - Extra Care Cover Accidental Death – $500,000 lump sum.
- difference between the benefit amount applied for and any existing insurance with OnePath which is to be replaced
- reduced amount insured that would be offered where under its current underwriting rules, OnePath would offer a lower sum insured to that applied for in the Application Form
- reduced amount insured the loaded premium would purchase when compared to the standard premium, where under its current underwriting rules OnePath would apply or has offered to accept the application with a premium loading.

* We will pay this amount or the equivalent instalment amount.
^ A maximum of $30,000 will be payable in total benefits for Income Secure and Business Expense Covers.

Where under its current underwriting rules OnePath would offer the cover subject to special terms and conditions, such special terms and conditions will apply to the Interim Cover.

If the cover was applied for a life insured across multiple policies and we pay less than the amount insured applied for, we pay each policy owner a share of the total amount paid in proportion to the amounts applied for.

Important Information:

This certificate is dependent upon the life insured and the policy owner have read and understood their 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.

They have read and understood their 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.

Zurich is a company within the Zurich Financial Services Australia Group. OnePath Custodians is a company within the Insignia Financial Group of Companies comprising Insignia Financial Ltd ABN 49 100 103 722 and its related bodies corporate (Insignia Financial Group). Zurich and OnePath Custodians are not related bodies corporate.

Signature of financial adviser ✗ Date (dd/mm/yyyy) / /

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