Member's personal statement

Information sheet

When to use this form

Use this form to apply for changes to the insurance cover in your SignatureSuper® account. You can apply for:

- new or additional insurance cover, or
- an increase to existing insurance cover.

Before completing this form, please read your **insurance guide** to understand the insurance cover and options available to you.

Your duty to take reasonable care

When you apply for insurance with TAL (the insurer), 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 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.

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.

F008_06 February 2025
Issued by N.M. Superannuation Pty Ltd ABN 31 008 428 322 (trustee), which is part of the AMP group (AMP).
The insurer of this plan is TAL Life Limited (TAL) ABN 70 050 109 450 AFSL No. 237848 (insurer).

Privacy information

The privacy of your personal information is important to us.

We may collect personal information directly from you or from anyone you have authorised. We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

The primary purpose for obtaining the information requested in this form (the information) is for the insurer to assess your application for insurance. The insurer may also use the information for directly related purposes—for example: deciding whether more information is needed, arranging reinsurance, assessing further applications, assessing and processing claims, and managing any policy which covers you (including group insurance plans). If the information you give us is not complete or accurate the insurer may not be able to provide you with the insurance you have applied for.

In addition to the insurer, the information may also be disclosed to:

- the trustee of your plan (if applicable)
- other members of the AMP group (including other insurers for their use in assessing any application by you for insurance and assessing any claim that might arise under insurance provided by them)
- the financial adviser or broker responsible for the account or employer plan
- your parent or guardian, if you are under 18
- your employer (if you are part of an employer-sponsored plan) only to the extent necessary to process any claim you make
- the administrator of your plan
- the insurer's reinsurers
- medical practitioners
- any person the insurer considers necessary to help either assess claims or resolve complaints, and
- anyone you have authorised or if required by law.

Some of these parties may be located overseas. A list of countries where they are likely to be located is contained in the AMP **privacy policy**.

Under the current AMP privacy policy, you may access personal information about you held by the AMP group.

The AMP privacy policy sets out the AMP group's policy on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy and information about how AMP deals with such complaints. You may obtain a copy by contacting us on 131 267 or visiting our website at **amp.com.au/privacy**.

The TAL privacy policy is available at **tal.com.au/privacy-policy** or call 1800 666 136 for a copy.

Please keep this information sheet for your records—don't return it with your completed form(s).

Member's personal statement

Use this form to apply for changes to the insurance cover in your SignatureSuper® account. You can apply for:

- new or additional insurance cover, or
- an increase to existing insurance cover.

Before completing this form, please read your **insurance guide** to understand the insurance cover and options available to you.

Use this form to apply for the following insurance cover types:

- Death
- Total and Permanent Disablement (TPD), and/or
- Income Protection (IP).

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

1. Personal details

Title

Date of birth D D M M Y Y Y Y

Surname

Given name(s)

Gender

☐ Male ☐ Female

Residential address

Suburb State Postcode

Preferred contact details

The insurer may contact you directly to clarify or gather information about this application.

What's your preferred method of contact:

Contact phone number Mobile number

Email address[1]

1 Please make sure you provide your personal email address because the insurer may send you information of a sensitive/personal nature.

2. Insurance cover

What type of cover would you like?

Please refer to your **welcome letter** and **insurance guide** for details on the type of cover (number of units/your plan's maximum cover amount) available to you.

Units of insurance cover

What total number of units of standard cover would you like to apply for (including your current cover)?

2. Insurance cover continued

Units of insurance cover continued

Units

Note: The maximum is:

- 99 times the standard cover, or
- your plan's maximum number of units.

What type of insurance cover are you applying for:

☐ Death only

☐ Death and TPD

> Large amounts of insurance cover may erode retirement income. Please speak to your financial adviser about the level of insurance cover that's appropriate for your needs.

Nominated insurance cover

☐ **Death:**

Existing sum insured $

Additional sum insured $

New total sum insured $

☐ **Total and Permanent Disablement (TPD):**

Existing sum insured $

Additional sum insured $

New total sum insured $

☐ **Income Protection (IP):**

IP cover is limited to a maximum of 75% of salary

Existing monthly benefit $

Additional monthly benefit $

New total monthly benefit $

2. Insurance cover continued

Nominated insurance cover continued

Please refer to your **insurance guide** for the waiting period and benefit period options available to you.

Choose the waiting period (select **one** only):

☐ 30 days ☐ 60 days ☐ 90 days
☐ 180 days ☐ 720 days

Choose the benefit period (select **one** only):

☐ 2 years ☐ 5 years ☐ To age 65

Complete the following if you want to make changes to the Superannuation Contribution benefit (SCB) on your account.

☐ **Add/include SCB** **Percentage:** %
☐ **No change**

Note: The percentage is only required where your plan allows you to select a percentage above the default. Refer to your **welcome letter** and **insurance guide** for details.

The percentage nominated is limited to your actual super contribution percentage at the time of application but not more than 15%.

3. Your occupation and income details

Please provide the following details:

1. Are you:
   ☐ Self-employed ☐ Full-time employee ☐ Part-time employee
   a. Hours worked per week:
   b. Weeks worked per year:
2. Occupation name:
3. Industry
4. Duties performed including percentage (%) of time in each:
5. Annual income before tax: $

4. Your insurance and claim history

1. Apart from this application, do you have or are you applying for any other Life, TPD or IP insurance? (Please include cover held and/or applied for through the insurer or under super).
   Note: Please use a separate sheet (and attach it to this form) to provide more details if you have more than one other insurance policy to declare.
   ☐ No
   ☐ Yes—provide the details below:

4. Your insurance and claim history continued

Name of company

Cover type: Sum insured/monthly benefit: $

State any loadings/exclusions:

Is the cover to be replaced?

☐ No ☐ Yes

2. Are you claiming or have you ever claimed a benefit from any source eg TPD benefit from any super fund, workers' compensation, disability pension, Veterans' Affairs or any other insurance cover providing accident or illness benefits?
   ☐ No
   ☐ Yes—provide the details below:

   Name of company

   Cover type: Sum insured/monthly benefit: $

   Claim date: D D M M Y Y Y Y

   State any loadings/exclusions:

   Reason for claim:

   Duration of claim:

3. Has an application for life, disability, trauma, accident or illness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?
   ☐ No
   ☐ Yes—provide the details below:

   Name of company

   Cover type: Sum insured/monthly benefit: $

   Application date: D D M M Y Y Y Y

   State any loadings/exclusions:

   Reason for decision:

5. Insurance in super election

☐ Cross this box for insurance cover to be provided and kept within your super account, even if:

- you're under age 25, or
- your super account balance is below $6,000, or
- your super account doesn't receive a contribution or rollover for 16 months.

Important details about insurance in super and how the super laws could affect your insurance are available at **amp.com.au/insuranceinsidesuper.**

6. Your habits and activities

1. Do you drink alcohol?
   - ☐ No
   - ☐ Yes—provide the details below:

     Alcohol type:

     Number of standard drinks[1] per day:

     Number of days per week when alcohol is consumed:

     1. A standard drink = 1 nip spirits, 1 x 100ml glass of wine, 1 x 10oz/285ml of beer.

2. Have you smoked in the past 12 months?
   - ☐ No
   - ☐ Yes—provide the details below:

     Type:

     Daily quantity:

3. In the last 5 years have you smoked any substance other than tobacco?
   - ☐ No
   - ☐ Yes—provide the details below:

     Substances smoked:

     Frequency of use

     Date first smoked: D D M M Y Y Y Y

     Date last smoked: D D M M Y Y Y Y

4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing?
   - ☐ No
   - ☐ Yes—state the activity/ies performed, frequency of participation, level of participation (eg, amateur or professional), maximum depth/speed, equipment used and location (if applicable):

6. Your habits and activities continued

5. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months?
   - ☐ No
   - ☐ Yes—state where, when, the duration and reason:

6. Are you an Australian citizen, a New Zealand citizen residing in Australia, a holder of an Australian permanent visa or a person who resides in Australia on an approved working visa?
   - ☐ Yes
   - ☐ No—state the type of visa you hold, expiry date, plans for applying for permanent residency and nationality/current citizenship:

7. Your medical details

Please provide your medical details below.

Note: The insurer may ask you for your consent if further medical information is needed from your health provider/s.

1. Please provide your:

   Height: cm Weight: kg

2. Please provide the name and address of your usual doctor or medical centre:

   Doctor's last name

   Doctor's given name

   Doctor's address

   Suburb State Postcode

3. Please provide details of your last medical consultation with your usual doctor or medical centre:

   Date of last consultation: D D M M Y Y Y Y

   Reason for consultation

   Consultation outcome/results:

7. Your medical details continued

4. If you've attended that doctor for less than 12 months, please provide the name and address of your previous doctor:

Doctor's last name

Doctor's given name

Doctor's address

Suburb | State | Postcode

8. Your 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 (eg, angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, Huntington's disease or any other inherited blood or neurological disorder?

☐ No

☐ Yes—provide details below (you can complete this for more than one family member):

Relationship to member 1

Medical condition (eg breast cancer, heart attack, type 2 diabetes)

Age when diagnosed | Age at death (if applicable)

Relationship to member 2

Medical condition (eg breast cancer, heart attack, type 2 diabetes)

Age when diagnosed | Age at death (if applicable)

Relationship to member 3

Medical condition (eg breast cancer, heart attack, type 2 diabetes)

Age when diagnosed | Age at death (if applicable)

Relationship to member 4

Medical condition (eg breast cancer, heart attack, type 2 diabetes)

Age when diagnosed | Age at death (if applicable)

9. Your medical history

If you answer 'yes' to any of the questions below, please provide the details to these questions in section **10. General medical questionnaire**.

1. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?

   a. Chest pain, high blood pressure, raised cholesterol or any heart / circulatory disorder?
   ☐ No ☐ Yes

   b. Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition?
   ☐ No ☐ Yes

   c. Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder?
   ☐ No ☐ Yes

   d. Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)?
   ☐ No ☐ Yes

   e. Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout?
   ☐ No ☐ Yes

   f. Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition?
   ☐ No ☐ Yes

   g. Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind?
   ☐ No ☐ Yes

   h. Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse?
   ☐ No ☐ Yes

   i. 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)?
   ☐ No ☐ Yes

   j. 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 hearing or tinnitus?
   ☐ No ☐ Yes

2. Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)?
   ☐ No ☐ Yes

3. Apart from treating 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)?
   ☐ No ☐ Yes

9. Your medical history continued

4. 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?
   ☐ No ☐ Yes
5. 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 per week), even if your actual employment is on part-time or casual basis?
   ☐ No ☐ Yes
6. 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 3 years?
   ☐ No ☐ Yes

10. General medical questionnaire

If you've answered 'yes' to any questions in section **9. Your medical history**, please enter the question references and provide the relevant details below.

Note: Please provide details on a separate sheet if you need to provide more information.

Enter question number reference:

1. Date symptoms first started:
   D D M M Y Y Y Y
   Description of symptoms
2. What was the condition and which part and side of the body was affected (if applicable)?
3. What was the medical diagnosis including results of x-rays and investigations?
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?

10. General medical questionnaire continued

6. How long were you unable to work or perform your normal duties/activities?
7. If a hospital visit was required, please provide date:
   D D M M Y Y Y Y
   Duration of your stay
8. What advice/treatment did you receive?
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.
10. Date treatment medication ceased (if applicable).
    D D M M Y Y Y Y
11. When did you last suffer from any symptoms?
12. Degree of recovery (%)?

Enter question number reference:

1. Date symptoms first started:
   D D M M Y Y Y Y
   Description of symptoms
2. What was the condition and which part and side of the body was affected (if applicable)?
3. What was the medical diagnosis including results of x-rays and investigations?
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?

10. General medical questionnaire continued

6. How long were you unable to work or perform your normal duties/activities?

7. If a hospital visit was required, please provide date:

   D D M M Y Y Y Y

   Duration of your stay

8. What advice/treatment did you receive?

9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.

10. Date treatment medication ceased (if applicable).

    D D M M Y Y Y Y

11. When did you last suffer from any symptoms?

12. Degree of recovery (%)?

Enter question number reference:

1. Date symptoms first started:

   D D M M Y Y Y Y

   Description of symptoms

2. What was the condition and which part and side of the body was affected (if applicable)?

3. What was the medical diagnosis including results of x-rays and investigations?

4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?

10. General medical questionnaire continued

5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?

6. How long were you unable to work or perform your normal duties/activities?

7. If a hospital visit was required, please provide date:

   D D M M Y Y Y Y

   Duration of your stay

8. What advice/treatment did you receive?

9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.

10. Date treatment medication ceased (if applicable).

    D D M M Y Y Y Y

11. When did you last suffer from any symptoms?

12. Degree of recovery (%)?

11. Acknowledgement and declaration

I acknowledge and declare that:

- I've received the SignatureSuper **product disclosure statement** and the relevant **insurance guide** and I understand that these are important documents that I should consider before deciding to apply for new or altered insurance cover.
- I've read the **duty to take reasonable care** as set out in the attached information sheet and understand that this applies to any information I provide to the insurer in connection with my application for insurance.
- The answers I've provided in this **member's personal statement** (and any other forms, questionnaires and information provided to the insurer) are true, accurate and complete to the best of my knowledge.
- The insurer will rely on the answers and information I've provided in my application for insurance. I understand that, notwithstanding any authorities which may be provided to the insurer, the insurer will not necessarily seek or obtain any further information in relation to my application.

11. Acknowledgement and declaration continued

– By signing this form, I consent to the collection, use and disclosure of my personal information (including financial and medical reports and tests) in accordance with AMP's and the insurer's privacy policies.

Member name

Member signature

X

Date

D	D	M	M	Y	Y	Y	Y

Where to send this form

Mail or email this completed form (and any attachments) to:

AMP Limited
PO Box 6346
WETHERILL PARK NSW 1851

ampsuper@amp.com.au

Any questions?
131 267

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