

Increase your insurance cover application - Part A



June 2011

When to use this form

Use this form if you are a new or existing HOSTPLUS Executive member and want to apply for, or vary your current amount of, Death only, Death and Total and Permanent Disablement (TPD) insurance cover or Salary Continuance cover.

OFFICE USE ONLY

How to use this form

To apply for or to increase your:	Complete:
Death only or Death and TPD cover, (Unit based)	Steps 1, 2, 3, 7, 8 and Increase your insurance cover application - Part B (if applicable).
Death only or Death and TPD cover, (Fixed level cover)	Steps 1, 4, 6, 7, 8 and Increase your insurance cover application - Part B (if applicable).
Death only or Death and TPD (Unit based) and Salary Continuance cover	Steps 1, 2, 3, 5, 6, 7, 8 and Increase your insurance cover application - Part B (if applicable).
Death only or Death and TPD (Fixed level cover) and Salary Continuance cover	Steps 1, 4, 5, 6, 7, 8 and Increase your insurance cover application - Part B (if applicable).
Salary Continuance cover only	Steps 1, 5, 6, 7, 8 and Increase your insurance cover application - Part B (if applicable).

For all other changes complete Step 1 and any other Steps relevant to your needs.

Note: When applying for insurance cover please keep in mind:

- If you are applying for Death and TPD cover, you must be aged between 11 and 64.
- If you are applying for Salary Continuance insurance cover you must be aged between 15 and 64.
- The insurer may ask you to provide more information than set out in this form to assist its assessment. You may also be asked to attend medical examinations or have other medical tests where necessary. If you are asked to have tests or an examination as part of your application for insurance, the insurer will pay for any medical expenses incurred.

Step 1. Member details

HOSTPLUS Executive membership number*

*Mandatory fields

Title*

 Mr Mrs Ms Miss Dr Other

Full given name*

Surname*

Date of birth*

 / /

Gender*

 Male Female

Current address*

 Suburb State Postcode

Home phone*

Mobile phone

Work phone*

Email address

I am

 Employed Self-employed Unemployed How many hours (on average) do you work per week

Occupation

Height and weight

 What is your current height in cm? What is your current weight in kg?

 Are you an Australian citizen or permanent resident? Yes No If no advise the type of working Visa you hold

Step 5. Salary Continuance insurance cover

Complete this Step to apply for Salary Continuance insurance cover.

Salary Continuance provides you with a benefit if you are unable to work as a result of injury or illness. **You have the choice of electing a Salary Continuance benefit period, of either two years or until age 65.** Refer to page 73 of the PDS for information on when a Salary Continuance benefit is payable and the cost of cover.

Put an (✓) next to the total amount of monthly Salary Continuance cover you require. If you prefer, you can nominate the number of units of cover you need in the Step after the table.

Salary*	Monthly benefit†	Units	Place ✓ here	Salary*	Monthly benefit†	Units	Place ✓ here
\$6,666	\$500	5	<input type="checkbox"/>	\$79,999	\$6,000	60	<input type="checkbox"/>
\$13,333	\$1000	10	<input type="checkbox"/>	\$93,333	\$7,000	70	<input type="checkbox"/>
\$20,000	\$1,500	15	<input type="checkbox"/>	\$106,666	\$8,000	80	<input type="checkbox"/>
\$26,666	\$2,000	20	<input type="checkbox"/>	\$120,000	\$9,000	90	<input type="checkbox"/>
\$33,333	\$2,500	25	<input type="checkbox"/>	\$133,333	\$10,000	100	<input type="checkbox"/>
\$40,000	\$3,000	30	<input type="checkbox"/>	\$199,999	\$15,000	150	<input type="checkbox"/>
\$46,480	\$3,500	35	<input type="checkbox"/>	\$266,666	\$20,000	200	<input type="checkbox"/>
\$53,120	\$4,000	40	<input type="checkbox"/>	\$333,333	\$25,000	250	<input type="checkbox"/>
\$66,666	\$5,000	50	<input type="checkbox"/>				

OR

Your annual salary:

What is your current annual gross (before-tax) salary, excluding employer super contributions? (you will be allocated the maximum number of units applicable to your salary)

OR

Nominate the number of units of Salary Continuance insurance cover you need:

 Units

Please choose your preferred waiting period:

 30 days 60 days 90 days (If no selection is made you will automatically default to 90 days)

The Waiting Period is defined as the period during which you must be totally or partially disabled before any benefit is payable. You are not entitled to any benefit for this period.

Please choose your preferred benefit period:

 2 year benefit period Benefit to age 65 (If no selection is made you will automatically default to 2 years benefit period)

*Salary is your annual gross (before-tax) salary, excluding employer super contributions.

†The maximum monthly benefit you are entitled to cannot be higher than 90% of your monthly salary (75% being paid to you and 15% to your account in HOSTPLUS Executive).

Step 6. Occupational rating

Your insurance cover will be matched to your occupational rating. The following will help us to determine which occupational rating applies to you.

Management/Clerical (white collar) scale	Light blue collar scale	Heavy blue collar scale
i) Are you employed for at least 15 hours per week on an ongoing basis? <input type="checkbox"/> Yes <input type="checkbox"/> No [^] ii) Do you work in an office or similar environment? <input type="checkbox"/> Yes <input type="checkbox"/> No [^] iii) Do you spend at least 90% of your working time in an office? For example 34.2 hours out of a 38-hour working week. <input type="checkbox"/> Yes <input type="checkbox"/> No [^] iv) Do you work in any of the following occupations? <input type="checkbox"/> Management <input type="checkbox"/> Clerical <input type="checkbox"/> Marketing <input type="checkbox"/> Administration <input type="checkbox"/> Accounting	Please select your occupation: <input type="checkbox"/> Wait Staff/Waitress/Waiter* <input type="checkbox"/> Hotel Owner/Manager/Publican/Bar attendant* <input type="checkbox"/> Chef/ Apprentice Chef/Cook <input type="checkbox"/> Room Attendant/House Keeper/Guest Service Agent/Attendant* <input type="checkbox"/> Food and Beverage Attendant* <input type="checkbox"/> Hospitality Worker* <input type="checkbox"/> Shop Assistant/Retail Assistant <input type="checkbox"/> Casino Worker/Dealer/Croupier/Gaming Attendant <input type="checkbox"/> Sales Assistant/Attendant/Consultant <input type="checkbox"/> Bottleshop Attendant* <input type="checkbox"/> Barista*	Please select your occupation: <input type="checkbox"/> Kitchen Hand/Crew <input type="checkbox"/> Cleaner (Commercial) <input type="checkbox"/> Cellar Hand <input type="checkbox"/> Security Officer/Guard (unarmed) <input type="checkbox"/> Store Person <input type="checkbox"/> Ski/Snowboard/Snow sports instructor <input type="checkbox"/> Fruit picker/Vineyard worker** <input type="checkbox"/> Gardener/Landscaper <input type="checkbox"/> Farmer/Farm Labourer <input type="checkbox"/> Labourer

* These occupations have a combination of two 'Collar' type ratings: Death and TPD = Light blue collar, Group Salary Continuance = Heavy blue collar.

** Please note that you are only eligible for Death and TPD cover.

[^] You are not eligible for the management scales, please provide your occupation below to be assessed.

If your occupation is not listed above, please specify your occupation and you will be assessed accordingly:

Occupation

Step 7. Personal statement – Part A (short questionnaire)

This Step must be completed in all circumstances.

1. Have you previously been paid, or been entitled to receive, a TPD benefit or entitled to, apply for any form of sickness, accident or disability benefit(s) from any source such as a life insurer or Workcover authority? Yes No

If yes - You may apply for Death only cover.

2. In the past 12 months have you smoked tobacco or any other substances? Yes No
3. Have you been advised by a medical practitioner to give up or reduce the amount of smoking or amount of alcohol consumed on specific medical grounds? Have you been informed that you have a medical condition as a result of your smoking or alcohol consumption? Yes No
4. Are you currently off work, or unable to perform all the duties on a permanent full-time basis, or are you receiving any form of medical treatment? Yes No
5. To the best of your knowledge have you taken more than a total of seven days off work over the past 12 months due to illness or injury (other than for colds or flu)? Yes No

At any time in your life have you ever suffered from, experienced symptoms, or been diagnosed with any of the following:

6. Rheumatic fever, vascular disorder, high blood pressure, high cholesterol, heart complaints, murmurs, palpitations or chest pain, stroke, diabetes, thyroid or glandular disorder, cancer, leukaemia, tumour or growth including breast lumps or skin lesions/moles (even if you have not seen a doctor)? Yes No
7. Back or neck pain/disorder, musculo-skeletal symptoms or any joint disorder, gout, arthritis, RSI, paralysis of any kind or chronic fatigue syndrome, epilepsy or neurological disorder, mental/nervous disorder including stress, anxiety, post traumatic stress disorder or depression? Yes No
8. Kidney, bowel, bladder, gall bladder, prostate, stomach, liver disease or disorder, hepatitis, hernia, blood disorder, sleep apnoea asthma, persistent cough or any lung complaint, any abnormality or hearing, speech or eyesight (excluding glasses or contact lenses)? Yes No
9. To the best of your knowledge are you suffering from Acquired Immune Deficiency Syndrome (AIDS), infected with HIV or carrying antibodies to HIV? Yes No

- I answered YES to one or more of the questions from 1 to 9 of the **Personal statement – Part A** (short questionnaire) and/or
- I applied for Death and/or TPD insurance cover in excess of \$1,000,000 (if less than 55 years of age or \$750,000 if 55 or over).
- I applied for Salary Continuance insurance cover in excess of \$4,000 per month sum insured.
- I applied for Salary Continuance insurance cover with a benefit period of up to age 65.
- I reduced my Salary Continuance insurance cover waiting period to either 60 or 30 days.

**If you have selected any of the above you must complete the *Increase your insurance cover application - Part B form*
Otherwise please go to Step 8 to read, sign and date the Declaration.**

Step 8. Declaration

This Step must be completed in all circumstances.

I, whose signature appears below, declare that:

- I have read and carefully considered the questions in this form, and all answers provided are true and correct (including those not in my own handwriting). I have told the insurer everything I know that could affect its decision to accept my application.
- I have read and understood the Duty of Disclosure and Non-disclosure section overleaf. I have not withheld any information that may affect the insurer's decision as to whether to accept this application. I understand that the Duty of Disclosure continues after I have completed this statement until I am notified of acceptance in writing by the trustee.
- I have read and understood the HOSTPLUS Executive privacy policy (available at hostplusexecutive.com.au). I consent to my personal information being collected and used in accordance with the policy.
- I have read the Member Guide (Product Disclosure Statement) and/or Insurance Guide dated 1 June 2011.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this form, my application will not be considered by the insurer.
- I understand that increases or changes to insurance premiums may apply and insurance deductions from my account will be adjusted.

**Don't
forget
to sign**

SIGNATURE OF APPLICANT*

Date*

 / /

*Mandatory fields

Important notice

HOSTPLUS Executive has taken out a contract of insurance with an insurer to provide the insurance benefits in the Fund. On becoming a member, you are bound by the terms and conditions of this contract of insurance.

Your duty of disclosure

You have a duty, under the Insurance Contracts Act 1984 to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance, and if so, on what terms. Your duty, however, does not require disclosure of a matter:

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

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of having entered into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time. An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum insured you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

When you have completed this form please send it to:

HOSTPLUS Executive
Locked Bag 969
Carlton South VIC 3053

or give it to your employer to send with their next contribution to the fund.
You will be sent a HOSTPLUS Executive membership card, along with any other information you have requested on the form.

Issued by Host-Plus Pty Limited ABN 79 008 634 704
Australian Financial Services Licence No. 244392
as trustee for the HOSTPLUS Superannuation Fund ABN 68 657 495 890
Registrable Superannuation Entity Licence No. L0000093
Registrable Superannuation Entity No. R1000054

5024 06/11

Increase your insurance cover application - Part B



June 2011

When to use this form

Use this form if you have been requested to complete *Increase your insurance cover application - Part B* (Full health questionnaire). You must sign and return this form with the *Increase your insurance cover application form - Part A*.

OFFICE USE ONLY

Member details

HOSTPLUS Executive membership number*

*Mandatory fields

Full given name*

Surname*

Date of birth*

Address*

Suburb

State

Postcode

Step 1. Full personal health statement – Part B (Full health questionnaire)

Please complete **ONLY** if you have answered **YES** to any questions in **Step 7: Personal statement – Part A of the Increase your insurance cover application** and/or you are applying:

- For Death or Death and TPD cover of \$1,000,001 or greater if less than 55 years of age; or
- For Death or Death and TPD cover of \$750,001 or greater if aged on or over 55 years; or
- For more than 40 units of Salary Continuance cover (equivalent to a monthly benefit of \$4,001 or greater); or
- To amend your existing Salary Continuance cover by reducing the waiting period that applies; or
- To amend your existing Salary Continuance cover by increasing the benefit period from 2 years to an 'age 65' benefit period.

Otherwise, please proceed to **Step 2 - Declaration**.

Please complete all questions in Part B below.

Height and weight

Has your weight varied by more than 10 kg (22 pounds) during the past 12 months?

 Yes No

If YES, please provide details below:

Smoking

During the past five years, have you smoked tobacco, cigars or a pipe or any other substance?

 Yes No

If YES, please state the type and quantity per day:

Alcohol

Do you consume alcohol? Yes No

If YES, please state the type and quantity per week: Beer Wine Spirits Others

Quantity per week

Have you been advised by a medical practitioner to give up or reduce the amount of alcohol consumed on specific medical grounds, or have you been informed that you have a medical condition as a result of your alcohol consumption?

 Yes No

If YES, please provide details below:

1. Have any of your near relatives (i.e. your father, mother, brothers or sisters) been diagnosed prior to age 60 with hereditary disorders such as diabetes, cancer, heart disease, mental disorder, haemophilia or Huntington's chorea?

 Yes No

If you answered 'YES' to this question, please advise the relationship, condition and age of the diagnosed:

2. Do you engage in, or intend to engage in (other than as a fare-paying passenger) any hazardous activities such as flying, motor racing, parachuting, hang gliding or diving? Yes No

If 'YES', please provide details of the activity and the frequency with which you participate in this activity, including maximum speed/height/depth:

I participate in this activity times per year.

3. Have you ever had an application for life, disability, accident or sickness insurance declined, postponed, modified or accepted on special terms (eg. exclusions or loadings)? Yes No

If YES, please provide details below:

4. Have you ever made a claim, or are any claims pending or intended for any type of accident or sickness, lump-sum total and permanent disablement, workers' compensation or personal injury insurance? Yes No

If YES, please provide details below:

5. Do you currently have or are you currently applying for Death, Total and Permanent Disablement (TPD) or Income Protection (Salary Continuance) insurance with any other superannuation fund or insurer? Yes No

If YES, please provide details below:

6. Have you ever had any of the following or, to the best of your knowledge, do you currently have any of the following:

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| (a) Ill health or disability? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (b) Asthma, sleep apnoea, bronchitis, persistent cough or any other chest or lung trouble or allergy? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (c) Heart trouble, murmur, high blood pressure, high cholesterol, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (d) Diabetes, thyroid or glandular trouble? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (e) Ulcers, bowel trouble or recurring indigestion? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (f) Epilepsy, fits or dizziness of any kind, or persistent headaches? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (g) Stress, anxiety, depression, mental or nervous disorders, Alzheimer's disease or dementia? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (h) Kidney or bladder problems, renal colic or stones, nephritis, pyelitis or cystitis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (i) Back, neck, shoulder or knee pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage, or limbs, including broken bones? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (j) Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, Chronic Fatigue Syndrome (Myalgic Encephalomyelitis)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (k) Cancer, tumour, cyst, growths of any kind, or breast lumps (even if you have not seen a doctor)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (l) Varicose veins, hernia or skin trouble? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (m) Any abnormality affecting eyesight, hearing, speech or physical mobility? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (n) Anaemia, haemophilia or any other disease of the blood? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (o) Bowel, liver, or gall bladder disease or hepatitis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (p) Any other disease or condition or relevant symptoms lasting more than four weeks or of an ongoing nature? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (q) Coughing of blood or passing of blood from the bowel or in the urine? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (r) Are you currently receiving or considering receiving medical attention, or taking prescribed drugs (other than for contraceptive purposes)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (s) Have you ever had any test for HIV (Human Immunodeficiency Virus) other than as a direct requirement of your employment, residency, pregnancy, being a blood donor or an application for insurance? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (t) i) Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| ii) Have you EVER worked as, or engaged in, sexual activity with a prostitute; or engaged in anal sexual activity? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| iii) Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

7. Question 7 is for females only.

(a) Are you currently pregnant? D D / M M / Y Y Yes No

If YES, please provide the due date

(b) Have you had any complications with pregnancy or childbirth? Yes No

If YES, please provide details:

(c) Have you ever had an abnormal pap smear, breast ultrasound or mammogram? Yes No

If YES, please provide detail

8. (a) Usual doctor or medical centre details:

Full name of usual doctor

Full name of medical centre

Telephone number:

Address of doctor:

Suburb

State

Postcode

Reasons for last consultation:

Date of last consultation:

Outcome:

(b) If you have more than one usual doctor, please provide details of additional doctors below:

Full name of usual doctor

Full name of medical centre

Telephone number:

Address of doctor:

Suburb

State

Postcode

Reasons for last consultation:

Date of last consultation:

Outcome:

Details of Full personal health statement questions

Please complete this Step if you answered YES to any questions from 1 to 7 in Step 1: Full personal health statement – Part B. If not, please proceed to Step 2 - Declaration. NOTE: If you answered YES to more than two questions, please photocopy this page, complete this Step, and attach the pages to your application.

1. Which question in Part B did you answer YES to?

Please advise if illness, injury or test:

Main symptoms/causes:

Date commenced:

Time off work:

Please tick YES or No boxes for each of the following questions:

Has the condition recurred?

 Yes No

If YES, state date range:

to

If NO, please provide degree of recovery:

 %

Full details of treatment:

Date of last symptom:

Further treatment recommended:

/ / /

Yes No

If YES, please give details:

Full name and address of doctor or hospital consulted:

Does your usual doctor have details of this condition?

Yes No

Other information:

2. Which question in Part B did you answer YES to?

Please advise if illness, injury or test:

Main symptoms/causes:

Date commenced:

Time off work:

/ / /

Please tick YES or No boxes for each of the following questions:

Has the condition recurred?

Yes No

If YES, state date range:

/ / /

to

/ / /

If NO, please provide degree of recovery:

%

Full details of treatment:

Date of last symptom:

Further treatment recommended:

/ / /

Yes No

If YES, please give details:

Full name and address of doctor or hospital consulted:

Does your usual doctor have details of this condition?

Yes No

Other information:

Step 2. Declaration

This Step must be completed in all circumstances.

I, whose signature appears below, declare that:

- I have read and carefully considered the questions in this form, and all answers provided are true and correct (including those not in my own handwriting). I have told the insurer everything I know that could affect its decision to accept my application.
- I have read and understood the Duty of Disclosure and Non-disclosure section overleaf. I have not withheld any information that may affect the insurer's decision as to whether to accept this application. I understand that the Duty of Disclosure continues after I have completed this statement until I am notified of acceptance in writing by the trustee.
- I have read and understood the HOSTPLUS Executive privacy policy (available at hostplusexecutive.com.au). I consent to my personal information being collected and used in accordance with the policy.
- I have read the Member Guide (Product Disclosure Statement) and/or Insurance Guide dated 1 June 2011.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this form, my application will not be considered by the insurer.
- I understand that increases or changes to insurance premiums may apply and insurance deductions from my account will be adjusted.

Don't forget to sign

SIGNATURE OF APPLICANT*

Date*

/ / /

*Mandatory fields

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Your duty of disclosure

You have a duty, under the Insurance Contracts Act 1984 to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance, and if so, on what terms. Your duty, however, does not require disclosure of a matter:

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

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of having entered into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time. An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum insured you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

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You will be sent a HOSTPLUS Executive membership card, along with any other information you have requested on the form.

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