LOCAL GOVERNMENT SUPER

Voluntary insurance cover

This form is for members of the LGS Accumulation Scheme

Use this form if you want to apply for or increase your voluntary insurance cover. For your application to be considered, you must complete all sections of this form.

Please use a black pen and CAPITAL letters or type directly into this form online, print it and send it to us. Use (✖) to mark boxes.

Before completing this form, please ensure you read the relevant Product Disclosure Statement (PDS) available at lgsuper.com.au/PDS

1. Your details

Member no. ☐☐☐☐☐☐☐☐☐ Date of birth DD/MM/YYYY Title eg. Mr

Given name/s

Family name

Email address

Phone (home) Phone (work)

Phone (mob)

Postal address

No./Street

Suburb/Town State/Territory ☐☐☐ Postcode ☐☐☐☐

Residential address ☐ **select if same as postal address above**

No./Street

Suburb/Town State/Territory ☐☐☐ Postcode ☐☐☐☐

These amounts must be multiples of $1,000 with a minimum of $50,000. There is no maximum for Death cover, however there is a maximum of $3,000,000 for Total and Permanent Disablement.

Cover is available in multiples of $100 with a minimum cover of $1,000 per month. The highest cover you can apply for is $25,000 per month with a waiting period of either 30, 60 or 90 days. This monthly benefit must not exceed 75% plus a Superannuation Contribution Benefit of 10% of your declared earned income.

2. Insurance level

I wish to apply for (or increase my level of voluntary insurance cover to):

☐ Death cover in the amount of: $

☐ Death and Total and Permanent Disablement cover in the amount of: $

☐ **Salary Continuance Cover:**

Short term (two-year benefit period) in the monthly amount of: $

Long term (to age 65 benefit period) in the monthly amount of: $

Monthly Income Benefit Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days

3. Occupation details

3.1 ☐ Self employed ☐ Employee ☐ Full time ☐ Part time ☐☐ hrs/wk ☐☐ weeks/year

3.2 Your occupation Industry

3.3 Duties performed

3.4 Annual salary $ (includes items such as your super contributions, but excludes bonuses/commission)

IMPORTANT

Accident cover applies for a maximum of 90 days after we receive this form. It is therefore important that you forward this application to us promptly.

4. Your Duty of Disclosure

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know that may affect their decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell the insurer anything that:

- reduces the risk they insure you for; or
- is common knowledge; or
- they know or should know as an insurer; or
- they waive your duty to tell them about.

If you do not tell the insurer something

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, they may apply the following rights separately to each type of cover.

If you do not tell the insurer anything you are required to, and they would not have insured you if you had told them, they may avoid the contract within three years of entering into it.

If the insurer chooses not to avoid the contract, they may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told them everything you should have. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within three years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell the insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

5. Group medical requirements

Death and Total Permanent Disablement levels of cover and initial requirements for members under 45 years of age.

Level of cover	Initial requirements
Up to $2,500,000	● Member's Personal Statement (refer to question 8)
$2,500,001 to $3,000,000	● Member's Personal Statement (refer to question 8) ● Blood Tests (upon receipt of your application, you will be notified if these are required) ● Fast Check Medical (upon receipt of your application, you will be notified if these are required)
Over $3,000,000	● Personal Medical Attendant's Report from your Doctor ● Please contact us for requirements

Death and Total Permanent Disablement levels of cover and initial requirements for members aged 45 years and over.

Level of cover	Initial requirements
Up to $1,500,000	● Member's Personal Statement (as above)
$1,500,001 to $2,000,000	● Member's Personal Statement (as above) ● Blood Tests (as above) ● Fast Check Medical (as above)
$2,000,001 to $3,000,000	● Member's Personal Statement (as above) ● Blood Tests (as above) ● Fast Check Medical (as above)
Over $3,000,000	● Personal Medical Attendant's Report from your Doctor ● Please contact us for requirements

Group Salary Continuance monthly benefit levels and initial requirements for members aged under 45.

Monthly benefit	Initial requirements
Up to $12,000	● Member's Personal Statement (as above)
$12,001 to $15,000	● Member's Personal Statement (as above) ● Blood Tests (as above)
$15,001 to $20,000	● Member's Personal Statement (as above) ● Fast Check Medical (as above) ● Blood Tests (as above)
$20,001 to $25,000	● Please contact us for requirements

Group Salary Continuance monthly benefit levels and initial requirements for members aged 45 and over.

Monthly benefit	Initial requirements
Up to $12,000	● Member's Personal Statement (as above)
$12,001 to $15,000	● Member's Personal Statement (as above) ● Personal Medical Attendant's Report from your Doctor ● Blood Tests (as above)
$15,001 to $20,000	● Member's Personal Statement (as above) ● Fast Check Medical (as above) ● Blood Tests (as above) ● Personal Medical Attendant's Report from your Doctor
$20,001 to $25,000	● Personal Medical Attendant's Report from your Doctor ● Please contact us for requirements

Complete this section if you want to make an insurance cover transfer application from your previous account to your LGS account.

6. Insurance transfer application

Death sum insured $ _____ TPD sum insured $ _____

Monthly income benefit $ _____ Benefit period _____

Monthly income benefit waiting period ☐ 30 days ☐ 60 days ☐ 90 days

6.1 Is this an increase? ☐ No ☐ Yes

6.2 Have you ever held or applied for any life, disability, accident and sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused? ☐ No ☐ Yes

6.3 Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? ☐ No ☐ Yes

6.4 Do you have, or are you applying for, any other life or disability cover? ☐ No ☐ Yes

If Yes to 6.2, 6.3 and/or 6.4, please provide full details below:

Name of company	Cover type	Sum insured/ monthly benefit	Date of application or claim	Accepted/ loaded Exclusion/ declined	To be replaced?
		$	DD/MM/YYYY		☐ No ☐ Yes
		$	DD/MM/YYYY		☐ No ☐ Yes
		$	DD/MM/YYYY		☐ No ☐ Yes

7. Habits and activities

7.1 Do you drink alcohol? ☐ No ☐ Yes

If Yes, state type, number of standard drinks per day and number of days per week when alcohol is consumed.

_____

7.2 Have you smoked in the past 12 months? ☐ No ☐ Yes

If Yes, state form and daily quantity _____

7.3 Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? ☐ No ☐ Yes

If Yes, state type and daily quantity _____

7.4 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? *If Yes, please complete a sports and pastimes statement* ☐ No ☐ Yes

7.5 Do you intend travelling outside Australia within the next two years? ☐ No ☐ Yes

If Yes, please provide details below (where, when, duration and reason)

_____

7.6 Are you an Australian Citizen or do you have an Australian Permanent Resident's Visa?

☐ No ☐ Yes

If No to 7.6, please advise type of visa and expiry date, plans for applying for permanent residency and nationality/current citizenship:

_____

8. Personal statement

8.1 Please state your: height cm weight kg

8.2 Name and address of your usual doctor

Doctor's name

No./Street

Suburb/Town State/Territory Postcode

Country Phone

8.3 Details of last medical consultation with your usual doctor

Date DD/MM/YYYY Reason

Outcome/ results

8.4 If you have attended that doctor for less than 12 months, please state the name and address of your previous doctor

Doctor's name

No./Street

Suburb/Town State/Territory Postcode

Country Phone

8.5 a) Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquillisers? No Yes

b) Have you EVER had an ECG, ultrasound, X-ray, transfusion, mammogram or any other investigation? No Yes

c) Have you EVER had any blood tests which revealed an abnormality e.g. raised blood sugar, liver function, kidney function results or anaemia, etc? No Yes

d) Do you contemplate seeking any medical examination, advice, treatment or surgery for any other current health condition in the future? No Yes

Please provide full details for all Section 8.5 'Yes' answers:

Question	Dates (From/To)	Name and address of doctor, hospital or clinic	Condition, medications, treatment and time off work	Recovery %

8.6 Have you ever had, been advised that you had, or received advice or treatment for any of the following:

a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? ☐ No ☐ Yes

b) Bowel, stomach or intestinal problem, gallbladder, hepatitis or liver disease? ☐ No ☐ Yes

c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks? ☐ No ☐ Yes

d) Depression, anxiety, panic attacks, stress, chronic fatigue, fibromyalgia or any mental or nervous condition? ☐ No ☐ Yes

e) Diabetes, sugar in urine, pancreatic or thyroid problems? ☐ No ☐ Yes

f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind? ☐ No ☐ Yes

g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? ☐ No ☐ Yes

h) Impairment of sight, hearing or speech? ☐ No ☐ Yes

i) Asthma, bronchitis, sleep apnoea, or any lung complaint? ☐ No ☐ Yes

j) Leukaemia, haemochromatosis, anaemia, or any blood problems? ☐ No ☐ Yes

k) Kidney, prostate, or bladder problems? ☐ No ☐ Yes

l) Psoriasis, eczema, or any skin problems? ☐ No ☐ Yes

m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? ☐ No ☐ Yes

n) To the best of your knowledge do you, or any of your current or past sexual partners, have HIV/AIDS, or do you/have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus? ☐ No ☐ Yes

Females only

o) Have you ever had any gynaecological conditions (e.g: endometriosis, abnormal pap smear, etc.)? ☐ No ☐ Yes

p) Have you ever had any complications of pregnancy or childbirth? ☐ No ☐ Yes

q) Are you currently pregnant? If Yes, what is the expected delivery date? DD/MM/YYYY

r) Have you ever had a breast lump (even if you have not seen a doctor about it)? ☐ No ☐ Yes

8.7 Family history

Please provide details of your family medical history.

Relationship to member	Current age	Medical condition (e.g. breast cancer, heart attack, Type 2 diabetes)	Age when diagnosed	Age at death (if applicable)

8.8 Has any of your immediate family (mother, father, brother or sister) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's disease or any other hereditary disease?

If Yes, please provide details: _____

Please provide full details for all 'Yes' answers in Section 8.6. Please continue on a separate sheet if required.

9. General medical questionnaire

	Question ___ Specific condition	Question ___ Specific condition	Question ___ Specific condition	Question ___ Specific condition
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
E. What was the severity (mild/ moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/ activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				
H. What advice/ treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
J. Date treatment/ medication ended.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)				
M. Please supply the name and address of all documents, hospitals or other practitioners consulted.				

10. Your declaration

IMPORTANT

From 1 July 2019, legislation requires that your insurance be cancelled if your account becomes inactive (i.e. has not received contributions for 16 months or more).

You must mark the following box if you do not wish your insurance to be cancelled if your account becomes inactive.

Please note: Basic insurance cover is provided automatically to members aged at least 25 years and have a super balance of at least $6,000. You can reduce or cancel your Basic insurance cover at any time. You can also opt in to receive Basic insurance cover before you become eligible by logging in to Member Online, via the LGS mobile app or completing the *Opt in to insurance cover* form. Please read the PDS and *Insurance in your super* fact sheet for more information.

To **keep your Voluntary insurance** cover:

☐ I elect to keep my Voluntary insurance cover even if my account becomes inactive in the event of not receiving any contributions or rollovers for 16 months or more.

I acknowledge that I have read the Duty of Disclosure under Section 4 of this form and I am aware about the consequences of non-disclosure. I understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting or typed online and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or Personal Statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Applicant, authorise and direct any medical or other practitioner to divulge at any time to the Insurer or to any lawfully constituted tribunal any and all information concerning my state of health and medical history acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I understand that insurance cover under this application, if accepted by the insurer, will be provided even if my account balance is less than $6,000 and/or I am under 25 years of age.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by the Trustee and the Insurer or its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information the Insurer collects on this form or future forms in relation to this insurance.

I _____

hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written or typed online by me or by any person on my behalf. I also declare that I have read and understood the Product Disclosure Statement and the *Voluntary Insurance* fact sheet, including the terms and conditions of Voluntary insurance cover, such as the types of cover, when cover commences, when cover ceases and how cover may be cancelled.

Signed _____ Date DD/MM/YYYY

11. Medical authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of member _____

Signature of member _____ Date DD/MM/YYYY

Please return your completed form to:

Mail: Local Government Super
PO Box N835
Grosvenor Place NSW 1220

Email: admin@lgsuper.com.au

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