Application Form

OneCare

25 May 2009

ING Life Limited ABN 33 009 657 176 AFSL 238341
ING Custodians Pty Limited ABN 12 008 508 496 AFSL 238346 RSE L0000673
ING MasterFund ABN 53 789 980 697 RSE R1001525
347 Kent Street, Sydney NSW 2000

Customer Services
Phone 133 667
Email customer@ing.com.au
Website www.ing.com.au

Risk Adviser Services
For use by advisers only
Phone 1800 222 066
Email risk.adviser@ing.com.au

Before you sign this Application Form, be aware that ING or your adviser is obliged to have provided you with a Product Disclosure Statement (PDS) containing a summary of the important information about the product(s) you are applying for. This information will help you to understand the product(s) and decide whether the product(s) are appropriate for your needs.

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, to disclose to the insurer every matter that you know, or could reasonably be expected to know, 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 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 of common knowledge
- that your insurer knows or, in the ordinary course of his/her 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 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 life 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 premium that would have been payable if you had disclosed all relevant matters to the insurer.

Your duty of disclosure continues until the contract of life insurance has been accepted and the policy has been issued by ING Life. Please make sure you answer all applicable questions completely and truthfully.

Application details – adviser to complete

Please note a separate Application Form must be completed for each life insured.
Please tick the boxes relating to the policies being applied for and/or amended:

New policy ☐

Modified terms ☐

Existing ING policy

		Existing policy number
☐	Increase to OneCare policy	
☐	Addition of new cover to OneCare policy	
☐	Replace ING policy	
☐	Alteration to OneCare policy	

		Name of fund and policy number	Exit date
☐	Continuation Option		D D / M M / Y Y Y Y

Income Secure Cover guaranteed payment type

If the life insured is applying for Income Secure Cover guaranteed payment type the financial evidence will be provided:

☐ prior to the policy/cover being issued.

☐ at a later date.

Packaging

Please tick the boxes that apply:	Existing policy/group number		List other lives and include dates of birth
☐ Packaging discount		or	
☐ Business Debt Protector			

If a packaging discount is being applied for, what is the relationship between the lives eligible for this discount?

☐ Family members ☐ Business partners

Purpose of cover*: ☐ Personal ☐ Key person ☐ Buy/Sell agreement ☐ Business loan ☐ Share purchase agreement

* If this is not indicated the purpose of cover will be assumed to be Personal.

Pre-assessment

Did you apply for an underwriting pre-assessment number? ☐ Yes ☐ No

If **yes**, please provide the underwriting pre-assessment number

Name of underwriter

Sections to complete

The table below indicates which sections need to be completed, depending on what you are applying for.

	Section A 1–5	Section B 1–3	Section C1	Section C2	Section C3 (1)	Section C3 (2–5)	Section C3 (6–9)	Section C4	Section C5	Section C6	Section C7	Section C8	Section C9	Section C10	Section C11	Section C12	Section C13	Section D 1–2	Section E	Section F	Section G*
Life Cover	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓				✓	✓	✓	✓
Trauma Cover	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓				✓	✓	✓	✓
TPD Cover	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓				✓	✓	✓	✓
Income Secure Cover (all types)	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓				✓	✓	✓	✓
Business Expense Cover	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓
Living Expense Cover	✓		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Child Care Cover	✓															✓		✓	✓		
Baby Care Option	✓																✓	✓	✓		
Extra Care Cover	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓				✓	✓	✓	✓
Life Cover	✓	✓			✓													✓	✓		
Life & TPD Cover#	✓	✓	✓	✓	✓	✓	✓			✓								✓	✓		
Income Secure Cover	✓	✓	✓	✓	✓	✓	✓	✓		✓								✓	✓		
OneAnswer to OneCare^	✓	✓	✓	✓	✓	✓	✓											✓	✓	✓	
ANZ OneAnswer to OneCare^	✓	✓	✓	✓	✓	✓	✓											✓	✓	✓	
Life or Trauma Cover	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓				✓	✓	✓	✓
Life and TPD Cover	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓				✓	✓	✓	✓
Income Secure Cover (all types)	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓				✓	✓	✓	✓
Business Expense Cover	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓
All covers	✓	✓																✓	✓		

* Section G to be completed as required (refer to Section C9)

Continuation of TPD Cover is not available from all Group policies. Please check the Policy Terms of the Group scheme from which the cover is being transferred prior to submission.

^^ Replacement of Integra Super, Corporate Super or ING Group Risk require full underwriting as per new business.

^ If more than $500,000 is required, a full underwriting assessment as per New Business will be necessary. If less than $500,001 is required, a Declaration of Continued Good Health and Circumstances will also need to be completed in addition to the sections above.

Applicant to complete

A1 Details of life insured

If there is more than one life insured, a separate Application Form should be completed for each life insured (with the exception of children to be insured under Child Cover – see table below).

Mr/Mrs/Ms/Miss/Dr (please circle one) Surname First name

Maiden name (if applicable) Date of birth D D/M M/Y Y Y Y

No. and street (home)

Suburb/Town State Postcode

Phone (h) (w) (m)

Email

Gender Male Female **Smoker** Yes No

Marital status Single De facto Married Widow/Widower

May one of our underwriting staff or ING authorised service providers contact you by phone if we require more information? Yes No

If **yes**, when is the most convenient time and on which phone number? (Monday to Friday between 8am to 6pm)

Days Time: From To Phone (h) (w) (m)

Please complete the table below if you are applying for Child Cover.

Children to be insured

Surname	First name	Male/ Female	Height (if over 10 years old)	Weight (if over 10 years old)	Date of birth	Relationship to life insured
1.					/ /	
2.					/ /	
3.					/ /	

A2 Details of policy ownership – non-superannuation

Please complete the section below only when the policy owner is different to the life insured.

If the policy owner is the same as the life insured Go to A3. If there is more than one policy owner, we will regard them as joint tenants.

1. Mr/Mrs/Ms/Miss/Dr (please circle one) Surname/Company name First name

Maiden name (if applicable) Date of birth D D/M M/Y Y Y Y

No. and street

Suburb/Town State Postcode

Phone (h) (w) (m)

Email Relationship to life insured

2. Mr/Mrs/Ms/Miss/Dr (please circle one) Surname/Company name First name

Maiden name (if applicable) Date of birth D D/M M/Y Y Y Y

No. and street

Suburb/Town State Postcode

Phone (h) (w) (m)

Email Relationship to life insured

A3 Mailing address

Please specify the preferred mailing address for policy ownership. All correspondence for this policy will be sent to this address.

No. and street/PO Box

Suburb/Town State Postcode

A4

Cover details

☐ Tick this box to confirm that a signed copy of the Product Illustration (quote) from ING's Illustrator has been attached to this Application Form. **It forms part of the Application Form and your application cannot be assessed without it.**

A5

Nomination of beneficiaries – non-superannuation

Please complete the table below to nominate the beneficiaries to whom death benefits under any cover will be paid and in what proportion.

If not nominating a beneficiary Go to B1.

I, the policy owner, nominate the following beneficiary(ies) to receive the specified proportion of the amount insured payable in the event of the life insured's death. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I understand that I reserve the right to alter this nomination at any time and that subsequent valid nominations supercede previous nominations. If the ownership of this policy is transferred at any time any existing nomination shall become void. ING may discharge its obligations to any minor beneficiary by paying monies due to a duly appointed legal guardian of any minor beneficiary or to the duly appointed trustee of any appropriate fund created for the purpose of receiving any monies so due, among other things.

Surname/Company name of nominated beneficiary	First name	Address	Relationship to life insured	Date of birth	Proportion of the amount insured (%)
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	
Estate/Policy owner			N/A	N/A	
				Total (must add up to 100%)	100%

B1

Policy details

Details of policy ownership – policy to be issued to the trustee of an external superannuation fund

This section is to be completed by the trustee of an external superannuation fund (the Fund) if the life insured is a member of that fund.

If you are not a member of an external fund Go to B2.

Name of the Trustee(s) of the Fund

No. and street

Suburb/Town State Postcode

Name of superannuation fund

Australian Business Number (ABN)

I/We hereby declare that there is an executed Trust Deed in existence for the Fund and all members admitted to the Fund will be bound by the provisions contained therein and that the Fund is regulated under the Superannuation Industry (Supervision) Act 1993.

I/We have read and understood the 'How do I apply?' section of the OneCare PDS.

Director/Trustee name

Director/Trustee signature ✗ Date D D / M M / Y Y Y Y

Director/Trustee/Secretary name

Director/Trustee/Secretary signature ✗ Date D D / M M / Y Y Y Y

B2 OneCare Super – policy to be issued to the trustee of the ING MasterFund

Please complete the following section if you are joining the ING MasterFund (ABN 53 789 980 697, RSE R1001525).

If you are not joining the ING MasterFund Go to C1.

For information on eligibility to contribute to superannuation please refer to 'Who can make contributions to superannuation' in the 'What is OneCare Super?' section of the OneCare Super PDS.

Are you eligible to make contributions to the ING MasterFund? ☐ Yes ☐ No

What type of contributions are being made by you or on your behalf? (Please tick one box only).

☐ Personal ☐ Eligible spouse ☐ Employer

Tax File Number

Before providing this information, please refer to 'Tax File Number' in the 'What is OneCare Super?' section of the OneCare Super PDS.

☐☐☐☐☐☐☐☐☐

B3 Nomination of beneficiaries – OneCare Super

For information on nominating a beneficiary please refer to 'Death Benefit' in the 'What is OneCare Super?' section of the OneCare Super PDS.

As a member of the ING MasterFund, you have two options in relation to your Death Benefit. You can either make a binding nomination, which must be confirmed or updated within three years of the date of the initial nomination, or any subsequent nomination, or you can make a non-binding nomination, which does not have to be confirmed or updated every three years. If you provide us with a binding nomination that satisfies all legal requirements, the Trustee must pay your Death Benefit to the beneficiaries you have nominated and in such proportions as you have specified. If you provide us with a non-binding nomination, the Trustee will ordinarily pay your Death Benefit to the beneficiaries you have nominated and in such proportions as you have specified.
A nominated beneficiary (whether binding or non-binding) must be your dependant (including financial dependant) or your estate.
Tick one of the boxes below to indicate whether you are choosing to make a binding or non-binding nomination:

☐ **Binding nomination (lapsing)**

I hereby advise the Trustee of my binding choices as to who should receive the amount insured payable on my death and in what proportions. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I reserve the right to alter my nomination at any time.

☐ **Non-binding nomination**

I hereby advise the Trustee of my preferences as to who should receive the amount insured payable on my death, how to pay the amount insured, and in what proportions. Such payment is subject to the terms and conditions of the policy and any limitations imposed by law at the time of payment. I reserve the right to alter my nomination at any time.

Please make your nomination/s in the space provided below, up to a maximum of five nominations. You should update your preferences as personal circumstances change, e.g. you marry, divorce or have a child/children.

Surname/Company name of nominated beneficiary	First name	Address	Relationship to life insured	Date of birth	Proportion of the amount insured (%)
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	
Estate/Policy owner			N/A	N/A	
				Total (must add up to 100%)	100%

Declaration for OneCare Super beneficiary nominations

1. I have read and understood the 'Death Benefit' section of the OneCare Super PDS which accompanies this Application Form and have provided my nomination to ING Custodians, the trustee of the ING MasterFund (Trustee).

2. I understand that if I choose to make a non-binding nomination, the Trustee will ordinarily pay my Death Benefit to the beneficiaries I have nominated and in such proportions as I have specified provided certain requirements as set out in the OneCare Super PDS are met.

3. I understand that if I choose to make a binding nomination:

- If I do not confirm or amend my nomination, or make no fresh nomination within three years of the date I make the initial nomination, or within three years after any subsequent nomination, then my nomination will become defective.
- My benefit will not be payable in accordance with my binding nomination if it is cancelled or is defective and instead, will be payable as set out in the OneCare Super PDS.

4. I understand and acknowledge that a non-binding nomination will not override a previous valid binding nomination. The previous binding nomination must first be revoked before making a new non-binding nomination.

5. I understand that any nomination I make on this form will only apply to the benefits payable under the OneCare Super policy, issued by ING Life Limited to the Trustee in respect of my life.

6. By completing this form, I acknowledge that it is my responsibility to ensure that each person I have nominated as a beneficiary is made aware that:

- they have been nominated as a beneficiary
- ING Life and the Trustee hold a record of their personal information for this purpose
- they may contact ING or request access to their information by calling Customer Services on 133 667.

Full name of life insured

Signature ✗ Date D D / M M / Y Y Y Y

Signature of two witnesses (required for all binding nominations)

I am aged 18 years or over, and am not named as a beneficiary on this form. The member signed and dated this form (above) in the presence of us both.

Witness name Date of birth D D / M M / Y Y Y Y

Witness signature ✗ Date D D / M M / Y Y Y Y

Witness name Date of birth D D / M M / Y Y Y Y

Witness signature ✗ Date D D / M M / Y Y Y Y

Life Insured's Personal Statement

All questions in Section C must be completed by the person whose life is to be insured. If there is more than one life insured, a separate Application Form must be completed for each life insured.

C1 Residence and travel details

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

2. How long have you lived in Australia? Years ☐ Months ☐

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

If **yes**, please complete the following:

Date of departure D D / M M / Y Y Y Y Duration of stay ☐

Destination(s) ☐

Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other Please specify if **other** ☐

C2 Insurance details

1. Do you have, or have you previously applied for any life, TPD, trauma, income protection, business expense, living expense, accidental death, stand alone terminal illness, stand alone needle stick cover or cover for pregnancy and/or infancy, with ING Life or any other company (this includes insurance through your superannuation fund and insurance your employer may have arranged for you)? ☐ Yes ☐ No

2. Please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below.

Name of company	Type of cover	Amount insured	Date commenced	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only)
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /

3. Have you ever had an application for insurance on your life declined, deferred, or accepted with a higher than normal premium, or with restrictions or exclusions? ☐ Yes ☐ No

If **yes**, please provide name of company, alteration, type of cover, date and reason (if known).

☐

☐

☐

☐

4. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If **yes**, please provide details, i.e. when, amount, period paid, type of disability suffered.

☐

☐

☐

☐

C3 Occupation details

1a. Occupation

b. How many hours per week do you work in total in your principal occupation (include any hours worked at home)?

c. Industry

d. Years in industry

2. Which of the following best describes your employment situation?

☐ Employed by family company ☐ Employed by my own company ☐ Partnership
☐ Sole trader ☐ Employed by an independent employer ☐ Employed under terms of a contract

3. When did your present job/employment situation start? D D / M M / Y Y Y Y

4. What is your current annual income net of business expenses but before tax and superannuation contributions? $

5. Are any of your duties hazardous (e.g. working from heights, working underground, handling dangerous substances/explosives/chemicals, handling needles, sharps or biohazardous materials)? ☐ Yes ☐ No

If **yes**, please provide details.

Hazardous activity	Maximum height/depth (metres)	Average height/depth (metres)	Average hours per week
Heights			
Underground			

Other hazardous duties

If you are applying for TPD, Income Secure, Business Expense or Living Expense Cover, please go to the next question.

Otherwise, please Go to C6**.**

6. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases).

Type of work	% of time	Please describe your specific duties and where they are performed. Please note, the examples below are to be used as a guide only.
Sedentary/Administration		(e.g. filing, computer work, answering telephone, reception duties)
Manual work – supervising		(specify where e.g. factory, building/construction site)
Manual work – light		(e.g. driving, warehousing, surveying, lifting under 5 kgs)
Manual work – heavy		(e.g. bricklaying, lifting, painting, carpentry, mechanic, driving heavy plant/machinery)
Site visits/inspections		(e.g. real estate sales, building industry inspector, contractor, underground)
Other (please specify)		
Total	100%	

7. Do you possess any trade or tertiary qualifications relevant to your occupation? ☐ Yes ☐ No

If **yes**, please provide details.

Qualifications, degree, licence number, etc.

When and where was the qualification received?

8a. Do you have a second occupation? ☐ Yes ☐ No

If **yes**, please specify occupation

b. Please provide details of duties and earnings of second occupation.

Duties

Current annual income net of business expenses but before tax and superannuation contributions from second occupation $

Hours per week in second occupation

9. Are you considering a change in your current occupation(s), employment situation(s) or duties? ☐ Yes ☐ No

If **yes**, please provide details (e.g. 'concluding contract in three weeks', 'moving to new, permanent job in 25 days', 'retiring permanently from the workforce in 12 months').

C4 Additional occupation details – Income Secure Cover/Business Expense Cover only

If you are not applying for Income Secure Cover or Business Expense Cover **Go to C6** **.**

1. Employer's name or name of business or practice

Business address no. and street

Suburb/Town State Postcode

2. Are any of your occupational duties performed at home? ☐ Yes ☐ No

If **yes**, advise how many hours you work at home and describe duties performed at home.

3. Please give details of your previous employment situation.

Previous employment situation

Industry Number of years in industry

4. If your present employment situation started within the last 12 months, please describe the circumstances under which you changed to your current occupation e.g. promotion, commenced/ceased self-employment, started/purchased a business/practice.

5. What was your annual income, through personal exertion from your principal occupation, net of business expenses but before tax and superannuation contributions for the two previous financial years?

Period	30/6/____	30/6/____
Annual income		

If the variance between the two years is greater than 20% please advise reason(s).

6. Is any of your income likely to continue if you become disabled e.g. sick pay, investment income, company profit share, income generated by your business while you are unable to work? ☐ Yes ☐ No

If **yes**, what is the source of this income?

How long will the income continue?

How much income will be received?

Additional occupation details – Income Secure Cover/Business Expense Cover only – continued

7. Have you or any entities owned or controlled by you ever been declared bankrupt or insolvent, or are you or any entities owned or controlled by you currently being declared bankrupt or insolvent? ☐ Yes ☐ No

If **yes**, please provide date, date of discharge and circumstances (if applicable).

Date declared bankrupt D D / M M / Y Y Y Y Date discharged D D / M M / Y Y Y Y

Circumstances of bankruptcy

Please complete the following for all employment situations other than 'Employed by an independent employer'.

8. In the event of your total disability, will the business continue to operate? ☐ Yes ☐ No

If **yes**, give an estimate of the ongoing trading capacity (please ensure this correlates with your answer to question 6). %

9. How many people do you employ other than yourself and your spouse? Full time Part time

10a. What percentage of the business do you own? %

b. What percentage does your spouse own? %

11. Is your business currently trading profitably? ☐ Yes ☐ No

If **no**, please give full details.

Please complete if applying for the Priority Income Option including Mortgage Maintenance and/or Superannuation Maintenance.

12. If you are applying for Mortgage Maintenance, what was the average of your share of the minimum monthly mortgage repayments made over the previous 12 months? $ per month

13. If you are applying for Superannuation Maintenance, what was the average monthly superannuation contributions made by you or your employer over the previous 12 months? $ per month

C5 Business Expense Cover Only

If you are not applying for Business Expense Cover Go to C6.

1. What percentage of:

a. business income is derived from your personal exertion? %

b. total business expenses are you responsible for? %

c. business income can be attributed to other income-producing employees? %

2. Please state the number of employees and briefly describe their duties.

3. If working in a partnership, please specify how many partners you have:

4. In the event of your total disability, will the business continue to operate? ☐ Yes ☐ No

If **yes**, please give an estimate of the ongoing trading capacity. %

5. Eligible expenses – please provide details in the table below of any average monthly expenses for which you are responsible and which will continue during your absence.

If income splitting exists, please indicate the annual amount paid to your spouse (please do not include this amount in the expenses below)	**Annual amount** $
Details of expenses (excluding recoverable GST)	**Monthly amount**
Business premises rent or business loan interest payment	$
Leasing of office equipment or motor vehicles	$
Salaries of employees not involved in the generation of revenue	$
Payroll tax for employees not involved in the generation of revenue	$
Superannuation contributions for employees not involved in the generation of revenue	$
Electricity, gas and water	$
Telephone	$
Business insurance premiums (excluding premiums payable on this policy)	$
Cleaning	$
Property rates	$
Locum cover (a person outside your business who is a direct replacement for you in your business) less any business earnings generated by the locum	$
Other expenses*	$
Total	**$**

* Other expenses cannot include personal remuneration, salary, fees or drawings for the life insured or any other employee generating income, cost of goods or merchandise, mortgage principal, cost of implements of profession, or depreciation.

Please describe other expenses.

C6 Pastimes

1. Have you any intention of engaging in:

a. motorcycle riding other than as a means of transportation to and from work (e.g. offroad, racing)? ☐ Yes ☐ No

b. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, gliding, recreations involving heights, underwater sports, caving, body contact sports, hang gliding? ☐ Yes ☐ No

c. aviation, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered **yes** to any of questions 1a, b or c above, please continue completing the section below for the relevant activity.

Motorcycle/Motor racing

Vehicle type

Engine size

Class

Races p.a

Max. speed (km/h)

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Scuba/Skin diving

Average depth (m)

Dives p.a.

Maximum depth (m)

Do you use explosives?

Do you dive in wrecks, caves or potholes? ☐ Yes ☐ No

If **yes**, please give details.

Pastimes – continued

Football/Soccer/Australian Rules, etc.

Code played and grade _____ Games p.a. _____

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income participating in Football/Soccer/Australian Rules etc.? ☐ Yes ☐ No

If **yes**, please provide amount and details.

_____

_____

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes**, state type and period held.

_____

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

Please complete the table below.

No. of hours flown	**Past 12 months**		**Future annual average**	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories

(e.g. ballooning, aerobatics, parachuting, paragliding)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

_____

_____

_____

_____

Other sports or pastimes

Do you participate in any other hazardous activities or sports (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

_____

_____

_____

_____

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

C7 Personal health statement

1. What is your current height and weight? Height (cm) Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance? ☐ Yes ☐ No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement treatment? ☐ Yes ☐ No

If **yes**, please state **type** used and **duration** of use.

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No

If **yes**, please state **type**, **quantity** per day and **date** ceased.

6. Do you consume alcohol? ☐ Yes ☐ No

If **yes**, please state how many standard drinks do you consume per week (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? ☐ Yes ☐ No

If **yes**, please provide full details.

8. Have you within the past five years suffered needle stick injury? ☐ Yes ☐ No

If **yes**, please provide date of incident, dates and results of all follow up blood tests.

9. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? ☐ Yes ☐ No

10. Have you **ever** engaged in sexual activity with, or worked as, a prostitute, or engaged in anal sexual activity? ☐ Yes ☐ No

If you answered **yes** to question 9 and/or 10, a confidential questionnaire will be sent to you to complete and return to ING's underwriting department.

If you are required to have a full medical examination Go to C10**.**

C8 Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to age 60 been diagnosed with diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, cervical cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed

C9 Medical history

To the best of your knowledge, have you ever had any of the following (please tick the appropriate box and circle the specific conditions that are applicable):

1. Asthma? ☐ Yes ☐ No

2. High blood pressure? ☐ Yes ☐ No

3. High cholesterol? ☐ Yes ☐ No

4. Diabetes? ☐ Yes ☐ No

5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No

6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No

7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No

8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 25 to 33.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No

10. Heart trouble or murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No

11. Thyroid or glandular trouble? ☐ Yes ☐ No

12. Ulcers, bowel trouble or recurring indigestion? ☐ Yes ☐ No

13. Epilepsy, fits, hydrocephalus, dizziness, fainting of any kind or persistent headaches? ☐ Yes ☐ No

14. Alzheimer's disease or dementia? ☐ Yes ☐ No

15. Kidney, liver, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No

16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No

17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No

18. Cancer (including carcinoma in situ of any organ), tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No

19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No

20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No

21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? ☐ Yes ☐ No

22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No

23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No

24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No

25. Any sexually transmittable disease including but not limited to HIV, gonorrhoea or syphilis? ☐ Yes ☐ No

26. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No

27. Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)? ☐ Yes ☐ No

28. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No

29. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation, or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc) ☐ Yes ☐ No

30. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No

31. Have you ever used or injected any drugs not prescribed for you by a medical attendant? ☐ Yes ☐ No

32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No

33. Females only

a. Have you ever had any complications with pregnancy or childbirth (e.g gestational diabetes)? Please do not include an elective caesarean section or miscarriage within the first 15 weeks of pregnancy as complications ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date D D / M M / Y Y Y Y ☐ Yes ☐ No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered **yes** to any questions from 9 to 33, please complete the following table.

To be completed if you have answered **yes** to any questions from 9 to 33 in section C9

	Question number	Question number
Condition or symptoms		
Date symptom started	/ /	/ /
Date symptom ceased (please state if ongoing)	/ /	/ /
How often did/do the symptoms occur (e.g. daily, weekly, monthly)?		
Severity of condition (e.g. mild, moderate, severe)		
Have you ever had an x-ray, scan, blood test or any other type of investigation for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Details: Dates: Results:	☐ Yes ☐ No Details: Dates: Results:
Did/Do you take medication or have any other treatment (e.g. physiotherapy, operation) for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Name of medication/treatment: Details:	☐ Yes ☐ No Name of medication/treatment: Details:
Are you still receiving medication/ treatment? If **no**, when did treatment cease?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been off work as a result of this condition? If **yes**, please elaborate.	☐ Yes ☐ No Total time off work (e.g. days, months, years):	☐ Yes ☐ No Total time off work (e.g. days, months, years):
Degree of recovery	☐ % Details:	☐ % Details:
Has a doctor given you a referral or recommended any further treatment, tests or investigations for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Doctor/Specialist to whom you were referred: Recommendation:	☐ Yes ☐ No Doctor/Specialist to whom you were referred: Recommendation:
Was/Is your treating doctor different to your usual doctor? If **yes**, please elaborate.	☐ Yes ☐ No Name of doctor: Doctor's address: Phone: Fax:	☐ Yes ☐ No Name of doctor: Doctor's address: Phone: Fax:

To be completed if you have answered **yes** to any questions from 9 to 33 in section C9

	Question number	Question number
Condition or symptoms		
Date symptom started	/ /	/ /
Date symptom ceased (please state if ongoing)	/ /	/ /
How often did/do the symptoms occur (e.g. daily, weekly, monthly)?		
Severity of condition (e.g. mild, moderate, severe)		
Have you ever had an x-ray, scan, blood test or any other type of investigation for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Details: Dates: Results:	☐ Yes ☐ No Details: Dates: Results:
Did/Do you take medication or have any other treatment (e.g. physiotherapy, operation) for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Name of medication/treatment: Details:	☐ Yes ☐ No Name of medication/treatment: Details:
Are you still receiving medication/ treatment? If **no**, when did treatment cease?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been off work as a result of this condition? If **yes**, please elaborate.	☐ Yes ☐ No Total time off work (e.g. days, months, years):	☐ Yes ☐ No Total time off work (e.g. days, months, years):
Degree of recovery	☐ % Details:	☐ % Details:
Has a doctor given you a referral or recommended any further treatment, tests or investigations for this condition? If **yes**, please elaborate.	☐ Yes ☐ No Doctor/Specialist to whom you were referred: Recommendation:	☐ Yes ☐ No Doctor/Specialist to whom you were referred: Recommendation:
Was/Is your treating doctor different to your usual doctor? If **yes**, please elaborate.	☐ Yes ☐ No Name of doctor: Doctor's address: Phone: Fax:	☐ Yes ☐ No Name of doctor: Doctor's address: Phone: Fax:

C10 Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone Fax

No. and street

Suburb/Town State Postcode

How many years have you been attending this doctor/medical centre? Years Months

2. Have you had **any** consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? Yes No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		
	/ /		
	/ /		

C11 TPD Cover (non-working) or Living Expense Cover

If you are not applying for TPD Cover (non-working) or Living Expense Cover **Go to C12****.**

1. What is your annual household income?

$0 to $30,000

$30,001 to $50,000

$50,001 and over

Please continue to complete this section only if you are age 65 or over.

2. Do you have children? Yes No If **yes**, how many?

3. Are you involved in social activities (e.g. bowls, golf, trips, volunteer work)? Yes No

If **yes**, describe what type.

4. Do you have family that lives close by, with whom you have regular contact? Yes No

5. Are there any duties you are unable to perform as part of your normal daily activities due to physical, mental, emotional or memory problems?

Bathing and showering	Yes	No	Shopping for groceries	Yes	No
Using the toilet, including getting up and down	Yes	No	Making telephone calls	Yes	No
Dressing and undressing, including putting on shoes and socks	Yes	No	Taking medications	Yes	No
Doing work around the house or garden	Yes	No	Walking across a room	Yes	No
Eating and drinking, including cutting up food	Yes	No	Getting in and out of bed	Yes	No
Managing money such as paying bills and keeping track of expenses	Yes	No			

If you answered **yes** to any of the above, please give details.

TPD Cover (non-working) or Living Expense Cover – continued

6. Do you need assistance with walking? ☐ Yes ☐ No

If **yes**, please give details (e.g. walking stick, zimmer frame, wheelchair).

7. If you have answered **yes** to questions 5 or 6 above, does anyone help you with these activities? ☐ Yes ☐ No

If **yes**, what relationship does the person providing assistance have to you (e.g. husband, daughter, friend, health worker etc)?

C12 Child Cover only

For any children listed under A1, please complete questions 1 – 4.

If you are not applying for Child Cover **Go to D1****.**

1. Do any of the children have any Life, TPD or Trauma Cover with ING Life or any other company? ☐ Yes ☐ No

If **yes**, please provide details.

Name of child	Name of company	Type of cover	Amount insured	Date commenced	Will this policy be discontinued/ replaced?
			$	/ /	☐ Yes ☐ No
			$	/ /	☐ Yes ☐ No
			$	/ /	☐ Yes ☐ No
			$	/ /	☐ Yes ☐ No

	Child 1 Name	Child 2 Name	Child 3 Name
2. Has this child ever had:			
• high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• rheumatic fever or any heart complaint?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• asthma, tuberculosis or any other lung disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• cancer, cyst, lesion or tumour of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• diabetes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• indigestion, or gastric or duodenal ulcer?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• epilepsy, fainting attacks or fits of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• a physical or neurological defect, impaired sight or hearing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• anaemia, leukaemia, haemophillia or any other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• kidney, liver or gall bladder problems, including hepatitis of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• or been diagnosed with, investigated for or displayed symptoms of any form of mental underdevelopment, incapacity or retardation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has this child ever :			
• been advised to have an operation or surgery in the future?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• been infected with the virus which causes AIDS (the Human Immunodeficiency Virus) or are they carrying antibodies to that virus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• been injected with or used any drug not prescribed by a medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• received a blood transfusion or treatment with human blood products?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Child 1	Child 2	Child 3
	Name	Name	Name
4. Has the child's mother, father, brother or sister suffered from diabetes, heart disease, cancer, stroke, mental disorder or breakdown, kidney disorder, Huntington's disease or any hereditary disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

For any **yes** answer for questions 2, 3, or 4, please advise the name of condition, dates of treatment, name and address of doctors or hospitals consulted and the relationship of the person who had the condition to the child.

Child 1

Child 2

Child 3

C13 Baby Care Option only

If you are not applying for Baby Care Option, go to **Go to D1**.

1. Have you ever given birth to a child with a birth defect, congenital abnormality or hereditary medical condition? ☐ Yes ☐ No

2. Have you ever lost a child prior to the age of two due to SIDS, stillbirth or any other medical related cause? ☐ Yes ☐ No

D1 Declarations

Information about ING's other products and services

I/We accept that ING may send me/us information about its other products or services from time to time.

If you do not wish to receive this information you must tick this box ☐ or advise us at a later date.

D2

- I/We have received the applicable OneCare Product Disclosure Statement (PDS) dated 25 May 2009 which accompanies this Application Form and have read and understood the duty of disclosure on page 1 of this Application Form.
- I/We acknowledge the privacy disclosures set out in the PDS and consent to the collection, use and disclosure of my/our personal information.
- I/We authorise my/our adviser, named on the back page of the Application Form, to receive and access my/our personal information including financial, medical and other matters, whether disclosed in this application or obtained from third parties (e.g. doctors, accountants), for the purposes of management and administration of my/our application, policy/policies and any claims. Where there is any change to this authority, or to my/our adviser, I/we will notify ING Life of the change.
- I/We understand that if ING Life is notified of a change in my/our personal information, ING Life will make this change on other life risk policies where I am/we are a policy owner, life insured, nominated beneficiary or nominated medical practitioner.
- I/We understand that if I/we fail to attend any medical appointments required by ING Life, I/we could be liable for any associated costs.
- I/We, whose signature(s) appear below, declare that the statements made in this Application Form including the Personal Statement and questionnaires are true and complete.
- As policy owner(s) I/we understand that if the life insured has not fully disclosed all known circumstances relevant to the policy/cover before the policy/cover commences, then ING may elect to decline to pay the claim or to reduce the payment of any claim arising from those known circumstances.
- I/We understand that all covers issued are conditional upon the life insured disclosing all matters known to them that are relevant to ING's decision to issue any cover. If this condition is met, the policy and/or cover may be cancelled and/or a benefit be reduced or not paid.
- I/We understand that if this application is to replace another life insurance policy (the 'other policy'), that I/we must cancel the other policy upon acceptance of this life insurance policy. In any event, if I/we do not cancel the other policy, the benefits paid under this policy will be offset or reduced to the extent of any of the benefits the policy owner is entitled to under the other policy.
- I/We understand that the insurance I/we have applied for will not become effective until my/our application is accepted by the insurer in writing.
- Where the proposed owner of this policy is a trust/company, I/we confirm that I/we have the capacity and authority to sign this application as authorised by the governing rules of the trust/company.
- I/We acknowledge that I/we are not currently receiving benefits or are eligible to receive benefits under any life insurance policy or compensation scheme.

Signature of life insured ✗ Date D D / M M / Y Y Y Y

Signature of policy owner(s) if different to life insured and not a OneCare Super (ING MasterFund) policy ✗ Date D D / M M / Y Y Y Y

Signature of policy owner(s) if different to life insured and not a OneCare Super (ING MasterFund) policy ✗ Date D D / M M / Y Y Y Y

E Payment Authority

Direct Debit Authority

Direct debit is not available from all account types. If in doubt please check with your financial institution.

By signing this Direct Debit Authority I/we acknowledge that I/we have read and understood 'Direct Debit Request Service Agreement' in the 'What else do I need to know?' section of the PDS and are bound by the terms and conditions contained in this authorisation.

I/We request and authorise ING Life Limited ABN 33 009 657 176 AFSL 238341 (user number 219313) to arrange for any amount ING Life Limited 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.

Details of the account to be debited

Name of account

Name of financial institution

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

☐ Initial payment only or

☐ All payments

Signature (all signatures if joint account)

Signature ✗ Date D D / M M / Y Y Y Y

Signature ✗ Date D D / M M / Y Y Y Y

Credit Card Authority

I/We understand my/our bank or financial institution may charge a processing fee to my/our credit card for each payment that is made under this authorisation.

I/We acknowledge it is my/our responsibility to notify ING Life Limited of any material change in credit card details, including a new expiry date.

I authorise ING Life Limited to charge my:

☐ Visa ☐ Mastercard

Cardholder's name

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date M M / Y Y Y Y

☐ Initial payment only or

☐ All payments

Cardholder's signature ✗ Date D D / M M / Y Y Y Y

Payment details

ING Life Limited will schedule premiums to be debited on the same day of the month that your insurance commences. For example, if your insurance commences on 17 March, your premium will be debited on the 17th of the month in which it becomes due.

If this is unacceptable, please provide the day of the month you would prefer as your billing date

OneCare Super Transfer Authority

This Transfer Authority allows you to pay your OneCare Super policy premiums by annual deduction from an eligible ING superannuation product. To use this Authority:

- The OneCare Super policy must have an annual premium frequency. If the current premium payment frequency is not annual, then this form will be taken as authority to change the frequency to annual.
- The member of the ING MasterFund (the 'Member') must have or be applying for OneAnswer Personal Super or ANZ OneAnswer Personal Super, or have an OptiMix Superannuation account.
- The member must be the same as the account holder of the relevant ING superannuation product.

Only one Transfer Authority can apply for each ING superannuation account.

ING MasterFund Details

Member number

Product name

Financial institution **ING Custodians Pty Ltd**

Fund name **ING MasterFund**

Transfer Authorisation

I authorise ING Life Limited ABN 33 009 657 176 AFSL 238341 to arrange for my OneCare Super premium payments to be deducted from my nominated ING MasterFund account. These amounts may include current and ongoing premium payments on an annual basis, and any adjustments that may occur from time to time.

ING MasterFund is a regulated and complying superannuation fund under the Superannuation Industry (Supervision) Act 1993.

I authorise the Trustee to provide all relevant information and any other documentation to ING Life Limited for the purposes of administering my OneCare Super policy.

I understand that I may cancel this Transfer Authority at any time by providing written notice to ING Life Limited. To prevent additional transfers, such notice should be received by ING Life Limited at least 14 days before the next transfer is due.

I understand the Trustee may cancel a transfer request if I am no longer eligible to maintain some or all of my OneCare cover.

Name of Member

Signature ✗

Date D D / M M / Y Y Y Y

F

Authorisations

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by ING. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth D D / M M / Y Y Y Y

Signature of life insured

✗

Date D D / M M / Y Y Y Y

Address of life insured

State Postcode

Policy number

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by ING. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth D D / M M / Y Y Y Y

Signature of life insured

✗

Date D D / M M / Y Y Y Y

Address of life insured

State Postcode

Policy number

G Questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in C9.

1. When did you have your first episode of asthma? Date D D/M M/Y Y Y Y

2. When was your most recent episode of asthma? Date D D/M M/Y Y Y Y

3. Approximately how many episodes have occurred in the last 12 months?

4. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)?

☐ Yes ☐ No

If **yes**, please provide details.

6. Have you sought medical treatment or advice for asthma? ☐ Yes ☐ No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y

7. How has your doctor described your asthma? ☐ Mild ☐ Moderate ☐ Severe

8. Have you ever used any medication, including steroids? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

9. Have you ever been hospitalised due to asthma? ☐ Yes ☐ No

If **yes**, please provide details.

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

Name and address of hospital

10. Have you ever had lung function tests performed? ☐ Yes ☐ No

If **yes**, please provide details.

Date	Test results
/ /	
/ /	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in C9.

1. When was your high blood pressure first diagnosed? D D/M M/Y Y Y Y

2. What was your blood pressure reading at that time? Systolic ____ Diastolic ____

3. Have you ever been treated by medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details.

Test performed	Date	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name ____

Address ____

Suburb/Town ____ State ____ Postcode ____

Date of last consultation D D/M M/Y Y Y Y

6. What was the date of your last blood pressure check? D D/M M/Y Y Y Y

7. What was your blood pressure reading at that time? Systolic ____ Diastolic ____

8. How has your doctor described your blood pressure control?

☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details

9. What is the date of your next blood pressure check-up? D D/M M/Y Y Y Y

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in C9.

1. When was your high cholesterol first diagnosed? D D/M M/Y Y Y Y

2. What were your cholesterol readings at that time? Cholesterol ____ Triglycerides ____

HDL Cholesterol ____ LDL Cholesterol ____

3. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details.

Test performed	Date	Results
	/ /	
	/ /	

4a. Have you ever used any medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ☐ Yes ☐ No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y

6. What was the date of your last cholesterol check? D D/M M/Y Y Y Y

7. What were your cholesterol readings at that time? Cholesterol ____ Triglycerides ____

HDL Cholesterol ____ LDL Cholesterol ____

8. How has your doctor described your cholesterol control?

☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next cholesterol check up? D D/M M/Y Y Y Y

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in C9.

1. When was your diabetes first diagnosed? D D/M M/Y Y Y Y

2. How is your diabetes controlled?

☐ Insulin – go to question 3

☐ Diet only – go to question 4

☐ Oral – list medications below and then go to question 4

3. How many times a day do you administer insulin?

☐ I'm on an insulin pump

☐ One or two times daily

☐ Three or more times daily

4. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details.

5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details.

Condition	Date	Treatment
	/ /	
	/ /	

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details.

Date	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details.

Date	Test results
/ /	
/ /	

7. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in C9.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa or bulimia
- ☐ Depression including major depression or dysthymia
- ☐ Manic depressive illness or bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness
- ☐ Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed	Date condition ceased (if applicable)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

4. Are you currently symptom free? ☐ Yes ☐ No

If **yes**, please provide date(s) of last symptoms.

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details.

7. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

Mental health questionnaire (continued)

8. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details.

Treatment (e.g. tranquilisers, sedatives, ECT, counselling)	Date commenced	Date ceased (if applicable)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details.

10. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details.

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y

11. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details.

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y Doctor(s) consulted

12. Does your usual doctor, as advised in C10 section , have details of this condition(s) ☐ Yes ☐ No

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in C9.

1. When did your back/neck condition first occur? D D / M M / Y Y Y Y

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash).

5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No

If **yes**, please provide details.

Tests	Results	Date of tests
		/ /
		/ /

6. Have you had recurrent or multiple episodes of the back/neck condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immoblisation)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? D D / M M / Y Y Y Y

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in C9.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Knee	☐	☐
Elbow	☐	☐	Wrist	☐	☐
Shoulder	☐	☐	Hip	☐	☐
Other	☐	☐	If **other**, state which joint		

2. When did this condition first occur? D D / M M / Y Y Y Y

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? Date D D / M M / Y Y Y Y

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in C9.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each.

Date of removal D D/M M/Y Y Y Y

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation D D/M M/Y Y Y Y

Adviser to complete

Checklist for advisers

Attachments

- ☐ Product Illustration (quote)
- ☐ Financial evidence
- ☐ Premium cheque(s) $

Have the following been completed or arranged?

- ☐ MediQuick
- ☐ Medical examination
- ☐ Fasting MBA-20
- ☐ HIV Test and Hepatitis B & C Serology
- ☐ Direct Debit or Credit Card Request
- ☐ Appropriate medical questionnaires
- ☐ Financial evidence
- ☐ Other tests

Additional information/comments

Reminder: for quicker processing, please make sure all applicable questions are answered in full.

Notes

Notes

Interim Cover Certificate

ING Life Limited ABN 33 009 657 176 AFSL 238341
ING Custodians Pty Limited ABN 12 008 508 496 AFSL 238346 RSE L0000673
ING MasterFund ABN 53 789 980 697 RSE R1001525
347 Kent Street, Sydney NSW 2000

Customer Services
Phone 133 667
Email customer@ing.com.au
Website www.ing.com.au

Interim Cover for policy owner _____ on the life insured _____

Thank you for applying for OneCare. While we assess your application for insurance, we will provide you with Interim Cover subject to the terms as set out in the OneCare Product Disclosure Statement dated 25 May 2009 (PDS) and in this certificate. Please refer to the 'Interim Cover' section of the PDS for further information.

Interim Cover does not apply if the cover applied for:

- is to replace existing insurance which is still in force (active), whether with ING Life Limited (ING Life) or another insurer or
- would normally be declined or deferred under ING Life's current underwriting rules.

When Interim Cover commences

Interim Cover commences when ING Life or an authorised adviser receives a fully completed OneCare application and the application includes either a cheque, a valid Direct Debit Authority, Credit Card Authorisation or Internal Transfer Authority for the payment of the first premium. Your Interim Cover will automatically expire 90 days from commencement, unless it ceases earlier due to any of the other events set out in 'Duration of Interim Cover' in the 'Interim Cover' section of the PDS.

Amount covered

Depending on the type of covers you have applied for, for each type of cover, the Interim Cover Benefit we will pay will be the lesser of the amount insured applied for or the maximum amount payable under Interim Cover for each type of cover, as specified below:

- Life Cover – up to $1 million lump sum*
- TPD and Trauma Covers – up to $500,000 lump sum*
- Income Secure and Business Expense Covers – up to $5,000 per month^
- Living Expense Cover – up to $2,000 per month
- Child Cover – up to $150,000 lump sum
- Extra Care Cover Accidental Death – up to $500,000 lump sum.

* We will pay this amount or the equivalent instalment amount

^ A maximum of $30,000 will be payable in total benefits for Income Secure and Business Expense Covers

Important Information:

This certificate is dependent upon the life insured and the policy owner providing complete and truthful answers in the application for insurance and complying with the duty of disclosure. The duty of disclosure continues until the contract of life insurance has been accepted and the policy is issued by ING Life.

Adviser details

To be completed by the authorised adviser who advised the applicant on the policies which are being applied for.

First adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature

✗

Commission: split/share %

Second adviser

Licensee Sales Account No.

Authorised Sales Account No.

Company name

Name of adviser

Phone

Fax

Email

Signature

✗

Commission: split/share %

Only complete if different from your default

☐ Upfront ☐ Stepped ☐ Hybrid ☐ Level

ANZ use only

Seller 2:

Seller 3:

Office use only

Life insured:

(Family name, in capitals)

(First names)

Underwriting

Start date: D D/M M/Y Y Y Y

Policy checked by:

(Initials)

Policy issue date: D D/M M/Y Y Y Y

Final assessment

Decision:

Signature

✗

Date: D D/M M/Y Y Y Y

Premium receipt details (cheques only)

Initial premium paid:

$

Date banked: D D/M M/Y Y Y Y

Head office

Office located at
347 Kent Street
Sydney NSW 2000

Postal address
ING Life Limited
GPO Box 4148
Sydney NSW 2001

State offices

New South Wales
Level 10
347 Kent Street
Sydney NSW 2000

GPO Box 483
Sydney NSW 2001

South Australia
Level 1
45 Pirie Street
Adelaide SA 5000

GPO Box 435
Adelaide SA 5001

Western Australia
Level 17
Forrest Centre
221 St. Georges Tce
Perth WA 6000

PO Box 7737
Cloister Square
Perth WA 6850

Queensland
Level 17
100 Edward Street
Brisbane QLD 4000

GPO Box 307
Brisbane QLD 4001

Victoria
Level 22
570 Bourke Street
Melbourne VIC 3000

GPO Box 481
Melbourne VIC 8060

Customer Services

Phone 133 667
Email customer@ing.com.au
Website www.ing.com.au

Risk Adviser Services

For use by advisers only
Phone 1800 222 066
Email risk.adviser@ing.com.au

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