PERSONAL HEALTH STATEMENT

ONLY COMPLETE THIS FORM IF YOU ARE APPLYING FOR INCREASED INSURANCE COVER.

IMPORTANT: Prior to completing this form, you should read about 'Your duty of disclosure' on page 6 of the Insurance Guide. Attach any required extra details to this form. Send your form to the Christian Super Member Care Centre.

1. PERSONAL DETAILS

Member Number _____ (leave blank if a new member)

Title Mr/Mrs/Miss/Ms/Dr/Other _____ Surname _____

Given Names _____ Sex ☐ M ☐ F

Date of Birth ____/____/____ Occupation _____ Salary $_____

Occupation Duties (include the percentage of time spent in each) _____

_____

2. INSURANCE DETAILS

A. Have you previously applied to an insurer of Christian Super or are other applications being submitted? (if YES, please attach details) ☐ Yes ☐ No

B. Have you any Life, Disability and/or Trauma cover with Christian Super's insurers or any other company or as a part of your employment, or have you recently proposed with any other company for such cover? ☐ Yes ☐ No

C. Have you ever had an application on your life declined, postponed, accepted with a higher than normal premium or otherwise than as submitted? (if YES, please attach details of insurance company, alterations made to policy, date and reason, if known) ☐ Yes ☐ No

D. Have you ever made a claim for or received sickness, accident, disability, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other similar compensation? (if YES, please attach details, i.e. when, amount, period paid, type and disability suffered, etc.) ☐ Yes ☐ No

3. GENERAL DETAILS

A. Are you a permanent resident of Australia? ☐ Yes ☐ No

B. How long have you lived in Australia? _____

C. Do you have any intention to travel outside Australia within the next two years? ☐ Yes ☐ No
(if YES, please attach details of estimated departure date, duration of stay, destinations and purpose of travel e.g. holiday, business)

4. SPORTS AND PASTIMES

Have you any prospect, or intention, of engaging in:

A. Aviation, other than as a fare-paying passenger? ☐ Yes ☐ No

B. Any hazardous activities or sports, e.g. motor or water sports (scuba, skin diving), football, parachuting, gliding, recreations involving heights, underground sports, underwater sports, caving, body contact sports, hang gliding etc? ☐ Yes ☐ No

C. Motorcycle riding/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No

(if YES to any of the three questions above, please attach details of type of sport, time spent training and participating, number of times per annum, any fees or payments received and any injuries sustained)

5. FAMILY HISTORY - to be completed in respect of relatives related by blood

A. Have any of your immediate family suffered from nervous disorders, epilepsy, diabetes, stroke, heart disease, mental disorders/breakdown, haemophilia, Huntington's Chorea or any hereditary disease. ☐ Yes ☐ No
(If YES please attach details including relation, condition diagnosed and age at which diagnosis was made.)

6. USUAL DOCTOR OR MEDICAL CENTRE DETAILS

A. Full name of usual doctor _____ Phone number _____

B. Full address of usual doctor _____

Suburb _____ State _____ Postcode _____

C. How many years have you been attending this doctor? _____ years _____ months
(if you have been attending your current doctor for less than 12 months, please attach the details above for the doctor who has details of your medical history)

D. Please give details of your last consultations with ANY doctors (please attach further details if room is insufficient).

Doctor's Name and Address	Date	Reason for Consultation	Outcome or Degree of Recovery

Please turn over

7. PERSONAL HEALTH STATEMENT

A. Height _____ cm Weight _____ kg

B. Do you consume alcohol? (If YES, state type and quantity per day. The word 'social' is not sufficient). _____ Yes No

C. During the past 12 months have you smoked tobacco or any other substance? Yes No
(If YES, please state type and quantity per day.) _____

8. HEALTH HISTORY

A. Do you have abnormality affecting eyesight, hearing, speech or physical mobility? Yes No

B. To the best of your knowledge, have you ever suffered from:

a. diabetes, epilepsy, multiple sclerosis or hepatitis? Yes No
b. anaemia, leukaemia, haemophilia or any other blood disorder? Yes No
c. cancer or tumor of any type? Yes No
d. chest pain, high blood pressure, high cholesterol, heart or vascular complaint, paralysis or stroke? Yes No
e. disease or complaint related to kidney, bladder, lung, bowel, liver, or stomach including gastric or duodenal ulcer? Yes No
f. mental or nervous disorder including stress, anxiety or depression? Yes No
g. arthritis, rheumatism, sciatica, any neck, back, shoulder or knee problems, broken bones, a repetitive strain injury, gout, muscle or joint pains? Yes No
h. chronic fatigue syndrome or other immune disorders? Yes No
i. asthma or any lung disorder? Yes No

C. AIDS Statement

a. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No
b. Have you EVER worked as, or engaged in sexual activity with, a prostitute, or engaged in anal sexual activity? Yes No
c. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Yes No
d. Do you believe that any of your sexual partners, past or present, would answer yes to any of above 3 questions? Yes No

D. a. Do you take, or have you EVER taken, drugs, tablets or any medications on a regular basis, whether prescribed by a medical attendant or not? Yes No
b. Have you had any other medical condition not mentioned above? Yes No

E. Are you contemplating surgery, intend to consult a doctor, or have you been advised to have an operation in the future? Yes No

F. FEMALES ONLY

a. Have you ever had any complications with pregnancy or childbirth? Yes No
b. Are you currently pregnant? (If YES, please advise due date) _____/_____/_____ Yes No
c. Have you ever had an abnormal pap smear, breast ultrasound or mammogram? Yes No

For any YES above, please complete provide additional details including the date commenced, any time off work, degree of recovery, details of treatment, date of last symptom, full name and address of doctor or hospitals consulted and any other relevant information. This does not mean that insurance is not available, but we may require additional information from you to assess your application.

9. DECLARATION BY THE MEMBER OR APPLICANT

- I have read and understood the questions in this Personal Health Statement.
- I declare that the answers to the questions in this Personal Health Statement signed by me and given to Christian Super's Insurers and/or the Medical Examiner are true and correct.
- I authorise the collection, use and disclosure of my personal information for the purposes of administration and maintenance of this policy, as outlined in the Privacy Statement. I understand that the Insurers will not be able to process a claim or administer this policy without this consent.
- I accept that where my employer (or former employer) or the Trustee of Christian Super has appointed an authorised administrator, financial adviser or other intermediary to arrange and/or administer the insurance policy on their behalf, my personal information will be provided to the administrator/financial adviser/intermediary in order to undertake the management and administration of the policy.
- I declare that I have been clearly informed in writing of the general nature and effect of the duty of disclosure.
- I authorise any medical practitioner, other professional or any person named in this Personal Health Statement to verify any aspect of it, and disclose any information that they may possess about me to Christian Super's Insurers in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis, that I have received and read a copy of the current Christian Super Product Disclosure Statement (PDS).

Signature of Member/Applicant _____ Date_____/_____/_____

If you have answered YES to any question requiring further information, please ensure it is attached to this form.

10. DOCTOR'S AUTHORISATION, to be completed and signed by the applicant.

To Doctor _____ I hereby authorise you to release details of my personal medical history to Christian Super's insurers. A photocopy (or similar) of this authorisation shall be as valid as the original (attach further authorisations if more than one doctor is listed in Section 6).

My Name _____ Date of Birth _____/_____/_____

Signature of Applicant _____ Date _____/_____/_____

Address _____ State _____ Postcode _____