Application Form
Priority Protection

Version 6.1 – Issued 1 July 2008

(Head Office Use Only)

Policy No:

Adviser No:

Campaign:

Please print in capital letters using a dark blue or black pen.

Please send completed applications to: PO Box 6111, St Kilda Rd Central VIC 8008

Before you sign this application, be aware that we or your adviser is obliged to have provided you with a Priority Protection Product Disclosure Statement containing a summary of the important information in relation to this product. This information will help you to understand the product and to decide whether it is appropriate for your needs.

Your Duty of Disclosure

Before you enter into a contract of insurance with an insurer, 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, which 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 those matters to the insurer before you extend, vary or reinstate this contract of insurance.

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 entering 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 insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the contribution that would have been payable if you had disclosed all relevant matters to the insurer.

A. Life Insured (Life insured to complete this section in full.)

1. Name — Title / Family Name / Given Name / Sex

2. Residential Address — No. / Street; Suburb / State / Postcode

We may need to contact you to clarify information you have provided in the application.

3. Contact Details — Phone (home) / Phone (work) / Mobile; E-mail

4. Mailing Address (if different to above) — Suburb / State / Postcode

5. Smoker ☐ Yes ☐ No **6.** Date of Birth (dd/mm/yy) **7.** Age next birthday

8. Marital status

9. Country of Birth

10. Are you currently an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship)? Yes ☐ No ☐

11. How long have you permanently lived in Australia? ____ years ____ months or ☐ All my life.

Issued by:
American International Assurance Company (Australia) Limited trading as AIG Life, ABN 79 004 837 861, AFS Licence No. 230043, 549 St Kilda Road, Melbourne 3004 and CCSL Limited, ABN 51 104 967 964, AFS Licence No. 287084, RSE Licence No. L0000758, Level 16, 114 William Street, Melbourne Australia 3000.

B. Proposer(s)/Policy Owner(s) **(To be completed by the policy owner/s.)**

This Priority Protection policy is to be owned by *(please tick appropriate box)*:

☐ **The life insured.** No further details are required.

OR

☐ **An individual/s other than the life insured.** Please complete the following.
If there are two or more policy owners, they will own the policy as joint owners.

Policy owner 1

Name: Title | Family Name | Given Name | Sex

Mailing Address

Suburb | State | Postcode

Contact Details: Phone (home) | Phone (work) | Mobile

Fax | E-mail

Relationship to Life Insured | Date of Birth (dd/mm/yy)

Are you currently an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship)? Yes ☐ No ☐

How long have you permanently lived in Australia? ____ years ____ months or ☐ All my life.

Policy owner 2

Name: Title | Family Name | Given Name | Sex

Mailing Address

Suburb | State | Postcode

Contact Details: Phone (home) | Phone (work) | Mobile

Fax | E-mail

Relationship to Life Insured | Date of Birth (dd/mm/yy)

Are you currently an Australian citizen or permanent resident of Australia (as approved by the Department of Immigration and Citizenship)? Yes ☐ No ☐

How long have you permanently lived in Australia? ____ years ____ months or ☐ All my life.

OR

☐ **Company.** Please complete the following:

Company Name/s | ABN/ACN

Contact: Nominated contact person

Mailing Address

Suburb | State | Postcode

Contact Details: Phone | Fax

E-mail

OR

☐ **The trustee of the Private/Self-Managed Superannuation Fund.**

OR

☐ **The trustee of the AIA Superannuation Fund.**

C. Policy Details

1. Are annual CPI increases required? ☐ Yes ☐ No *Please note CPI increases will be automatically provided if you do not select an option. (Not available for Home Expenses or Child's Recovery)*

2. (a) Reasons for cover: ☐ Personal Cover ☐ Keyman Cover ☐ Partnership ☐ Loan Protection ☐ Buy/Sell, Share Purchase

(b) Is a concurrent application for a Business Partner or Spouse being submitted? If 'Yes' please provide details.

D. Payment Options

Please select your premium frequency. ☐ Monthly ☐ Half-yearly ☐ Yearly

Deposit Premium

An initial deposit premium is required.
Please select one option:

☐ A cheque for the first premium payment is attached to this application.
NOTE: Please make cheque payable to: AIG Life.

☐ Please debit my Financial Institution Account for the first premium payment and all future premium payments.
Please complete the Direct Debit Request.

☐ Please debit my credit card for the first premium payment.
Please complete the Credit Card Authority.

Future Premiums

For half-yearly or yearly, we will send you a premium renewal notice prior to each premium due date.
Please select one option:

Direct Debit (monthly, half-yearly or yearly)

☐ Financial Institution Account.
Please complete the Direct Debit Request.

☐ Credit Card. *Please complete the Credit Card Authority.*

Direct Billing (half-yearly or yearly only)

☐ Please send me a premium renewal notice prior to each premium due date.

E. Nomination of Beneficiaries **(Not applicable for the Superannuation Term Life Plan.)**

Proposer to complete if required. Please list your nominated beneficiary(ies) and the proportion of death benefit you would like each to receive.

Nominated Beneficiaries (full name)	Address	State	Post Code	Date of Birth	Relationship to Life Insured	Percentage of Benefit
				/ /		%
				/ /		%
				/ /		%
				/ /		%
If more than four beneficiaries are to be nominated use a separate Nomination of Beneficiary form available from us or your adviser.						100 %

F. Child's Guaranteed Insurability **(Proposer to complete if purchasing this benefit.)**

Family Name of Child	Given Name	Date of Birth	Sex M/F	Age Next Birthday	Place of Birth

1. Are the children in good health and free from mental or physical impairment? (If 'No', please give full details below.) Yes ☐ No ☐

2. Have the children received medical attention for any illness or serious injury? (If 'Yes', please give full details below.) Yes ☐ No ☐

G. Personal History (Life insured to complete this section in full.)

1. (a) Do you have, or are you applying for life, disability or trauma insurance on your life (including any pending applications held with any insurer)? If 'Yes', please complete policy details below. .... Yes ☐ No ☐

Policy Number	Commencing Date	Policy Owner	Insurer	Type of Cover	Amount of Cover	Terms of Acceptance (eg loading, exclusion)	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

IMPORTANT NOTE IF YOU ARE REPLACING AN EXISTING POLICY: *If you intend to replace an existing policy with an AIG Life policy, we may require that you cancel your existing policy. Your adviser can confirm when this requirement applies. In these cases the replacement policy issued by AIG Life will only start when the existing policy is cancelled. Failure to cancel your existing policy within a reasonable time may make your AIG Life policy void.*

(b) Have you ever been declined, deferred or accepted on special terms for life, disability or trauma insurance? .... Yes ☐ No ☐

(c) Have you ever claimed benefits from any source (eg. Accident, Sickness, Workers' Compensation, Social Security, Disability Insurance or Pension)? If 'Yes', please give the name of the company, date, amount and reason for each claim below. .... Yes ☐ No ☐

2. (a) Have you smoked tobacco or any other substance during the last twelve months? If 'Yes', please state substance and quantity below. (Please note 'packet' is not sufficient detail.) .... Yes ☐ No ☐

(b) Do you drink alcohol? If'Yes', please state weekly quantity and type below. (Please note 'social' is not sufficient detail.) .... Yes ☐ No ☐

(c) Have you ever received advice, treatment or counselling for use of drugs or alcohol? .... Yes ☐ No ☐

(d) Within the last five years, have you occasionally or regularly taken any stimulants, sedatives, medications or drugs? .... Yes ☐ No ☐

(e) Females: Are you pregnant? If 'Yes', please provide estimated date child is due. ..../......../........ .... Yes ☐ No ☐

3. Have you in the last five years been admitted to hospital or are you suffering from any injury, disease or condition that may require nursing care in a hospital or other care facility or require nursing care at home? .... Yes ☐ No ☐

4. (a) What is your height? Height ______ cm (b) What is your weight? Weight ______ kg

(c) Are you left or right handed? ☐ Left ☐ Right

5. Do you intend to travel or reside overseas? If 'Yes', please provide countries, reason for travel, duration, frequency below. .... Yes ☐ No ☐

6. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes), long-distance sailing, hang gliding, scuba diving, motor racing, parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? If 'Yes', please fill in Section P (Activities/Pursuits Questionnaire). .... Yes ☐ No ☐

7. Are you aware of any other circumstances or matters which may be relevant to the insurer's decision whether to accept your application? Yes ☐ No ☐

If you answered 'Yes' to any of the above questions (except 1(a) and 6) please provide details below. If insufficient space, continue on page 21.

....

Both 8(a) and 8(b) must be completed in all circumstances.

8. (a) Have any of your immediate family (living or dead) ever suffered from high blood pressure, heart disease, cancer, kidney disease, tuberculosis, asthma, diabetes, epilepsy, mental illness, stroke, haemophilia, Huntington's chorea, any hereditary disease or committed suicide? .... Yes ☐ No ☐

(b) **FAMILY HISTORY**

	Age now if alive	Age at death	List all medical conditions, age at diagnosis and cause of death. Give cancer site/details, if applicable.
Father			
Mother			
Brothers			
Sisters			

H. Doctor's Details **(Life insured to complete this section in full.)**

1. (a) Details of your personal doctor.
IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.

Name:

Address: Postcode

Phone ( ) Fax ( ) Email (if known)

(b) What was the date of your last consultation? / /

(c) What was the reason for the consultation?

(d) What was the result?

(e) How long have you been attending this surgery or practice?

(f) If less than 12 months, please provide the name and address of your previous personal doctor or medical centre.

Name:

Address: Postcode

Phone ( ) Fax ( ) Email (if known)

Please note: A medical report is not always obtained.
Medical reports are obtained, however, on a random basis to check the validity of medical information provided.

I. Medical History **(Life insured to complete this section in full.)**

(If a medical examination is being arranged – complete only questions 7 and 8. Note: This does not apply to short medicals.)

1. Have you ever suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

(a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. Yes ☐ No ☐

(b) Asthma, bronchitis, tuberculosis, pleurisy, sleep apnoea or other respiratory complaint. Yes ☐ No ☐

(c) Indigestion, gastric or duodenal ulcer or any bowel disorder. Yes ☐ No ☐

(d) Diabetes, abnormal blood sugar, gout or thyroid disorder. Yes ☐ No ☐

(e) Depression, anxiety/stress state, fatigue, panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder. Yes ☐ No ☐

(f) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches. Yes ☐ No ☐

(g) Back or neck complaint, whiplash, sciatica, rheumatism or any other disorder of joints, bones or muscles. Yes ☐ No ☐

(h) Arthritis, RSI, chronic fatigue, tenosynovitis or myalgia. Yes ☐ No ☐

(i) Psoriasis or eczema, skin disorder, defect in hearing or sight. Yes ☐ No ☐

2. Have you had any routine examinations or check-ups in the last 5 years? Yes ☐ No ☐

If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections Q to V). Please use Section V, Multi-Purpose Questionnaire, if a specific questionnaire for the condition is not provided.

3. Have you ever suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

(a) Cancer, cyst, breast lump (even if you have not seen a doctor) or tumour of any kind. Yes ☐ No ☐

(b) Liver, kidney or bladder disease, renal colic or stone. Yes ☐ No ☐

(c) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia. Yes ☐ No ☐

(d) Advice to restrict your diet or undergo surgery. Yes ☐ No ☐

(e) Any other illness, disease or disorder. Yes ☐ No ☐

(f) Hepatitis B or C or have you ever been told you are a chronic hepatitis B or C carrier? Yes ☐ No ☐

4. Are you currently considering or have you been advised to undergo any treatment, therapy, special tests, operation or procedure? Yes ☐ No ☐

5. Have you had any other operation, accident, x-ray, pathology test or genetic test in the last 5 years? Yes ☐ No ☐

6. Females only: Have you ever had an abnormal pap smear, breast ultrasound or mammogram? Yes ☐ No ☐

7. Complete only if Female Crisis Assistance Benefit is purchased

Have you ever had or been advised to have treatment for:

(a) An abnormal cervical smear (Papanicolaou – PAP) test including the detection of Human Papilloma Virus (HPV)? Yes ☐ No ☐

(b) Any cysts, lumps or biopsy or other abnormality of the breasts or ovaries? Yes ☐ No ☐

(c) Abnormal vaginal bleeding within the past 12 months? Yes ☐ No ☐

(d) An abortion (miscarriage), stillbirth or complication of pregnancy? Yes ☐ No ☐

(e) A child with congenital anomalies? Yes ☐ No ☐

8. AIDS STATEMENT

(a) Have you suffered from Acquired Immune Deficiency Syndrome (AIDS) or been infected with the HIV virus or are you carrying antibodies to the HIV virus? Yes ☐ No ☐

(b) Since 1980, have you used intravenous drugs, engaged in male to male anal sexual activity or worked as a prostitute? Yes ☐ No ☐

(c) Have you had sexual intercourse with someone you know or suspect to be HIV positive? Yes ☐ No ☐

(If 'Yes' to question 8 above, a 'Confidential Lifestyle' Questionnaire is required.)

For each 'Yes' answer in questions 3–7 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

J. Present Occupation **(Life insured to complete this section in full.)**

1. (a) Please give details of your **current and previous occupations** or jobs over the **last five years**, including any period **unemployed, travelling, studying etc**.

	From	To	Occupation	Industry	*Tick which is applicable*			
					Employee of own company	Self-employed	Employee	Partnership
Current Occupation	/ /	Present						
Previous Occupations	/ /	/ /						
Previous Occupations	/ /	/ /						

(b) What type of products or services do you or your employer sell?

(c) What trade, professional, business or tertiary qualifications do you have?

(d) What are the principal duties of your occupation and where do you perform these duties? **Include any manual work performed.**

Daily duties (eg office work, site inspection, supervision, selling etc)	Percentage of time	Location (eg office, on site, at home, driving etc)	Percentage of time
	%		%
	%		%
	%		%
	%		%
	100 %		100 %

(e) How many hours a week do you work? How many weeks per year?

2. What is your annual income? $

3. (a) Do you have any other occupation? Yes ☐ No ☐

(b) Do you contemplate any change in occupation? Yes ☐ No ☐

4. Does your occupation require you to work underground; at heights; off-shore; near dangerous materials, substances, machinery or building or factory sites? If 'Yes', please give details below, eg locations, depths, heights, frequency etc. Yes ☐ No ☐

If you answered 'Yes' to Question 3 or 4, please provide full details below.

K. Further Occupational Information (Life insured to complete.)

If you are applying for Disability Income Plan or Business Expenses Insurance Plan, please also complete the additional questions below.

1. What is your business/employer name and address?

2. Do you work at home? Yes ☐ No ☐ If 'Yes', please state percentage of time. %

3. Do you perform any manual work? Yes ☐ No ☐

(a) If 'Yes' – please state percentage of time %

(b) Is the manual work an important duty in your occupation? Yes ☐ No ☐

If you are self-employed, in a partnership or employee of own company, please complete the remaining questions.

4. Do you operate as a ☐ sole trader ☐ partnership ☐ company, or ☐ trust?

5. (a) What percentage of your work is: Freelance? % Contract? %

(b) Is your work seasonal? ☐ Yes ☐ No If 'Yes', please provide details

(c) Please state what percentage of interest/shareholding you have in the business/practice? %

6. When was the business purchased/started? / /

7. What percentage of Monthly Business Turnover is derived from your personal exertion? %

8. How many people do you employ?

9. Please provide employee details (excluding yourself) in the table below.

Occupation of all Partners/Employees	Family Member Y/N	Daily Duties	Full-time Part-time or Contractor?	Monthly Remuneration	% Interest in Business

L. Income Details

(Life insured to complete if Disability Income Plan is being purchased.)
(If Business Expenses Insurance is being purchased complete only Question 7 below.)

1. What is your income from your current occupation? (Personal income is income earned by your personal exertion. Do not include investments.)

Employee

Your income is the total remuneration paid by your employer including salary, fees, commission, regular bonuses, regular overtime, fringe benefits and superannuation contributions (statutory or voluntary).

Last financial year 30/6/ ______ Previous financial year 30/6/ ______

Remuneration package $ ______ Remuneration package $ ______

Self Employed (sole trader, partner, employee of own company)

		Last financial year 30/6/		Previous financial year 30/6/
Gross business income/revenue		$		$
Total business expenses	–	$	–	$
Net business income/revenue (before tax)	=	$	=	$
% Share of net business income		%		%
Add backs (**your own portion** of personal salary/wages, superannuation contributions, spouse's income if income splitting, share of depreciation)	+	$	+	$
Total net earned income (before tax)	=	$	=	$

2. Is your current income different than that stated above for the last financial year? .... Yes ☐ No ☐

If 'Yes', reasons for change. ______ Current income $ ______

3. **If you have a second occupation, please provide the following details.**

Nature of occupation ______

Hours worked per week ______ Number of weeks worked per year ______

Last financial year 30/6/ ______ Previous financial year 30/6/ ______

Net income (before tax) $ ______ Net income (before tax) $ ______

4. Do you earn commission or bonuses? .... Yes ☐ No ☐

If 'Yes', please state percentage of total income. ______ %

5. Will any of your income (from any source) continue if you become disabled? .... Yes ☐ No ☐

If 'Yes', state source (eg sick leave, directors' fees, salary, renewal or trail commission, salary continuance insurance, profit share from the business etc)

______

For how long will it continue? ______ Amount of income (per month). $ ______

6. Do you receive any unearned income from investments (eg rental property, dividends etc.)? .... Yes ☐ No ☐

If 'Yes', please state the amount per month **(net of costs and expenses)**. $ ______ *(Do not include negatively geared investments)*

Please state the source. ______

7. (a) **For self employed, employed by own company or partnership.**
Has your company had a net operating loss in the last 2 years? .... Yes ☐ No ☐

If 'Yes', please provide details of your company's profit and loss statements for all entities.

(b) Have you or any business with which you have been associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? .... Yes ☐ No ☐

If 'Yes', when? ______ Date of discharge / /

M. Business Expenses Insurance

(Life insured to complete this section in full only if Business Expenses Insurance is being purchased.)

1. Please state the value of all monthly business expenses. (**Do not include** personal remuneration, mortgage principal, depreciation on real estate, cost of goods, wares and merchandise, equipment, fixtures and fittings, salaries of revenue producing employees.)

Alternatively, the supply of copies of taxation returns and profit and loss statements for all entities associated with your business will be accepted in place of completing the details below.

	Eligible Expenses	Monthly Expenses
(a)	Rent, property rates and taxes*	$
(b)	Insurance of premises (eg fire etc)*	$
(c)	Security costs*	$
(d)	Electricity, gas, water, heating, telephone and cleaning*	$
(e)	Mobile phone	$
(f)	Bank fees/charges, interest on business loans	$
(g)	Hire and lease of plant and equipment	$
(h)	Business insurance premiums (eg liability, professional indemnity)	$
(i)	Membership fees, publications and subscriptions to professional bodies	$
(j)	Accountant's and auditor's fees	$
(k)	Regular advertising expenses, postage, printing and stationery	$
(l)	Salaries and costs of employees who **do not** generate revenue (e.g.: superannuation contributions, payroll tax, workers' compensation for employees who **do not** generate revenue)	$
(m)	Net cost of locum, ie. cost to employ less revenue generated by locum	$
(n)	Other fixed business expenses – **please specify**	$
		$
		$
		$
(o)	**Total Monthly Business Expenses**	$

**Not insurable if working from home*

2. What percentage of Monthly Business Expenses are you responsible for/liable to pay? .... %

N. Home Expenses Benefit Only (Spouse to complete this section in full.)

1. SPOUSE DETAILS

(a) Spouse's Family Name | Spouse's Given Name | Sex

(b) Date of Birth / / Age next birthday Country of birth

2. Are you a permanent resident of Australia? Yes ☐ No ☐

3. Please provide details of any income protection or salary continuance insurance held by you.

Policy Number	Commencing Date	Insurer	Type of Cover	Amount of Cover	Terms of Acceptance (eg loading, exclusion)	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

4. Have you smoked tobacco or any other substance during the last 12 months? Yes ☐ No ☐

5. (a) What is your height? Height cm (b) What is your weight? Weight kg

6. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes), long-distance sailing, hang gliding, scuba diving, motor racing, parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? (If 'Yes', please complete Section P Activities/Pursuits Questionnaire). Yes ☐ No ☐

7. (a) Have you ever been treated for any of the following:

- High blood pressure, chest pains or high cholesterol? Yes ☐ No ☐
- Heart condition or stroke? Yes ☐ No ☐
- Cancer, lump or growth of any kind? Yes ☐ No ☐
- Back, neck or joint pain or other musculoskeletal disorder or arthritis? Yes ☐ No ☐
- Blood disorder, haemophilia, haemochromatosis, chronic fatigue, RSI or myalgia? Yes ☐ No ☐
- Diabetes, hepatitis, epilepsy? Yes ☐ No ☐
- Alcohol or drug abuse? Yes ☐ No ☐
- Any disorder of the kidney, bladder, liver, bowel or stomach? Yes ☐ No ☐
- Asthma or other respiratory disease? Yes ☐ No ☐
- Depression, anxiety, stress or other mental illness? Yes ☐ No ☐

(b) Other than for any condition listed above, have you in the past 3 years, sought medical advice or treatment from a doctor or other health professional, or been prescribed medication (excluding antibiotics or contraceptives) for any condition? Yes ☐ No ☐

(c) Are you currently considering or have you been advised to undergo any treatment, therapy, special tests, or operation? Yes ☐ No ☐

If you have answered 'Yes' to question 7 above, please provide full details below. If insufficient space continue on page 21.

Question	Name of condition/test	Date started	Degree of recovery %	Details of treatment/result	Date of last symptoms	Full name, address, phone number of doctor(s) or hospital

8. Occupation (including details of manual duties) **Industry**

9. AIDS STATEMENT

(a) Have you suffered from Acquired Immune Deficiency Syndrome (AIDS) or been infected with the HIV virus or are you carrying antibodies to the HIV virus? Yes ☐ No ☐

(b) Since 1980, have you used intravenous drugs, engaged in male to male anal sexual activity or worked as a prostitute? Yes ☐ No ☐

(c) Have you had sexual intercourse with someone you know or suspect to be HIV positive? Yes ☐ No ☐

(If 'Yes' to question 9 above, a 'Confidential Lifestyle' Questionnaire is required.)

O. Child's Recovery Benefit* (Proposer to complete if purchasing this benefit.)

Child 1 (Personal Details)

1. Family name

   Given name

2. Sex
3. Country of birth
4. Date of birth / /
5. Age next birthday
6. (a) Is the child a permanent resident of Australia? Yes No

   (b) How long has the child lived in Australia?

   years months or All their life

7. State your relation to the child.
8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for? Yes No

   If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms? Yes No

   If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment? Yes No

    If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury? Yes No

    If 'Yes', please give details below.

    Illness or injury: Date started: / /

    Details of treatment:

    Length of treatment: Time off school:

    Date of last symptom: / / Degree of recovery: %

    Name and address of doctor/hospital:

12. Name and address of the child's family doctor.
13. Has the child's biological mother or father or any brother or sister or grandparent suffered from diabetes, cancer, epilepsy, high blood pressure, heart disease, stroke, mental disorder or depression, haemophilia, Huntington's disease, polycystic kidney or any other hereditary disease? Yes No

    If 'Yes', please give details below.

Family Member (relationship to child)	Condition/Illness (for cancer/ heart disease – specify type)	Age at onset	Age at death

Child 2 (Personal Details)

1. Family name

   Given name

2. Sex
3. Country of birth
4. Date of birth / /
5. Age next birthday
6. (a) Is the child a permanent resident of Australia? Yes No

   (b) How long has the child lived in Australia?

   years months or All their life

7. State your relation to the child.
8. Is there any insurance cover currently in force on the child's life, and/or is there any other cover on the child's life being applied for? Yes No

   If 'Yes', please give details.

9. Has an application of insurance cover on the child's life ever been declined or accepted with an increased premium or on non-standard terms? Yes No

   If 'Yes', please give details.

10. Is the child in good health and free from mental or physical impairment? Yes No

    If 'No', please give full details.

11. Has the child ever suffered from any illness or injury necessitating any hospitalisation, or is the child taking prescribed medication or has the child ever had more than 2 weeks off school as a result of illness or injury? Yes No

    If 'Yes', please give details below.

    Illness or injury: Date started: / /

    Details of treatment:

    Length of treatment: Time off school:

    Date of last symptom: / / Degree of recovery: %

    Name and address of doctor/hospital:

12. Name and address of the child's family doctor.
13. Has the child's biological mother or father or any brother or sister or grandparent suffered from diabetes, cancer, epilepsy, high blood pressure, heart disease, stroke, mental disorder or depression, haemophilia, Huntington's disease, polycystic kidney or any other hereditary disease? Yes No

    If 'Yes', please give details below.

Family Member (relationship to child)	Condition/Illness (for cancer/ heart disease – specify type)	Age at onset	Age at death

** Please photocopy this page if more than two children are to be covered under the Child's Recovery Benefit.*

Questionnaires (Life insured to complete.)

P. Activities/Pursuits Questionnaire

1. Please describe the activity or pursuit.
2. Please advise the number of times you engage in the activity per year.
3. How many actual events/hours/trips/flights/dives/climbs/jumps did you participate in over the last twelve months approximately?
4. What qualifications, certificates, licences, associations and club memberships do you hold?
5. How long have you been involved in this activity?
6. Where do you engage in this activity and in what locations?
7. Do you ever engage in this activity alone, or are you always with a group?
8. Do you compete in this activity? ☐ Yes ☐ No
   If 'Yes', please advise the level of competition and names of events.
9. Do you receive any payments for your involvement in this activity? ☐ Yes ☐ No
   If 'Yes', please advise details.
10. Please advise the maximum heights, speeds, depths the activity includes.
11. Are any of the above likely to change over the next 2 years? ☐ Yes ☐ No
    If 'Yes', please provide full details.
12. Are you involved in any record attempts? ☐ Yes ☐ No
    If 'Yes', please provide details.
13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details.
14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.
15. Have you ever been involved in any accident/mishap whilst participating in this activity? ☐ Yes ☐ No
    If 'Yes', please provide details.

Q. Asthma Questionnaire

1. Date asthma first diagnosed. / /
2. How often do you experience symptoms? eg. wheezing, breathlessness, chest tightness.
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Other
3. When was your most recent episode of asthma? / /
4. Are you aware of any causes that trigger your symptoms? eg. allergy, exercise.
5. Have you ever been off work due to asthma? ☐ Yes ☐ No
   If 'Yes', please advise when, and for how long.
6. Name of medication(s).
   (a) Dosage
   (b) Frequency
   (c) What treatment do you use to control an attack?
   (d) Do you take any form of medication between attacks? ☐ Yes ☐ No
   If 'Yes', please state nature and dosage.
   (e) When was the last time you received medication?
7. Have you ever required steroid therapy (by tablet or syrup)? ☐ Yes ☐ No
   If 'Yes', please provide details.
8. Have you ever been in hospital or received emergency treatment for asthma? ☐ Yes ☐ No
   If 'Yes', please state when, for how long and where?
9. Have you ever undergone a lung function test? ☐ Yes ☐ No
   If 'Yes', please advise dates and highest and lowest readings, if known.
10. Have you ever consulted a specialist for this condition? ☐ Yes ☐ No
    If 'Yes', please advise name and address of doctor of last consultation.
11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

R. Spinal/Joints Disorder Questionnaire

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. left knee, right hip, shoulders, elbows etc).

2. Please state the precise diagnosis.

3. When did symptoms first occur?

4. (a) What was the cause?

(b) Please describe your symptoms.

(c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ☐ Yes ☐ No

(d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms? ☐ Yes ☐ No

(a) If 'No', date of last experienced symptoms. / /

(b) If 'Yes', how frequently have symptoms occurred since commencing treatment?

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

(b) Are you still receiving treatment? ☐ Yes ☐ No

(i) If 'No', when did you cease treatment? / /

(ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

(c) Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor.

8. Have you had an operation for this condition or is an operation being considered? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long? ☐ Yes ☐ No

(b) Are your occupational duties restricted in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

(c) Is it necessary to avoid lifting or to restrict your daily activities in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

S. High Blood Pressure/High Cholesterol Questionnaire

1. When was high blood pressure/ high cholesterol first diagnosed?

2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage

4. Are you still on treatment? ☐ Yes ☐ No
If 'No', when was treatment discontinued and why?

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Results

6. Regarding the monitoring of your condition:

(a) Name of medical attendant:

(b) How often do you attend for follow-up?

(c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time, if known.

(d) Have you suffered from any of the following conditions:

(i) Eye disorder (other than short/long sightedness)? ☐ Yes ☐ No

(ii) Symptoms or disorder relating to heart or circulatory system? ☐ Yes ☐ No

(iii) Kidney disorder or protein in urine? ☐ Yes ☐ No

(iv) Dizziness, fainting episodes or stroke? ☐ Yes ☐ No

If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigations	Results

(e) How long has your blood pressure/cholesterol been well controlled?
☐ < 6 months ☐ 6 months to 12 months ☐ > 12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application.

8. Please attach copies of any reports or results (eg. xray, pathology, ultrasound, etc) you may have.

T. Mental Health Questionnaire

1. Please indicate the condition(s) you have had or received treatment for.

- ☐ Anxiety including generalised anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression or mild depression
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenic or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Other (please specify) ______

2. Describe your symptoms including the date started and how long they lasted.

Symptoms	Date from	Date to

3. (a) Has any reason for your condition been identified or are there any factors which trigger your condition?

______

(b) Have you ever had suicidal thoughts or attempted suicide?

______

4. (a) Date symptoms commenced. / /

(b) Have you had any recurrences of this condition? ☐ Yes ☐ No

If 'Yes', how many times? ______ When? / /

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased

(b) Are you currently receiving treatment? ☐ Yes ☐ No

(c) If 'Yes', please provide details.

______

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition? ☐ Yes ☐ No

If 'Yes', when and how long?

______

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? ☐ Yes ☐ No

If 'Yes', please provide details.

______

U. Check-up Questionnaire

1. Please state the reason/s for your regular check-up/blood test.

______

2. Please state the dates of your last two check-ups and results.

______

3. Were any test/s or further investigation/s performed? ☐ Yes ☐ No

If 'Yes', please provide details or attach copies of reports.

Date	Type of tests/investigations	Results

4. Was any treatment prescribed? ☐ Yes ☐ No

If 'Yes', please provide details.

Date	Type of treatment (eg. medications & dosage, physiotherapy, procedures, etc)

5. Were/Are you required to return for a follow up? ☐ Yes ☐ No

If 'Yes', please state when and reason.

______

V. Multi-Purpose Questionnaire
(may be photocopied for additional conditions)

1. Name of condition (exact diagnosis).

2. (a) What part of the body was affected?

(b) Please state which side. ☐ Left ☐ Right ☐ Not applicable

3. The cause.

4. (a) Date symptoms commenced / /

(b) How long have you been free of symptoms?

(c) How often do/did you have symptoms?

5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
If 'Yes', please state when, duration and reason/restriction.

6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
If 'Yes', please give details.

7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
If 'Yes', advise names of medication(s), dosage(s) and frequency.

Are you still taking this medication? ☐ Yes ☐ No

8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No

9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No

10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No

11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
If 'No', provide name and address of doctor who has full details.

V. Multi-Purpose Questionnaire
(may be photocopied for additional conditions)

1. Name of condition (exact diagnosis).

2. (a) What part of the body was affected?

(b) Please state which side. ☐ Left ☐ Right ☐ Not applicable

3. The cause.

4. (a) Date symptoms commenced / /

(b) How long have you been free of symptoms?

(c) How often do/did you have symptoms?

5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
If 'Yes', please state when, duration and reason/restriction.

6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
If 'Yes', please give details.

7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
If 'Yes', advise names of medication(s), dosage(s) and frequency.

Are you still taking this medication? ☐ Yes ☐ No

8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No

9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No

10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No

11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
If 'No', provide name and address of doctor who has full details.

W. Private/Self-Managed Superannuation Fund

The following is to be completed where benefit is to be owned by the Trustee of a Private/Self-Managed Superannuation Fund.
Please note: the Trustee is also required to complete the Declaration in Section Y.

When selecting benefits please ensure that the benefits can be paid from a superannuation fund in accordance with the Superannuation Industry (Supervision) Act 1993 (SIS Act). Please note there may be situations where even though a benefit, such as a TPD benefit, is paid to the trustee of the superannuation fund, superannuation legislation or the rules of the superannuation fund may prevent the release of the benefit until the preservation rules are satisfied.

Declaration

To be signed by two directors, or one director and the company secretary in the case of a company trustee.
I/We, the trustee/s of the superannuation fund named below, request AIG Life to issue the insurance policy/ies described on this form. The policy document/s will be held subject to the trusts of the superannuation fund.
I/We agree to be bound by the terms and conditions of the policy document and the trust deed governing the superannuation fund.
I/We confirm that the superannuation fund of which I am/we are trustee is a complying superannuation fund within the meaning of the SIS Act and Income Tax Assessment Act (Tax Act).
I/We undertake to advise AIG Life immediately if the superannuation fund at any time ceases to be a complying fund as defined in the SIS Act and/or the Tax Act.
I/We confirm that I/we have the power under the trust deed governing the superannuation fund to effect the policy/ies described on this form.

Details of policy owner/s

To be completed by the trustee/s of the superannuation fund which will own the policy/ies.

Full name of the superannuation fund

ABN/ACN

Trustee's address for communications

State

Postcode

Phone (home)

Phone (work)

Trustee details

Company Trustee name

ABN/ACN

If applicable, the common seal of: *(name of corporate Trustee)*

Was hereto affixed in accordance with the Constitution of the company in the presence of:

Director Signature

✗

Director/Company Secretary Signature

✗

Date (dd/mm/yyyy)

And/or

Individual Trustee names (if more than four individuals, please attach further names).

First Individual Trustee

Title

Family Name

Given Name/s

Signature

✗

Date (dd/mm/yyyy)

Second Individual Trustee

Title

Family Name

Given Name/s

Signature

✗

Date (dd/mm/yyyy)

Third Individual Trustee

Title

Family Name

Given Name/s

Signature

✗

Date (dd/mm/yyyy)

Fourth Individual Trustee

Title

Family Name

Given Name/s

Signature

✗

Date (dd/mm/yyyy)

X. AIA Superannuation Fund – Membership Application

Membership Application to the AIA Superannuation Fund (the Fund) is issued by: CCSL Limited, ABN 51 104 967 964, AFS Licence No. 287084, RSE Licence No. L0000758, Level 16, 114 William Street, Melbourne Australia 3000.

PERSONAL SUPERANNUATION

The following is to be completed by the Life Insured where the Superannuation Term Life Plan is to be owned by CCSL Limited (Trustee) ABN 51 104 967 964; AFS Licence No. 287084; RSE Licence No. L0000758, as Trustee of the AIA Superannuation Fund, RSE Fund Registration No. R1067682 (the Fund) – a Registrable Superannuation Entity (RSE) Licensee under the Superannuation Industry (Supervision) Act 1993. (Before you sign this Membership Application, the Trustee is obliged to have provided you with a Product Disclosure Statement containing a summary of the important information in relation to the AIA Superannuation Fund. This information will help you to understand the product and decide whether it is appropriate for your needs.)

Your Duty of Disclosure to the Trustee

It is a condition of this Application that you disclose to the Trustee every matter that you know, or could reasonably be expected to know, which is relevant to the Trustee's decision whether to accept your Application and if so on what terms. This duty of disclosure also applies before you extend, vary or reinstate your membership in the Fund.

Non-Disclosure – If you fail to make disclosure as required above and the Trustee would not have accepted your Application for membership on any terms if that failure had not occurred, the Trustee may terminate your membership in the Fund which would result in the termination of cover by the insurer.

Application for Membership

My full name, address, date of birth and occupation details appear in the body of this form. I hereby apply for membership of the AIA Superannuation Fund and agree to be bound by the trust deed constituting the Fund. I acknowledge that my contributions may not be accepted and a risk only interest under the Fund will not be issued if I have not provided my Tax File Number.

1. Will any employer pay contributions to the Fund on your behalf? Yes ☐ No ☐

   If 'Yes', commencement date with employer.   /   /   Contributions to begin.   /   /

2. Nominated Retirement Date   /   /   or Nominated Retirement Age ☐

3. **Personal or Employer Contributions**

   I declare that I am under age 65 years or that I am age 65 or over and under age 75 and have been gainfully employed for at least 40 hours in a period of not more than 30 consecutive days in the latest financial year. I will write and advise the Trustee if at any time this is no longer correct.

4. **Nomination of Beneficiary (optional)**

   Please refer to the section 'Nominating a Beneficiary' on page 37 of the PDS before completing this part of the form.

   You may nominate one or more of your dependants to receive a benefit payable from the Fund in the event of your death, A 'dependant' includes your spouse (legal or de facto), your child or any other person who is financially dependent on you at the time of your death. A 'child' includes an adopted child, a step-child or an ex-nuptial child.

   Type of nomination: ☐ Binding ☐ Non-binding

Dependant(s) Nominated (full name)	Address	State	Post Code	Date of Birth	Relationship to You	Percentage of Benefit
				/ /		%
				/ /		%
				/ /		%
				/ /		%
If more than four beneficiaries are to be nominated use a separate Nomination of Beneficiary form available from us or your adviser.						100 %

5. **Signatures**

   I declare that:

   - I am applying for membership in the Fund as a risk only member;
   - I am eligible to contribute to the Fund;
   - the information contained in this Membership Application is true and correct;
   - I agree to be bound by the terms and conditions of the Trust deed of the Fund as amended from time to time;
   - I acknowledge that the Trustee will apply to AIG Life to be issued with a Superannuation Term Life Plan and that my benefit in the Fund is limited to the benefits provided by AIG Life under the Superannuation Term Life Plan to the Trustee;
   - I acknowledge the policy conditions for the Superannuation Term Life plan, including that the policy may lapse if premiums are not paid within 30 days of falling due. I agree that it is my responsibility to ensure that contributions to the Fund are sufficient for the Trustee to pay the policy premiums;
   - I agree to notify the Trustee of the Fund in writing immediately if I cease to be eligible to contribute to the Fund;
   - I acknowledge that legislation governing superannuation fund restricts payments of benefits except as provided by the governing rules of the Fund and superannuation law;
   - I have read the conditions and the important information in the 'Nominating a Beneficiary' section in the PDS;
   - I acknowledge that if I have made a binding death benefit nomination that it should be reviewed every three years or earlier if my circumstances change;
   - I have read the Trustee's Privacy Statement set out in the AIA Superannuation Fund section of the Superannuation Term Life Plan of this Product Disclosure Statement and I consent to the collection, use and disclosure of my personal and sensitive information by the Trustee in the manner described in the Privacy Statement.

   Signature of Applicant ✗   Date   /   /

   Signatures of Witnesses – declaration and statement by TWO witnesses (must not be nominated beneficiaries).

   Only complete this section if you wish to make a binding nomination. We declare that this form was signed by the applicant for membership of the Fund in our presence. We state that we are each over 18 years and that we are not nominated as a beneficiary on this form.

   Signature of Witness A ✗   Date   /   /

   Full name of witness A   Date of birth   /   /

   Signature of Witness B ✗   Date   /   /

   Full name of witness B   Date of birth   /   /

Applicant's Tax File Number ☐☐☐ / ☐☐☐ / ☐☐☐

Y. Declaration (Life insured and Proposer(s) must complete this section.)

II/We declare that the information contained in the attached statements (whether written in my/our hand or not) or input into the computer using the electronic application system (eApp) is true and correct and that no information material to the insurance has been withheld.

I/We agree that any personal statements made or completed electronically, together with any relevant documents shall form the basis of the proposed contract of insurance with American International Assurance Company (Australia) Limited, trading as AIG Life.

I/We have read the Product Disclosure Statement including Your Duty of Disclosure notice set out in the Significant Risks section and understand its contents and what is meant by my/our duty to disclose. I also understand that my/our duty to disclose continues after I/we have completed this application until AIG Life has accepted the risk.

I/We declare that I/we have read the Privacy Statement set out in the Product Disclosure Statement and I/we consent to the collection, use and disclosure of my/our personal and sensitive information in the manner described in that Privacy Statement.

I/We consent to AIG Life collecting sensitive information, i.e. health information about me/us, for the purpose of the performance of this contract.

I/We understand that if I have indicated I intend to replace an existing policy with this AIG Life policy, I may be required to cancel my existing policy. I acknowledge that in this case the replacement policy issued by AIG Life only starts when my existing policy is cancelled. I acknowledge that failure to cancel my existing policy within a reasonable time may make my AIG Life policy void.

I/We agree that cover will not commence until the premium is paid and AIG Life has accepted the risk.

☐ A signed copy of the quotation is attached to this application

OR

☐ I/we accept quotation number: ______ attached to this Application Form.

Premium $ ______ monthly ☐ half-yearly ☐ yearly ☐

Do you consent to AIG Life disclosing personal medical information to your adviser, obtained to assess your application for insurance? **Yes** ☐ **No** ☐

Do you wish to receive direct marketing material from us?

a) Policy owner 1: Director; Trustee 1 **Yes** ☐ **No** ☐

b) Policy owner 2: Director/Company Secretary; Trustee 2 **Yes** ☐ **No** ☐

Note: If 'No', your name will be deleted from AIG Life's direct marketing mailing list.
AIG Life will not sell or give its mailing list to third parties for promotions independent of AIG Life.

Note: Your premium will be held in a trust account administered by us until the policy is issued to you.
Under the Corporations Act we are entitled to retain any interest earned during the period the funds are held in trust.

Signature of Life Insured: ✗

Name of Life Insured:

Date: / /

Signature of Spouse (if Home Expenses selected): ✗

Name of Spouse:

Date: / /

POLICY OWNER/S

Individual/s

Signature of Policy Owner 1: ✗

Name of Policy Owner 1:

Date: / /

Signature of Policy Owner 2: ✗

Name of Policy Owner 2:

Date: / /

Company

Executed by (Company Name):

Company ABN/ACN:

Signature of Director: ✗

Name of Director:

Date: / /

Signature of Director/Secretary: ✗

Name of Director/Secretary:

Date: / /

Please note for a proprietary company, which has a sole director who is also the company secretary, then the director can sign the Application Form as owner.

Trustee

Signature of Trustee 1: ✗

Name of Trustee 1:

Date: / /

Signature of Trustee 2: ✗

Name of Trustee 2:

Date: / /

Adviser Use Only

Adviser 1 details (Servicing Adviser)

Name of Adviser

Adviser Code

Company Name of Adviser (if applicable)

ABN/ACN (if applicable)

Telephone number

Fax number

E-mail

Adviser 2 details

Name of Adviser

Adviser Code

Has a medical examination, HIV or other test been arranged? ☐ Yes ☐ No

If 'Yes', please provide details of name and address of medical examiner or clinic in the space below.

Special Instructions

English literacy

Can the proposed Policy Owner/s and/or Life Insured(s) read and understand English? ☐ Yes ☐ No

If 'No', what language was used to explain the policy?

Adviser Declaration

eApp No.

I declare that I have given the Policy Owner a copy of the relevant Product Disclosure Statement, attached the quotation to this Application Form, the Policy Owner has checked the details provided in the Application Form and the Life Insured has checked the health information provided. ☐ Yes ☐ No

Adviser 1 Signature ✗ Date / /

Adviser 2 Signature ✗ Date / /

Remuneration Structure

☐ Upfront ☐ Hybrid ☐ Level (where applicable)

Remuneration Plan

Please specify if other than standard

Remuneration Split

Please specify if more than one adviser Adviser 1 % Adviser 2 %

Adviser Notes

Direct Debit Request

If this Direct Debit Request is for more than one policy then please list all relevant policy numbers.

Payment options: **1.** ☐ Deposit premium and all future premiums **2.** ☐ All future premiums

Request and Authority to debit the account named below to pay AIG Life ☐ **Monthly** ☐ **Half-yearly** ☐ **Yearly**

Please refer to the Direct Debit Request Service Agreement in the Product Disclosure Statement.

I/We

Account holder 1 — Title | Family Name or Company Name | Given Name or ABN

Address | Postcode

Account holder 2 — Title | Family Name or Company Name | Given Name or ABN

Address | Postcode

request and authorise American International Assurance Company (Australia) Limited, trading as AIG Life (User ID 142) to arrange for any amount AIG Life may debit or charge me to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement.

Insert details of account to be debited

Name account is held in

BSB number ☐☐☐ – ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Acknowledgment I/We have read and understood the terms and conditions governing the debit arrangements between myself and AIG Life as set out in this Request and in the Direct Debit Request Service Agreement.

Insert the name and address of financial institution at which account is held

Financial institution name

Address | Postcode

Insert your signature and address

Account Holder 1 Signature ✗ | Account Holder 2 Signature ✗ | Date (dd/mm/yyyy)

Credit Card Authority

If this Credit Card Authority is for more than one policy then please list all relevant policy numbers.

Payment options: **1.** ☐ Deposit premium only **2.** ☐ All future premiums **3.** ☐ Deposit premium and all future premiums

Please debit my ☐ Visa ☐ MasterCard ☐ Diners ☐ AMEX

No. Expiry Date /

This authority enables American International Assurance Company (Australia) Limited, trading as AIG Life, to debit your credit card until you advise AIG Life in writing to cancel this authority. The amount debited may vary from time to time as a result of contractual premium variations which apply to your policy. This only applies if option 2 or 3 above is chosen.

If you choose the option of using a credit card for the one-off payment of the deposit premium please enter the amount. $

Name as shown on credit card

Cardholder's Signature ✗ Date (dd/mm/yyyy)

IMPORTANT NOTICE:

Credit Card refunds will be processed by us in the ordinary course of business. We will not accept any responsibility for credit card charges or fees incurred due to expired or cancelled cards or timing delays in processing refunds by the credit card issuer.

Authority to Release Medical Information

I, Name of Life Insured

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to American International Assurance Company (Australia) Limited, trading as AIG Life, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured ✗ Date / /

Authority to Release Medical Information

I, Name of Life Insured

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to American International Assurance Company (Australia) Limited, trading as AIG Life, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured ✗ Date / /

Priority Protection
Direct Debit Request
(see over)

Priority Protection
Credit Card Authority
(see over)

Priority Protection
Authority to Release Medical Information
(see over)

Priority Protection
Authority to Release Medical Information
(see over)