Increases/Alterations Application Form

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This Increases/Alterations Application Form can be used as follows:

(Please note, new benefits or options cannot be added to any of these product types).

Product	Change
Leading Life Leading Life in Retirement Portfolio Service Recovery Cash Stand Alone Recovery Merc Term Life	• Increase the sum insured for an existing benefit
Income Safe *Plus* Income Cover Income Safe Business Expenses Plan	• Increase the monthly benefit • Increase the benefit period • Decrease the waiting period

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.

A Details of life insured

If an increase or alteration is being made to cover more than one life insured, a separate Increases/Alterations Application Form must be completed for each life insured.

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

Surname First name

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

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

If **yes**, what is your daytime phone number and when is the most convenient time to contact you?

Daytime phone Days Time: From To

Policy details

Please note: Any option(s) on the existing benefit will apply to this increase.

B1 Leading Life

Policy number

Does Business Safeguard apply to this policy? ☐ Yes ☐ No

☐ Increase – only state the additional sum insured for each benefit as required:

Benefit	**Sum insured**
Life Cover	$
Trauma Cover	$
TPD Cover	$

Please complete the following if applying for an increase to TPD Cover:

TPD Cover

TPD occupation loading* ☐ 0% ☐ 50% ☐ 100%

Occupation

B2 Recovery Cash

Policy number

Does Business Safeguard apply to this policy? ☐ Yes ☐ No

☐ Increase – only state the additional sum insured for each benefit as required:

Benefit	Sum insured
Recovery Cash	$
Recovery Cash TPD Cover	$
Additional Life Cover	$
Additional TPD Cover	$

Please complete the following if applying for an increase to TPD Cover:

Recovery Cash TPD/Additional TPD Cover

TPD occupation loading* ☐ 0% ☐ 50% ☐ 100%

Occupation

B3 Stand Alone Recovery

Policy number

☐ Increase – only state the additional sum insured required:

Benefit	Sum insured
Stand Alone Recovery	$

* Your premium is based on various factors including your occupation. Your adviser can tell you what occupation category applies to you.

Policy details

Please note: Any option(s) on the existing policy will apply to this increase or alteration.

B4 Income Protection Portfolio

Policy number

Plan type (please tick one) ☐ Income Safe *Plus* ☐ Income Cover ☐ Income Safe ☐ Merc Income Protection Plus† ☐ Merc Income Protection Basic†

Please tick one or both of the following:

☐ Increase – only state the additional monthly benefit required:

Monthly Benefit $

Superannuation Maintenance Benefit‡ (Maximum 15% of monthly earnings) ☐☐ % $

Total $

† Increases are not available if lifetime benefit period applies.
‡ Only available for Income Safe *Plus*, Income Cover and Income Safe.

☐ Alteration – please comment briefly on the nature of the change:

Benefit period ☐ 2 years ☐ 6 years ☐ to age 55 ☐ to age 60 ☐ to age 65

Waiting period ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days ☐ 730 days

Occupation class* ☐ 1 ☐ 1P ☐ 2 ☐ 2B ☐ 3 ☐ 4

Note: 1P is not applicable to Merc Income Protection.

B5 Business Expenses Plan

Policy number

Please tick one of the following:

☐ Increase – only state the additional monthly benefit required ..... $ ☐☐,☐☐☐

Monthly Benefit

☐ Alteration – please comment briefly on the nature of the change:

Waiting period ☐ 14 days ☐ 30 days

Occupation class* ☐ 1 ☐ 1P ☐ 2 ☐ 2B ☐ 3 ☐ 4

*Your premium is based on various factors including your occupation. Your adviser can tell you what occupation class applies to you.

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 should be completed for each life insured.

C1 Residence and travel details

1. Are you a permanent resident of 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 expense or living expense cover, with any company, including OnePath (other than this application), including benefits under superannuation or insurance benefits by your employer? ..... ☐ Yes ☐ No

1b. If **yes,** 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)
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /

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

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

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

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

C3 Occupation details

1a. Occupation

Industry

Years in industry

1b. How many hours per week do you work in total in your principal occupation (include any hours worked at home)?

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

☐ Employed by family company/trust ☐ Working director ☐ Partnership

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

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

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

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

If **yes**, please provide details as applicable below:

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 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')

If your application is to alter or increase TPD, income protection or business expense plan, please go to the next question. Otherwise **Go to C6****.**

7. 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. Please note the examples below are to be used as a guide only.
Sedentary/Administration (e.g. filing, computer work, answering telephone, reception duties, etc.)	0%	
Manual work – supervising (specify where e.g. factory, building/ construction site, etc.)	0%	
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5 kg, etc.)	0%	
Manual work – heavy (e.g. bricklaying, lifting, painting, carpentry, mechanic, etc.)	0%	
Site visits/Inspections (e.g. real estate sales, building industry supervisor, contractor, underground, etc.)	0%	
Other (please specify)	0%	
Total	100%	

C3 Occupation details (continued)

8. 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?

9a. Do you have a second occupation? ☐ Yes ☐ No

If **yes**, please specify occupation:

9b. Please provide details of duties and earnings of second occupation.

Duties:

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

Hours worked in second occupation per week ☐☐

C4 Additional occupation details – income protection/business expense plan only

If you are not applying for income protection 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

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, etc:

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

Period	Annual Income
30/06/	$ ☐☐,☐☐☐,☐☐☐
30/06/	$ ☐☐,☐☐☐,☐☐☐

C4 Additional occupation details – income protection/business expense cover only (continued)

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?

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, circumstances and date of discharge (if applicable).

Circumstances of bankruptcy

Date declared bankrupt (dd/mm/yyyy) / / Date discharged (dd/mm/yyyy) / /

Please complete the following for all employment situations other than 'Employed by an independent employer'.

8. In the event of your total disability, will the business income continue for more than three months? ☐ Yes ☐ No

If **yes:**

a. What level of income (net of business expenses but before tax and your personal superannuation contributions) would you expect your business to continue to generate in the event of your total disablement? ☐ 1–20% ☐ 21–75% ☐ 76–100%

b. How long do you estimate this income will continue for?

9. How many people do you employ other than yourself and your spouse? Full time Part time

10. a. What percentage of the business do you own? ☐☐☐ %

b. What percentage does your spouse own? ☐☐☐ %

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

If **no**, please give full details

C5 Business expense plan only

If you are not applying for business expense plan 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. State number of employees and briefly describe their duties:

C5 Business expense cover only (continued)

3. If working in a partnership, please specify:

a. how many partners you have .....

b. their percentage interest in the business ..... %

4. In the event of your total disability, will the business continue to operate? ..... Yes No

If **yes**, please give an estimate of the ongoing trading capacity ..... %

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

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 expense (excluding recoverable GST)	**Monthly amount**
Business premises rent or business loan interest payments	$, , , , , ,
Leasing of office equipment or motor vehicles	$, , , , , ,
Salaries of employees not involved in the generation of revenue	$, , , , , ,
Payroll tax for employees not involved in the generation of revenue	$, , , , , ,
Superannuation contributions for employees not involved in the generation of revenue	$, , , , , ,
Electricity, gas and water	$, , , , , ,
Telephone	$, , , , , ,
Business insurance premiums (excluding premiums payable on this policy)	$, , , , , ,
Cleaning	$, , , , , ,
Property rates	$, , , , , ,

Details of expense costs (excluding recoverable GST)	**Monthly amount**
Locum cover (a person outside your business who is a direct replacement for you in your business) less any business earnings generated by the locum	$, , , , , ,
Other expenses*	$, , , , , ,
Total	$, , , , , ,

Other expenses:

* 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.

C6 Pastimes

Have you any intention of engaging in:

1. motorcycle riding/racing other than as a means of transportation to and from work? ..... Yes No

2. 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, etc? ..... Yes No

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

If you answered **yes** to any of questions 1, 2 or 3 above, please complete the relevant questionnaire on page 24.

C7 Personal health statement

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

2. Has your weight varied by more than 10 kg during the last 12 months? ☐ 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 **type** and **quantity** per day (the word 'social' is not sufficient)

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

If you are required to have a full medical examination Go to C10.

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, ovarian cancer, 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:

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 15–23.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart problem, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness 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 in the future? ☐ 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 drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No
31. 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
32. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

If you answered **yes** to question 32 a private and confidential questionnaire will be sent to you.

33a. Is the combined total of your existing insurance(s) detailed in section C2 question 1b, 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 33a, please proceed to 33b, otherwise continue to question 34.

33b. 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

34. Females only

a. Have you ever had any complications with pregnancy or childbirth? ☐ 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? ☐ Yes ☐ No

If **yes**, please advise date due to return back to work (dd/mm/yyyy) / /

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 9–32 and 34, please complete the following table. If there is not enough space here, please provide details on page 25.

	Question number	Question number	Question number
Disability, illness, injury, or condition			
Investigation type(s) and result(s)			
Date of first symptoms	/ / (dd/mm/yyyy)	/ / (dd/mm/yyyy)	/ / (dd/mm/yyyy)
Frequency of symptoms			
Type of treatment (and date provided and ceased)	/ / (dd/mm/yyyy)	/ / (dd/mm/yyyy)	/ / (dd/mm/yyyy)
Has further treatment, referral or investigation(s) been recommended?	☐ Yes ☐ No Details:	☐ Yes ☐ No Details:	☐ Yes ☐ No Details:
Time off work	☐ Yes ☐ No Details:	☐ Yes ☐ No Details:	☐ Yes ☐ No Details:
Have you completely recovered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date of last symptoms	/ / (dd/mm/yyyy)	/ / (dd/mm/yyyy)	/ / (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

No. and street

Suburb/Town State Postcode

Phone Business Fax

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

2.

When was your last visit to this doctor/medical centre?	
Reason for check up or consultation?	
Outcome including medication, treatment, etc.	
Degree of recovery?	

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

If **yes**, please provide details:

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

D1 Declarations

- I/We are applying for an increase/alteration on the product stated in this Application Form. The Policy Terms and Policy Schedule were issued to me pursuant to my original application.
- I/We 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/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 consent to (and request where required) OnePath contacting me 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 understand that if OnePath and OnePath Custodians are notified of a change in my/our personal information, OnePath will make this change on other risk policies where I am/we are a policy owner, life insured, nominated beneficiary or nominated medical practitioner.
- 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, whose signature(s) appear below,have read and understood the 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 for an increase or alteration is to replace another life insurance policy (the 'other policy'), that I/we must cancel the other policy upon acceptance of this increase/alteration. In any event, if I/we do not cancel the other policy, the benefits payable under this policy will be offset or reduced to the extent of any of the benefits payable under the other policy.
- I/We understand that any increase/alteration applied for will commence upon written acceptance by OnePath.
- 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 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 (formerly known as IOOF Holdings 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 life insured	✗	Date (dd/mm/yyyy)	/ /
Signature of policy owner(s) if different to life insured and not a Retirement Portfolio Service policy	✗	Date (dd/mm/yyyy)	/ /
Signature of policy owner(s) if different to life insured and not a Retirement Portfolio Service policy	✗	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 ABN 92 000 010 195 AFSL 232510 (Zurich, OnePath), 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

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 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.

Name

Signature ✗

Date (dd/mm/yyyy) / /

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

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to 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 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.

Name

Signature ✗

Date (dd/mm/yyyy) / /

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

2. When was your most recent episode of asthma? ..... Date (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:

Date (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 commenced	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

10. Have you ever been hospitalised due to asthma? ..... ☐ Yes ☐ No

If **yes**, please provide details: Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Name 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? ..... Date 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

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

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

If **yes**, please provide details:

Test performed	Date (dd/mm/yyyy)	Test 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.....Date (dd/mm/yyyy) / /

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

9. When is your next blood pressure check-up? .....Date (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? ..... Date 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:

Test performed	Date (dd/mm/yyyy)	Test 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 commenced (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? ..... Date (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. When is your next cholesterol check up? ..... Date (dd/mm/yyyy) / /

Diabetes questionnaire

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

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

2. How is your diabetes controlled?

☐ insulin – go to question 3

☐ diet only – go to question 4

☐ oral – list medications below and then go to question 4:

3. 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

4. How often do you monitor your sugar levels? ..... ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details:

5. 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
	/ /	
	/ /	

6. 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 **yes**, please provide details:

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

7. 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
- ☐ Depression including major depression, dysthymia
- ☐ Alcohol or other substance abuse or addiction
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Other
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Post traumatic stress
- ☐ Stress, sleeplessness, chronic tiredness

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:

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 this condition? ☐ Yes ☐ No

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

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

If **yes**, please provide details:

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

10. Do you feel that this condition has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details:

11. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details:

Name of consultant

Address

Suburb/Town State Postcode

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

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

If **yes**, please provide details:

Name of consultant

Address

Suburb/Town State Postcode

Date of hospitalisation (dd/mm/yyyy) / / Date released (dd/mm/yyyy) / / Doctors consulted / /

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?..... Date (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, etc)

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
		/ /
		/ /

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, etc.)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation, etc.)
		/ /	
		/ /	
		/ /	

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? ..... Date (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 ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Knee	☐	☐
Elbow	☐	☐	Wrist	☐	☐
Shoulder	☐	☐	Hip	☐	☐
Other	☐	☐	If **other**, state which joint		

2. When did this condition first occur? ..... Date (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, etc.)	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 the condition is ..... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? ..... Date (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, etc.)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole, etc.)	Pathology results (e.g. malignant, benign, unknown, etc.)
	/ /		
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each:

Date of removal Date (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 of consultant

Address

Suburb/Town State Postcode

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

Pastimes questionnaire

Motorcycle/motor racing

Vehicle type | Races p.a.

Engine size | Max. speed (km/h)

Class | ☐ Recreational ☐ Amateur ☐ Professional

Scuba/skin diving

Average depth (m) | Maximum depth (m)

Dives p.a. | Do you use explosives? ☐ Yes ☐ No

Football/Soccer/Aussie 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 participating in Football/Soccer/Aussie Rules, etc.? ☐ Yes ☐ No

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

Aviation/flying

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

If **yes**, state the type and the 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 Crew	Past 12 months Passenger	Future annual average Crew	Future annual average 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, etc.)? ☐ Yes ☐ No

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

Other sports or pastimes

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

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

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

Adviser to complete

Checklist for advisers

Attachments

☐ Premium cheque(s) $ ☐☐☐,☐☐☐.☐☐

☐ Financial evidence

Have the following been completed or arranged?

☐ MediQuick

☐ Medical examination

☐ Fasting MBA-20

☐ HIV Test and Hepatitis B & C Serology

☐ 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.

Please note: the commission type must remain the same as the original policy. However, the commission split/share may be changed for the increase or alteration.

First adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature ✗

Commission: Split/share ☐☐☐ %

Second adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature ✗

ANZ use only

Seller 2:

Seller 3:

Office use only

Life insured:

(Family name, in capitals)

(First names)

Application/Policy No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Underwriting

Start date (dd/mm/yyyy): / /

Policy checked by (initials):

Policy issue date (dd/mm/yyyy): / /

Final assessment

Decision:

Signature: ✗

Date (dd/mm/yyyy): / /

Premium receipt details (cheques only)

Initial premium paid: $ ☐☐☐,☐☐☐.☐☐

Date banked (dd/mm/yyyy): / /

Postal address

OnePath
GPO Box 4148
Sydney NSW 2001

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