Increase your cover above the automatic limits

Use this form if you're a member of AustralianSuper Select and you want to increase your basic (salary-based) cover amount above the automatic limits. Please complete in pen using CAPITAL letters. Print (✗) to mark boxes where applicable.

AustralianSuper insurance is provided by TAL Life Limited (the Insurer), ABN 70 050 109 450, AFSL 237848.

Your application is subject to consideration by the Insurer. Go to **australiansuper.com/ChangingCover** to understand how the Insurer considers your application.

Prefer online?
Log into your account and go to *Insurance, Manage insurance* and then *Change cover.* Select the *Change your cover* application and look for the *Increase above AL* option when changing your basic (salary-based) cover.

1 Personal details

Last name

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

First name/s

Date of birth (D D M M Y Y Y Y)

Member number

Male ☐ Female ☐

Street address

Suburb

State

Postcode

Telephone (business hours)

Telephone (after hours)

Mobile

While processing your application, the Insurer may ask you to complete specific questionnaires regarding your health. If you would like us to email you any required questionnaires, please provide your email address below.

Email

Provide your salary and occupation to apply for more cover.

Annual (before-tax) salary, excluding Superannuation Guarantee contributions[1]. $ ☐,☐☐☐,☐☐☐.00

Main occupation/Job title

How many hours do you work in a typical week? ☐ hours a week

[1] Your AustralianSuper Select employer may have arranged a tailored definition of salary, check the AustralianSuper Select booklet for your employer at **australiansuper.com/select**

2 Increase your basic cover

You can only increase the basic (salary-based) cover type(s) that have reached the automatic limits using this application. Check which cover type(s) this applies to in the *Changes to your basic (salary-based) insurance cover* letter we recently sent you.

If your employer pays for your basic cover, they'll still pay for it if you increase your basic cover above the automatic limit using this form.

If you want to change your extra (fixed) cover, fixed cover, Income Protection waiting period and/or benefit payment period, please complete the *Change your insurance* form for AustralianSuper Select at **australiansuper.com/select**

Put an (✗) next to each type of basic (salary-based) cover you want to increase above the automatic limits.

☐ Death ☐ Total & Permanent Disablement (TPD) ☐ Income Protection (if applicable)[2]

[2] Your employer may have set up basic Income Protection for you. For specific details of the basic cover arranged for you by your employer, see the AustralianSuper Select booklet for your employer at **australiansuper.com/select**

3 Duty to take Reasonable Care and Medical eligibility

The duty to take reasonable care

When you apply for insurance, you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

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

If you do not meet your legal duty, this can have serious impacts on your insurance. Under the Insurance Contracts Act 1984 (Cth) there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it would have been in if the duty had been met. For example, the Insurer may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including:

- whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances;
- what the Insurer would have done if the duty had been met – for example, whether it would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

Guidance for answering the questions in this form

You are responsible for the information provided to the Insurer. When answering questions, please:

- Think carefully about each question before you answer. 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 before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Please note that there may be circumstances where the Insurer later investigates whether the information given to it was true. For example, it may do this when a claim is made.

Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances. As any changes might require further assessment or investigation, it could save time if you let us or the Insurer know about any changes when they happen.

If you need help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know 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.

Check your medical eligibility for increased cover

You're not eligible to apply for increased cover if you:

- are awaiting investigation for any symptoms, lump, tumour or growth which could include a biopsy, gastroscopy, colonoscopy, or endoscopy, or
- have to have surgery other than on your arm, hand, joint, or leg.

You may be able to re-apply if your circumstances change. Any insurance cover and costs you already have will remain unchanged. If you have any questions or disagree with this outcome, please contact the Insurer on 1300 302 961 or send an email to **aussuper@tal.com.au**

4 Health questions

To increase your basic (salary-based) cover above the automatic limits please complete this section.

1. Have you ever had an application for Life, Total & Permanent Disablement, Trauma, Income Protection or Salary Continuance insurance declined, or have you been accepted with varied terms from what you had applied for, such as loadings (extra costs) or exclusions (events or circumstances that you will not be covered for) or a restriction (an amount less than what you applied for)? Yes ☐ No ☐

Insurance company name	Date	Terms offered and reason

4 Health questions (continued)

2. Due to illness or injury, are you claiming or have you ever claimed a benefit from any source, such as superannuation, workers' compensation, a disability pension, Veterans' Affairs or any other insurance providing accident or illness benefits? Yes ☐ No ☐

   If **Yes** please provide details below.

   Benefit type/source/reason for claim

   Claim date D D M M Y Y Y Y | Claim amount $ ☐☐☐,☐☐☐ | Date claim finalised D D M M Y Y Y Y

   Benefit type/source/reason for claim

   Claim Date D D M M Y Y Y Y | Claim amount $ ☐☐☐,☐☐☐ | Date claim finalised D D M M Y Y Y Y

3. What's your height and current weight (to the nearest centimetre and kilogram)? Height (cm) ☐☐☐ Weight (kg) ☐☐☐

If you answer **Yes** to questions 4 to 8 below, you'll also need to complete a general health questionnaire in **section 9**.

4. Have you ever received medical advice or had any investigations or treatment (including surgery) for any of the following conditions:
   a) Chest pain, high blood pressure, raised cholesterol or any heart/circulatory disorder? Yes ☐ No ☐
   b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? Yes ☐ No ☐
   c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, urinary bladder, prostate, ovaries or uterus? Yes ☐ No ☐
   d) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? Yes ☐ No ☐
   e) Cancer, tumour, melanoma, sunspot, mole or malignant growth of any kind? Yes ☐ No ☐
   f) Drug dependence or overuse (either prescribed or non-prescribed), or alcohol dependence or overuse? Yes ☐ No ☐
   g) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)? Yes ☐ No ☐
   h) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery), or impaired speech or hearing (including tinnitus)? Yes ☐ No ☐
   i) The Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes ☐ No ☐
5. **Apart from any condition already disclosed**, have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives and treatment for hay fever, hair loss and acne)? Yes ☐ No ☐
6. **Apart from any condition already disclosed**, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms? Yes ☐ No ☐
7. **Apart from any condition already disclosed**, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours a week), even if your actual employment is on a part-time or casual basis? Yes ☐ No ☐
8. **Apart from any condition already disclosed**, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last three years? Yes ☐ No ☐

If you answer **Yes** to question 9 below, you'll also need to complete a specific health questionnaire in **section 10**.

9. Have you ever received medical advice or had any investigations or treatment (including surgery) for any of the following conditions:
   a) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? Yes ☐ No ☐
   b) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? Yes ☐ No ☐

5 Doctor details

To continue the assessment of your application, the Insurer may need to contact your usual doctor for more information. Please provide your usual doctor's name and contact details below.

If you don't know your doctor's details, you can leave this section blank. If the Insurer needs more information, they'll use the details you've provided in section 1 to contact you.

Full name of doctor or medical centre

Street address

Suburb

State

Postcode

Telephone

Fax number

Part Two: Detailed Health Statement

The Insurer may require medical evidence based on your age, amount of cover or health history. This may involve a medical exam or test which the Insurer will pay for.

Complete the next **three sections (6, 7 and 8)** if you answer **Yes** to any of the questions below:

Will your total cover (existing plus additional) exceed $800,000 for Death or TPD cover if this application is accepted? Check the *Changes to your basic (salary-based) insurance cover* letter we recently sent for your Estimated cover amount. Yes ☐ No ☐

Will your total cover (existing plus additional) exceed $10,000 a month for Income Protection if this application is accepted? Check the *Changes to your basic (salary-based) insurance cover* letter we recently sent for your Estimated cover amount. Yes ☐ No ☐

If you answer No to all of the above questions, please read, then sign and date the Authorisation, declaration and acknowledgement in section 11.

If you answered **Yes** to certain questions in section 4, you'll also need to complete the health questionnaires in section 9 and/or 10. Go to section 4 to check.

6 Activities and pastime details

Do you currently engage in or intend to engage in any pastime and/or sport that may increase the likelihood of injury or illness compared to others not involved in such activity(ies)? For example:

- Underwater diving
- Football, rugby, soccer
- Horse/equestrian sports
- Martial arts, combat sports
- Competitive road cycling, mountain bike riding
- Mountaineering, outdoor rock climbing or abseiling
- Hang gliding, paragliding, skydiving, parachuting
- Competitive surfing, water or snow skiing/boarding
- Motor sports (excluding using motorcycle/vehicle for commuting purpose)
- Flying as a pilot, crew or passenger in an aircraft/vessel (other than travel with a major commercial airline). Yes ☐ No ☐

If **Yes**, provide further details below:

What are the activities you engage in?

At what level do you participate?

☐ Recreational only (non-competition) ☐ Recreational with competition ☐ Semi-professional/professional

Number of times you participate on average in these activities a year (for example hours flown, number of drives, events)

Do you receive any income from participating in these activities? Yes ☐ No ☐

Maximum depth (metres) or speed (kms) reached (if applicable)

7 Personal health details

1. Have you smoked, vaped, used tobacco or nicotine replacement products in the last 12 months? Yes ☐ No ☐

   If **No**, go to question 2.

   If **Yes**, please advise substances smoked or vaped, frequency of use, date first smoked or vaped and when last smoked or vaped.

Substance smoked	Frequency	Date first smoked	Date last smoked
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y

2. In the last five years have you smoked or vaped any substance other than tobacco or nicotine products? Yes ☐ No ☐

   If **Yes**, please advise substances smoked or vaped, frequency of use, date first smoked or vaped and when last smoked or vaped.

Substance smoked	Frequency	Date first smoked	Date last smoked
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y

3. Do you drink alcohol? Yes ☐ No ☐

   3.1 If **Yes**, what is the most number of standard drinks that you would drink in a day? ☐☐

   Note: One standard drink is: 1 glass of wine, 1 full-strength beer, 1 nip of spirits

   Please round to the nearest whole number. If between 0 and 1, please enter 1.

   3.2 How often would you drink this amount?

   3.3 How many standard drinks do you have per day on average? ☐☐☐

8 Family history

Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 65: heart disease (e.g. angina, heart attack, cardiomyopathy), cancer (i.e. prostate, breast, bowel, ovaries), diabetes, neurological condition (i.e. Alzheimer's disease, motor neurone disease, multiple sclerosis, Parkinson's disease, stroke), Huntington's disease, polycystic kidney disease, muscular dystrophy, blood disorder (i.e. bleeding problem, thalassaemia, sickle cell disease), or any other medical condition (which a medical practitioner indicated may be inherited)?

If family history is unknown, answer No.

☐ No ☐ Yes – complete the following table

Relationship to member	Condition (e.g. Type 2 diabetes, breast cancer)	Approximate age of onset	Age at death (if applicable)

9 General health questionnaire

If you have answered **Yes** to questions 4 to 8 in **section 4**, please complete the table below.
Please ensure you write the question number in the box above each column.

	Question number	Question number	Question number
1. Name of condition			
2. Date symptoms first started	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
3. Date symptoms ceased (if ongoing please state)	D D M M Y Y Y Y Yes ☐ No ☐	D D M M Y Y Y Y Yes ☐ No ☐	D D M M Y Y Y Y Yes ☐ No ☐
4. How often do/did you have symptoms? Please choose one of the following **daily, weekly, monthly, quarterly, half-yearly, yearly, one-off, other**.			
5. Severity of condition Please choose from one of the following **mild, moderate, severe, never had symptoms, symptoms ceased**.			
6. Did you take medication or have you had any other treatment (ie physiotherapy or an operation) for this condition? If **Yes**, name the treatment:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Are you still on treatment, including medication?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Have you ever been off work due to this condition? Details (if there is insufficient space please attach an additional sheet) If **Yes**, please state the total time off work: Date from: Date to:	Yes ☐ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y	Yes ☐ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y	Yes ☐ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y
9. Have you had any residual, ongoing effects or restrictions as a result of this condition? If **Yes**, please provide details and dates: Date from: Date to:	Yes ☐ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y	Yes ☒ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y	Yes ☐ No ☐ D D M M Y Y Y Y D D M M Y Y Y Y
10. Is your treating doctor different from your usual doctor? If **Yes**, please provide doctor's details:	Yes ☐ No ☐ Full name of doctor Address (street/state/postcode) Phone and fax number	Yes ☐ No ☐ Full name of doctor Address (street/state/postcode) Phone and fax number	Yes ☐ No ☐ Full name of doctor Address (street/state/postcode) Phone and fax number

10 Specific health questionnaire

Please complete the relevant questionnaire below if you've answered **Yes** to question 9 in **section 4**.

A. Asthma and bronchitis or any other lung complaint questionnaire

a) Name of condition

b) Have you been diagnosed within the last 12 months? Yes ☐ No ☐

c) Frequency of symptoms in the last five years:

- Daily ☐
- Weekly ☐
- Occasionally ☐
- One-off episode ☐
- None – childhood only ☐

d) Severity of symptoms in the last five years:

- Nil symptoms – childhood only ☐
- Mild ie exercise-induced only, seasonal (related to hay fever allergy, colds or flu) ☐
- Moderate (ie all year round, specific triggers) ☐
- Severe (ie constant, reduced lung capacity, restriction of lifestyle or work duties) ☐

e) Have you required over the last five years:

- Daily preventative inhalers, such as ventolin Yes ☐ No ☐
- Occasional use of a nebuliser or oral steroid medication eg prednisolone Yes ☐ No ☐
- Hospitalisation/emergency treatment Yes ☐ No ☐

f) Maximum number of consecutive days off work/school you've had over the last two years due to this condition:

Number of days

g) Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If **Yes**, please complete details below:

Full name of doctor

Street address

Suburb State Postcode

Phone number

Fax number

B. Joint/musculoskeletal questionnaire

If applying for Death cover only complete questions a) and b) only.

If applying for TPD cover or Income Protection, complete all questions.

a) Nature of complaint (doctor's diagnosis), ie sciatica, back pain, broken bone

b) Location of complaint, eg lower back, right knee, sciatic nerve

c) When did symptoms first begin? D D M M Y Y

d) Cause of condition, eg lifting, car accident, fall in workplace, unknown

e) Was an x-ray or scan taken?

No ☐ Go to question f)

Yes ☐ Complete below

Date of x-ray/scan taken D D M M Y Y

Details of results of x-ray/scan taken

f) Is the nature of the condition degenerative or a disc problem? Yes ☐ No ☐

g) Are you still undergoing treatment or experiencing symptoms? Yes ☐ No ☐

If **No**, complete below:

Date symptoms ceased D D M M Y Y

Date treatment ceased D D M M Y Y

h) Have you ever been off work as a result of this complaint or been unable to perform your normal day-to-day activities? Yes ☐ No ☐

If **Yes**, please indicate period/s off work:

Date from D D M M Y Y Date to D D M M Y Y

i) Do you have any residual, ongoing effects or restrictions as a result of this condition? Yes ☐ No ☐

If **Yes**, please provide dates and details

j) Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If **Yes**, complete below:

Full name of doctor

Street address

Suburb State Postcode

Phone number

Fax number

11 Authorisation, declaration and acknowledgement

This section must be completed in all circumstances.

I authorise:

- The Insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers).
- The Insurer and any person appointed by the Insurer to obtain relevant information on my financial history from the Insurance Reference Association and any other body holding information on me.

I declare that:

- I've read and understood the information on this application form, including the Duty to take reasonable care. I understand that the answers I've provided, together with any special conditions will form the basis of the Insurer's decision.
- The answers I've provided are true, complete and correct.
- I've read and understood the *AustralianSuper Select Product Disclosure Statement,* the AustralianSuper Select booklet for my employer and the *Insurance in your super* guide for AustralianSuper Select members at **australiansuper.com/select** and understand that the additional information referred to in the booklet and guide is also part of the Product Disclosure Statement.

I acknowledge that:

- My eligibility to claim for benefits will be determined in line with AustralianSuper's insurance policy terms and conditions.
- Insurance cover will only be provided in line with the insurance policy terms and conditions as agreed between AustralianSuper and the Insurer. Those terms and conditions may change from time to time and AustralianSuper will notify me of those changes where required by law.
- AustralianSuper will only make changes to the cover I've applied to increase on this application (subject to the Insurer accepting my application where applicable).
- Any increase in cover that's been accepted by the Insurer will start from the date the change is accepted by the Insurer.
- A photocopy of this authorisation is as valid as the original.

Sign here

Date D D M M Y Y Y Y

Print full name

A summary of AustralianSuper's Privacy Collection Statement is on page 1. Our Privacy Collection Statement and Privacy Policy may change from time to time. The latest versions will be available online at **australiansuper.com/CollectionStatement** and **australiansuper.com/privacy-policy**

For information on the Insurer's privacy and information handling practices, read their Privacy Policy Statement at **tal.com.au/privacy** or call **1300 302 961** for a copy.

Privacy Collection Statement

AustralianSuper Pty Ltd (ABN 94 006 457 987) of GPO Box 1901, Melbourne, Victoria 3001, collects your personal information (PI), including health information (if applicable) to assess, administer, manage and keep you updated on your insurance cover application or insurance claim and improve our products and services. If we can't collect your PI we may not be able to provide these services. PI is collected from you but sometimes from third parties like your employer. Health information is collected (if applicable) from you or your employer, adviser, other insurer or reinsurer, or other representative authorised by you and is provided to us, our administrator or to our insurers. If required, we or the Insurer will obtain independent medical reports directly from your medical practitioner(s). We will only share your PI where necessary to perform the above listed activities with the Insurer (TAL Life Limited (ABN 70 050 109 450, AFSL 237848) or other relevant insurer for certain insurance claims, our administrator (Australian Administration Services Pty Ltd, being a part of MUFG Pension & Market Services Holdings Ltd), our contact centre provider (Concentrix Services Pty Ltd), service providers, as required by law or court/tribunal order, or with your permission. Our Privacy Policy details how to access and change your PI, as well as the privacy complaints process. For complete details go to **australiansuper.com/privacy-policy** or call us on **1300 300 273**.

Please email this completed form to: **as.select@australiansuper.com**
or post it to **AustralianSuper, GPO Box 1901, MELBOURNE VIC 3001**
Questions? Call **1300 300 273** or visit **australiansuper.com**