

Section 6: Personal Health Statement

If you are outside the Automatic Acceptance Limit (AAL) criteria, you must complete this section. Please be aware that our insurer may require further information, in addition to that provided below.

If you are unsure if AAL applies to you, please review the Product Disclosure Statement or contact the Fund.

Personal Statement Questions :

	YES	NO	If yes please state type	Daily Quantity
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>
Have you smoked in the past 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>
Please state your:			Height <input type="text"/> cm	Weight <input type="text"/> kg

Please answer 'YES' or 'NO' for each of the following questions:

	YES	NO
1. Have you ever had, been told you had, received advice or treatment for any of the following?		
a) High blood pressure, raised cholesterol, stroke or circulatory disorder?	<input type="radio"/>	<input type="radio"/>
b) Bowel, stomach or intestinal problem, liver disease?	<input type="radio"/>	<input type="radio"/>
c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks?	<input type="radio"/>	<input type="radio"/>
d) Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition?	<input type="radio"/>	<input type="radio"/>
e) Diabetes, sugar in urine, pancreatic or thyroid problem?	<input type="radio"/>	<input type="radio"/>
f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind?	<input type="radio"/>	<input type="radio"/>
g) Disease or disorder of joints, spine or bones, gout, arthritis?	<input type="radio"/>	<input type="radio"/>
h) Impairment of sight hearing or speech?	<input type="radio"/>	<input type="radio"/>
i) Asthma, bronchitis, any lung complaint?	<input type="radio"/>	<input type="radio"/>
j) Leukaemia, hemochromatosis, any blood problems?	<input type="radio"/>	<input type="radio"/>
k) Kidney, bladder problems?	<input type="radio"/>	<input type="radio"/>
l) Psoriasis, eczema, any skin problem?	<input type="radio"/>	<input type="radio"/>
m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury?	<input type="radio"/>	<input type="radio"/>
2. 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?	<input type="radio"/>	<input type="radio"/>
3. To the best of your knowledge, do you, or any of your current or past sexual partners have HIV/AIDS?	<input type="radio"/>	<input type="radio"/>
i) are you experiencing any unexplained night sweats or unintentional weight loss;	<input type="radio"/>	<input type="radio"/>
ii) do you or have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus?	<input type="radio"/>	<input type="radio"/>
4. Within the last 5 years have you consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist counsellors, chiropractor, physiotherapist or any other health care professional (e.g. naturopath) or been in hospital or been advised to have an operation?(not including advice or treatment for minor viral infections, colds and influenza)	<input type="radio"/>	<input type="radio"/>
5. Within the last 5 years have you had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation?	<input type="radio"/>	<input type="radio"/>
6. Within the last 5 years have you had any blood tests which revealed an abnormality (e.g. raised blood sugar, liver function or renal function results or anaemia?)	<input type="radio"/>	<input type="radio"/>
7. Has any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental disorder or breakdown, haemophilia, Huntington's Chorea or any other hereditary disease?	<input type="radio"/>	<input type="radio"/>

If you have answered **YES** to any of the above questions please provide details in **Section 6**; if there is insufficient space please attach further information to the form.

If you have answered **NO** to all these questions, please proceed to **sections 7 to 10**.



Section 6: Personal Health Statement (continued)

Question Number	Qu <input type="text"/>	Qu <input type="text"/>	Qu <input type="text"/>	Qu <input type="text"/>
Specific Condition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date symptoms first started and description of symptoms				
What was the condition and which part of the body was affected?				
What was the medical diagnosis including results of x-rays and investigations				
What was the frequency (daily ,weekly etc) of attacks or symptoms?				
What was the severity (mild/moderate/severe) and duration of attacks or symptoms				
How long were you unable to work or perform your normal duties/activities?				
If a hospital visit was required, please provide date and duration of your stay				
What advice/treatment did you received?				
Are you still receiving treatment? if so, please advise nature and frequency of treatment.				
When did you last suffer any symptoms?				
Degree of Recovery? (%)				
Please supply the name and address of all doctors or hospitals or other consultants:				



Section 6: Personal Health Statement (continued)

8. Have you ever held or applied for, any life, disability, trauma or accident and sickness insurance, that was declined, or modified in any way, or have you claimed on any type of disability, trauma, sickness and accident or workers compensation policy? YES NO

Name of Company	Cover Type	Sum Insured	Date of application	Modified	Declined
				<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>

9. Have you ever, or do you intend to engage in any hazardous activity or sport? (e.g. aviation other than as a fare paying passenger travelling over recognised routes, competitive football, climbing, diving, motor racing or any extreme sport) YES NO

Activity	Times per annum	Location	Amateur or professional	If no longer participating date ceased

Depending on the nature of the activity TAL may also require a sports/activity questionnaire to be completed. WALGSP will contact you should this be requested.



Section 7: Your Duty of Disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984 as amended, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose to the insurer before you extend, vary or reinstate a contract of life insurance. 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 business, ought to know; or
- As to which compliance with your duty is waived by the insurer.

Non Disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered in the contract on any terms if the failure had not occurred, the insurer may void the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may void the contract at any time.

An insurer who is entitled to void a contract of life insurance may, within 3 years of entering into it, elect not to void it but to reduce the sum insured 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.

Section 8: Privacy Statement

Privacy laws protect your privacy. We may collect and use or disclose your personal information (including health and sensitive information) to assess, verify and process your application. Please be aware that the duty of disclosure explained in the previous section applies to the information you have submitted. If you fail to comply with this, you may be in breach of it.

We may collect or disclose information in relation to you or your application to or from a range of services including: insurers, past or present medical practitioners, health professionals, hospitals, government department(s) which retain health records or as part of our regulatory requirements, personal accountants or current or former employer or lawyers.

You have a right of access to any personal information held about you unless we are legally entitled to deny access. The way in which we collect, use and handle your information is described in the WA Local Government Superannuation Plan privacy statement. You can view the statement on our website www.walgsp.com.au or call the Fund to obtain a copy.

To obtain a copy of TAL's privacy statement you can contact TAL on (02)9448 9000.

Section 9: Acknowledgement & Declaration

- I understand that in completing and signing this form that any previous details will be replaced by the new details on this form.
- I acknowledge that the changes requested will become effective when approved by the insurer.
- I have read and understood the Fund's Product Disclosure Statement. In signing this form I acknowledge that I will continue to be bound by the Fund Trust Deed and Rules in all respects.
- I acknowledge that I have read the notice of my duty of disclosure above and understand that this duty also applies until formal notification of acceptance.
- I have read and checked any answers not completed in my handwriting 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 Fund's 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 consent to my personal information (including health and sensitive information) being collected, used or disclosed by the Fund's 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 collected on this form or future forms in relation to this insurance.

Applicant's Signature

Date

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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