This form is dated 2 October 2018

ZURICH

Zurich Insurance

Application form

Before completing or signing this Application form, you should read the Product Disclosure Statement (PDS) relevant to your policy. For new applications, this is the Zurich Wealth Protection PDS dated 15 May 2017, the Zurich Active PDS dated 30 April 2018, the Zurich Sumo PDS dated 15 May 2017 or the Zurich FutureWise PDS dated 1 October 2016.

If you are requesting an alteration to an existing policy, you should refer to the PDS and policy document issued at the time you applied for your policy (and any policy updates for your product) for the applicable terms.

The relevant PDS must be provided to you with this Application form. It will help you to understand the policies and decide if they are appropriate to your needs.

You must fill out an additional Application form if you wish to insure more than one life (unless you are insuring another life under the Home support option or a Child Cover policy).

All parties to any policy issued must be Australian residents, including policy owners, lives insured and payors.

Please use black pen, BLOCK LETTERS and ticks (✓) where applicable. DO NOT USE HIGHLIGHTERS.

1. Type of application

Use this Application form to apply for the policies offered in the Zurich Wealth Protection, Zurich Active, Zurich Sumo or Zurich FutureWise PDS. It should also be used to increase or change any of those policies that already exist, including existing Zurich Super Protector policies.

What are you using this Application for?

◯ To apply for one or more new Wealth Protection, Active, Sumo or FutureWise policies

◯ To increase an existing policy → provide policy type and number in section 2 below

◯ To change an existing policy → provide policy type and number in section 2 below

2. Details

Complete the table below with details of the policies that you are applying for.

Usually the life insured is also the policy owner, but the life insured and the policy owner can be different. You can nominate a person, company, trustee or business partner to own the policy/policies. All policy owners must sign the declaration on page 23.

Policy owner details are not required if you are applying for a policy through the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust.

For platform business, some details will be obtained from your Zurich premium quote:

- payor details are not required as premiums will be automatically deducted from the platform account
- policy owner details are not required where the policy is to be owned by a superannuation trustee

Policy	Policy type	Policy owner name/s	Life insured name	Payor name	Policy commencement/admin instructions
1 (sample)	*Protection Plus*	*Mr A Sample*	*Mr A Sample*	*A B Sample Pty Ltd*	*change/replace existing policy no. 12345678*
1					
2					
3					
4					

Policies being replaced will be cancelled upon acceptance of the Application.

Additional information

3. Life insured

Provide details for the life insured

Title | Surname | First name | Middle name

○ Male ○ Female | Date of birth / /

Address | State | Postcode

Work phone number ( ) | Home phone number ( )

Mobile number | Email

4. Policy owners

Provide details for all policy owners

If you are applying for more than one policy, ensure you also complete section 2 on the previous page.

If the life insured and the policy owner are the same person, you do not have to provide the details again.

Do not complete this section for policies to be owned by the trustee of the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust.

Policy owner 1

Nominate a person

Title | Surname | First name | Middle name

Date of birth / /

OR nominate the trustee of a superannuation fund

Trustee/s name/s (and ABN if trustee is company)

Fund name and ABN

Preferred short name (maximum 45 characters)

OR nominate a company/trustee/business partner

company name and ABN/trustee/s/business partners

Provide contact details for the nominated policy owner

Mailing Address | State | Postcode

Country of residency

Work phone number ( ) | Home phone number ( )

Mobile number | Email

Relationship to the insured | your % interest in business (if any) | %

If there is only one policy owner → go to section 5

Continue filling out this form on the following page ↘

Policy owner 2

Generally, where there is more than one policy owner, the party nominated as policy owner 1 will receive the correspondence relating to the policy.

Nominate a person

Title Surname First name Middle name

Date of birth / /

OR nominate a company/trustee/business partner

company name and ABN/trustee/s/business partners

Provide contact details for the nominated policy owner

Mailing Address State Postcode

Country of residency

Work phone number ( ) Home phone number ( )

Mobile number Email

Relationship to the insured your % interest in business (if any) %

5. Beneficiary nomination (non-superannuation death benefits only)

A beneficiary nomination is optional. If you are the sole policy owner and life insured, you can nominate one or more beneficiaries to receive your benefits when you die. Beneficiary nominations are only applicable for death benefits under Zurich Protection Plus, Zurich Active, Zurich Sumo or Zurich FutureWise.

For important information about nominating beneficiaries, refer to the relevant PDS.

Nominate your preferred beneficiaries below. Use their full name. The share of benefit sections must total 100%. If you wish for your estate to receive a proportion of your benefits, write 'my legal personal representative'.

Name of **beneficiary 1**

Address State Postcode

Date of birth / / Relationship Share of benefit %

Name of **beneficiary 2**

Address State Postcode

Date of birth / / Relationship Share of benefit %

Name of **beneficiary 3**

Address State Postcode

Date of birth / / Relationship Share of benefit %

Name of **beneficiary 4**

Address State Postcode

Date of birth / / Relationship Share of benefit %

If you need more space to nominate beneficiaries, attach a separate page, signed and dated by you.

Continue filling out this form on the following page ↘

6. Premium quote

Complete a Zurich premium quote with your adviser and attach the Application submission report to this Application.

The insurance premium quote forms part of this Application. Refer to the premium quote for underwriting requirements.

Have you attached a Zurich premium quote for the insurance policies you are applying for?

◯ No → consult your adviser before proceeding

◯ Yes → go to section 7

7. Life insured's statement

To apply for new or additional cover, complete the Zurich Insurance Life Insured's Statement, starting on page 7.

Will you attach a completed Life Insured's Statement?

◯ No → consult your adviser before proceeding

◯ Yes → go to the next page

This form is dated 2 October 2018

Zurich Insurance-only Superannuation Plan

Membership application

You must become a member of the Zurich Insurance-only Superanuation Plan, a division of the Aon Master Trust, ('Zurich Plan') to apply for a Zurich policy owned by the trustee of the Zurich Plan. You must also complete the tax file number notification section on this page.

If you are not applying for a Zurich policy owned by the trustee of the Zurich Plan, do not complete this section and instead go to page 7.

1. Member declaration

Read the following information and sign below to confirm your agreement.

I apply to join the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust. I understand that, in accordance with the conditions of the Trust Deed and Rules of the Aon Master Trust (the Fund) and relevant superannuation legislation:

- the trustee owns any policy taken out on my life
- I cannot use the Fund as collateral security, that is, for borrowing purposes
- benefits provided through the Fund are fully preserved until I have retired and attained my preservation age, or in circumstances allowed by superannuation legislation or the Australian Prudential Regulation Authority, as detailed in the Zurich Insurance-only Superannuation Plan Product Disclosure Statement (PDS)
- I have read and understood the Privacy Statement under the Privacy section of the Zurich Insurance-only Superannuation Plan PDS and the further information available at www.eqt.com.au/global/privacystatement and consent to the collection and use of personal information and sensitive personal information about me in the manner described (including discussing any information obtained from me and any doctors or accountants with the financial adviser associated with this application)
- I can only make contributions to the Fund in accordance with the relevant legislation, as detailed in the Zurich Insurance-only Superannuation Plan PDS
- I apply to the trustee of the Fund, for membership of the Fund as set out in this Application form. Upon my Application being accepted I agree to comply with the rules governing the Fund, and
- the trustee may bill me directly for any liability arising under any government charges or imposts relating to my Fund membership or may deduct any such liability from an insured benefit that is or becomes payable to me.

I also certify that:

- I am eligible for membership of the Fund in accordance with the relevant legislation
- my decision to apply for membership of the Fund is based on the information in the current Zurich Insurance-only Superannuation Plan PDS and the current Zurich Wealth Protection PDS, Zurich Active PDS or Zurich FutureWise PDS, as relevant to my application for membership, which has been provided to me
- I will notify the trustee in writing if I cease to be eligible for membership of the Fund
- I understand that my participation in the Fund will only commence after I have been advised in writing by the trustee that my Application has been accepted.

Applicant's signature ✗ Date / /

2. Tax file number notification

You must complete the Tax File Number (TFN) details below to become a member of the Zurich Plan. Failure to do so will mean that the trustee will be unable to accept your Membership application.

Read the important information regarding TFNs in the Zurich Insurance-only Superannuation Plan PDS before providing us with your TFN.

2.01. Fund details

Fund name Aon Master Trust Fund address Level 33, Aon Tower, 201 Kent Street, Sydney, NSW, 2000

Fund phone number 1300 880 588

2.02. Your details

Title Surname First name Middle name

○ Male ○ Female Date of birth / / Membership number (if known)

Residential Address State Postcode

Your tax file number

Applicant's signature ✗ Date / /

Continue filling out this form on the following page ↘

3. Contribution type

Make a selection below to advise the source of payments. You must advise us of any change to your contribution type as it may affect how your contributions are reported to the ATO.

Even if you intend to pay by rollover, make a selection below to advise the source of any other contributions made.

- ◯ Personal
- ◯ Self-employed
- ◯ Spouse
- ◯ Compulsory Employer (Superannuation Guarantee)
- ◯ Employer Additional
- ◯ Employer Award
- ◯ Salary Sacrifice
- ◯ Other (specify)

Employer's full name

If your employer is making contributions on your behalf, only certain payment options will meet the ATO's data and payment standards for superannuation contributions (these are referred to as SuperStream compliant payment methods). Your employer should contact the ATO for more information. If you are paying by rollover, also complete section 4.

4. Rollover authority

Complete this section if you wish to rollover amounts from another superannuation fund ('transferring fund') to pay the premiums on your policy owned by the trustee of the Zurich Plan.

4.01. Transferring fund

Fund name

Unique Superannuation Identifier (USI) ABN

Address of fund State Postcode

Telephone number ( )

Account/Membership/Policy name Account/Membership/Policy number

4.02. Rollover instructions

- ◯ One-off (single) rollover
- ◯ Ongoing automatic yearly rollover

4.03. Rollover declaration

- I confirm that I have read and agree to the rollover terms and conditions set out in the section 'Paying premiums by rollover from another superannuation fund' of the Zurich Insurance-only Superannuation Plan PDS.
- I request and consent to the trustee of the transferring fund to transfer any benefits from the transferring fund to the Zurich Plan as required to fund the premium amount payable under the policy, as quoted by Zurich.
- I am aware that I may ask the trustee of the transferring fund for any information I require in relation to the effect of the rollover/s on my entitlements in the transferring fund (including information on fees or insurance benefits) and, before any rollover, I have either asked them or I do not require such information.

Applicant's signature

✗ Date / /

This form is dated 2 October 2018

ZURICH

Zurich Insurance

Life Insured's Statement

Read before proceeding with your Application

YOUR DUTY OF DISCLOSURE

Before entering into a life insurance contract, we must be told anything that each of you as the proposed policy owner and the life to be insured (if a different person to the proposed policy owner) knows, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms.

The duty applies until we agree to provide the insurance. It also applies before the insurance contract is extended, varied or reinstated.

We do not need to be told anything that:

- reduces the risk we insure; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive the duty to tell us about.

If you are the life to be insured (but not also the proposed policy owner), you not telling us something that you know, or could reasonably be expected to know, that may affect our decision to provide the insurance and on what terms, may be treated as a failure by the proposed policy owner to tell us something that they must tell us with the following consequences for the proposed policy owner.

If we are not told something

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

If we are not told anything that we are required to be told, and we would not have provided the insurance if we had been told, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if we had been told everything we should have been told. However, if the insurance contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the insurance contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if we had been told everything we should have been told. However, this right does not apply if the contract has a surrender value or provides cover on death.

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

ZURICH PLAN - TRUSTEE OBLIGATIONS

It is a condition of your participation in the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust (Zurich Plan) that you have the same duty of disclosure to the Trustee.

When a person applies for insurance benefits through the Zurich Plan any personal information disclosed to the Trustee will be given to the Insurer.

TELEPHONE CONTACT

After you submit your Application, we may contact you by telephone to collect personal information regarding your health, medical history, occupation, financial position, activities and other details to collect any information missing from your Application form and Life Insured's Statement. The information provided by you will be recorded and used in the assessment of your Application for insurance cover.

The duty of disclosure also applies to you during the course of any telephone contact with us.

YOUR PRIVACY

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with your personal and, perhaps, sensitive information. The collection and management of this information is governed by the Act. Please refer to the Privacy section contained in the current PDS for the product you are applying for. For a more detailed explanation of Zurich's Privacy Policy please visit our website at www.zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au

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This form is dated 2 October 2018

ZURICH

Zurich Insurance

Life Insured's Statement

1. Life insured

Title Surname First name Middle name

○ Male ○ Female Date of birth / /

2. Residence and travel

Cover is only available to Australian residents.

2.01. Are you currently living in Australia, either

- **as an Australian or New Zealand citizen, or**
- **as a permanent resident of Australia?**

○ No → please clarify your current citizenship and residency details, including Visa type, expiry date, and application date for permanent residency

○ Yes → go to 2.02

Citizenship and residency details

Visa type Expiry date / /

Application date / /

2.02. Do you intend to travel or live outside Australia for any purpose within the next two years?

○ No → go to 3

○ Yes → provide details

Country City/Area/Region

Date you are travelling / / How long you are travelling for

Reason for travel: ○ Holiday ○ Business ○ Study ○ Visit family/friends ○ Other → provide details

3. Insurance history

3.01. Other than the insurance being applied for in this application, do you or does anyone else currently hold or are you or anyone else applying for any Death, Trauma, Total & Permanent Disablement (TPD), Health Events (Zurich Active), Income Protection or Business Expenses cover on your life?

○ No → go to 4

○ Yes → provide details of all existing policies in the table below

Policy No (if known)	Company	Benefit Type	Amount	Waiting Period	Benefit Period	Risk Comm Date	Replacing
			$				
			$				
			$				
			$				

If you need more space to provide your answers, attach a separate sheet signed and dated by you. Note: if this Application for insurance is intended to replace any existing policy/ies you must cancel said policy/ies as soon as we notify you that we have accepted your Application for insurance. If you do not cancel the existing policy/ies the insurance applied for and accepted by Zurich will be ineffective and any claim made to Zurich, by you or any other applicable person, will be rejected

4. Cover details

4.01. Are you applying for

- Life cover in excess of $3,000,000 (or $1,500,000 for domestic duties)
- TPD cover in excess of $3,000,000 (or $1,500,000 for domestic duties)
- Trauma cover in excess of $1,500,000 or
- Active Health Events cover in excess of $3,000,000 (or $1,500,000 for domestic duties)?

○ No → go to 4.02

○ Yes → complete the Financial questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application or tick the following box if you wish to provide a copy of the Statement of Advice ('SOA') instead (make sure the SOA answers all the questions in the Financial questionnaire)

○ SOA will be provided

4.02. Are you applying for

- Income protection cover in excess of $20,000 per month or
- Business expenses cover in excess of $20,000 per month?

○ No → go to 5

○ Yes → – do you have net assets (excluding the family home or superannuation) exceeding $5m (including assets that are owned by you, your spouse or any other related entities); or

– do you receive or expect to receive net income from other sources (such as rental income, dividends etc.) in excess of $250,000 per annum?

○ No → go to 5

○ Yes → complete the Financial questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application or tick the following box if you wish to provide a copy of the SOA instead (make sure the SOA answers all the questions in the Financial questionnaire)

○ SOA will be provided

5. Occupation

5.01. Are you non-working (e.g. home duties/student/retiree)?

○ No → go to 5.02

○ Yes → go to 7

5.02. What is your job and industry?

Occupation

Business/Employer name and physical address

Website Email

Industry

5.03. Are you a member of the armed forces, either full-time or part-time?

○ No → go to 5.04

○ Yes → Is your involvement limited to army reserve only, AND can you confirm that you have no current deployment orders or have any reason to suspect that a deployment would take place within the next 12 months?

- ○ No → provide full clarification as to your involvement with the armed forces, and details of any current or previous deployments
- ○ Yes → go to 5.04

5.04. Are you applying for

- TPD cover
- Active Health Events cover
- Income protection cover or
- Business expenses cover?

○ No → go to 6

○ Yes → complete questions below

5.05. Do you have a degree, trade or other professional qualification?

○ No → go to 5.06

○ Yes → provide details

5.06. Does your job require you to perform any of the following hazardous duties:

- using or handling explosives, chemicals, dangerous substances or asbestos
- working underground, offshore, underwater or at heights over 10m
- agricultural flying (e.g. mustering) or
- any other hazardous duties not listed above?

○ No → go to 5.07

○ Yes → provide details of the duties, including the amount of time spent undertaking each duty

Continue filling out this form on the following page ↘

5.07. What duties do you perform?

Complete the table below

Duty	**% of time**
Administrative/sedentary	
Supervision of manual labour	
Manual duties usual to qualification/trade	
Other manual duties (specify)	
Travel or working in the field	
Other duties (specify)	
	100 %

5.08. How long have you worked in your current role? years months

If less than 2 years, advise your work history for the last 3 years

5.09. On average, how many hours per week do you work in your principal job? hours per week

5.10. Do you have a second job?

◯ No → go to 5.11

◯ Yes → provide details

Occupation/Industry

Duties

Hours per week Income per annum $

Do not include this income amount in your current annual income in question 6.01

5.11. Do you intend to change your current job (including change of duties, hours or employment status)?

◯ No → go to 5.12

◯ Yes → provide details

5.12. In the next 12 months, do you have plans to take leave for more than three months?

◯ No → go to 6

◯ Yes → provide details

6. Income

6.01. What is your current annual income from your principal job?

Employee: total remuneration paid by employer, including superannuation and other benefits

Self-employed: gross income of the business, less any business expenses incurred to earn this income

$

6.02. Have you:

- ever been declared bankrupt, or
- had any entity associated with you placed into receivership, liquidation or administration in the last 5 years?

◯ No → go to 6.03

◯ Yes → are you currently bankrupt, or have you had a bankruptcy discharged within the last 3 years?

◯ Yes → complete the Bankruptcy questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ No → provide full details including date of discharge

6.03. Are you applying for Income Protection cover or Business expenses cover?

◯ No → go to 7

◯ Yes → complete questions below

6.04. Are you an employee only with no ownership (directly or otherwise) in the business you work in?

◯ No → go to 6.09

◯ Yes → go to 6.05

Employee only

6.05. On what basis are you employed?

◯ Permanent (full- or part-time) ◯ Casual contractor* ◯ Fixed term contractor*

* If casual or fixed term contractor is selected, provide full details, including the date you commenced your current contract, the contract term/expiration date and your plans following the contract expiry.

6.06 When did you start working for your current employer? Date / /

6.07. Provide your annual income details for the last 2 years below

	Year ending 30/06/	Year ending 30/06/
Wages/salary		
Superannuation contributions		
Bonus		
Commission		
Other benefits (specify)		
TOTAL		

If you make a claim, the income figures provided may need to be substantiated with the appropriate financial evidence.

6.08. Do you have any sick leave entitlements?

◯ No

◯ Yes → provide details Days per annum Total accumulated sick days

Now go to 7

Self-employed only

6.09. How long have you been self-employed or owned your own business? years months

If less than 2 years, advise your work history for the last 3 years

6.10. Do you own 100% of the business personally (if only sharing ownership with your spouse for income splitting purposes, select 'Yes')?

◯ No → provide details of your ownership in the business, the names and ownership percentages of your business partners as well as a description of their role in the business

◯ Yes → go to 6.11

6.11. Has your ownership interest for your business changed during the last 3 years?

◯ No → go to 6.12

◯ Yes → outline the changes

6.12. What proportion of total business earnings are from your personal exertion? %

6.13. Do you have any employees?

◯ No → go to 6.14

◯ Yes → complete the table below

	Total	Number of income producing
Full-time		
Part-time		
Casual		

6.14. If you were unable to work, would your business continue to operate?

◯ No → go to 6.15

◯ Yes → provide details including percentage and duration of ongoing business earnings

6.15. If you were unable to work, would your business hire a replacement person to complete your role?

◯ No → go to 6.16

◯ Yes → estimated replacement cost (at market rates) $ per month

Continue filling out this form on the following page ↘

6.16. Advise the following income details as per your Profit and Loss account for the last 2 years

Your income is the gross income earned before tax, from personal exertion, less any business expenses incurred to earn that income.

	Year ending 30/06/	Year ending 30/06/
Your share of gross business income		
Your share of net business profit		
Your personal salary or directors fee		
Salary paid to a non-working spouse or other family members not working in this business		
Superannuation payments to yourself, a non-working spouse or family members not working in this business		
Other add backs (e.g. depreciation, donations or personal use of motor vehicles)		
Total		

If you make a claim, the income figures provided may need to be substantiated with the appropriate financial evidence.

If you need more space to provide your answers, attach a separate page, signed and dated by you.

6.17. Are you applying for Business expenses cover (Fixed or Key Person Replacement)?

◯ No → go to 7

◯ Yes → complete the Business expenses questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

7. Hazardous activities/sports

Do you take part in, or do you intend on taking part in any potentially hazardous sport or pastime?

Examples include but are not limited to aviation (other than as a fare-paying passenger), diving, hang gliding, skydiving, motor sports, rock or mountain climbing, football, boxing, martial arts and bungy jumping.

◯ No → go to 8

◯ Yes → provide details where indicated below

If you are applying for TPD, Active Health Events, Income Protection cover or Business expenses cover and you engage in this activity at a professional level, you must have disclosed this job/duties and income in section 6 of this Application.

Select ALL activities which you participate in below:

◯ Aviation (other than as a fare-paying passenger) → complete the Aviation questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Diving → complete the Diving questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Motor sports (car/cycle) → complete the Motor sports questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Football
◯ Amateur/Recreational ◯ Competitive Code:

◯ Boxing
◯ Amateur/Recreational ◯ Competitive ◯ Group boxing/Fitness class only

◯ Martial arts
◯ Non-contact ◯ Contact

◯ Cycling, including mountain biking, BMX, road, and track/velodrome
◯ Amateur/recreational ◯ Competitive Type (i.e. BMX/road etc):

If you participate in any other hazardous activities, complete the questions below. If you participate in multiple activities, you must provide details for each one.

An additional Other activity questionnaire can be found in the 'Underwriting questionnaires' booklet attached to this Application.
If you need more space to provide your answers, attach a separate sheet signed and dated by you.

◯ BASE jumping ◯ Caving/potholing ◯ Equestrian sports ◯ Hang-gliding
◯ Mountain climbing ◯ Rock climbing ◯ Sailing/yachting ◯ Skydiving
◯ Snow skiing/boarding ◯ Water skiing/boarding ◯ Other, specify

Continue filling out this form on the following page ↘

7.01. On what basis do you participate in this activity? ○ Amateur/Recreational ○ Competitive ○ Professional

7.02. How often do you participate in this activity? Events/Hours per year

7.03. Provide details of the level at which you participate in this activity, e.g. maximum depths, heights, speeds or grades

7.04. Provide details of any injuries you have sustained from this activity

8. Personal details

8.01. What is your height? Height cm **or** feet/inches

8.02. What is your weight? Weight kg **or** lb

8.03. Has your weight changed by more than 10 kgs (or 22 lbs) during the last 12 months?

○ No → go to 8.04

○ Yes → provide details (loss/gain, amount, reason and time period)

Lifestyle

8.04. Which of the following best describes your smoking status?

○ Life long non smoker → go to 8.05

○ Smoker → what do you smoke? and how many per day?

○ Ex smoker → when did you last smoke?

○ Occasional/social smoker → what do you smoke?

○ User of e-cigarettes/vaping → when did you last smoke?

○ User of nicotine replacement products → when did you last smoke?

8.05. Have you ever consumed alcohol?

○ No → go to 8.09

○ Yes → go to 8.06

8.06. How many standard alcoholic drinks do you consume in a typical week?

One standard drink is equal to 285ml of full strength beer, 100ml of wine, or 30ml of spirits.

8.07. Have you ever consumed on average more than 4 standard drinks per day?

○ No → go to 8.08

○ Yes → go to 8.08

8.08. Have you ever been advised to reduce or stop your alcohol consumption by a doctor, nurse or other medical professional?

○ No → go to 8.09

○ Yes → please provide details, including type of advice, treatment and dates

8.09. In the last 10 years have you used recreational drugs? Including: cannabis, ecstasy, cocaine, heroin, amphetamines and anabolic steroids

○ No → go to 9

○ Yes → provide details

9. Family medical history

9.01. Have your natural parents, brothers or sisters had any hereditary conditions before the age of 65?

- Alzheimer's or dementia
- cancer (provide details of type and site)
- cardiomyopathy
- diabetes – specify type 1 or type 2 below
- heart condition or stroke
- Huntington's disease
- mental health condition
- Motor Neurone Disease ('MND')
- multiple sclerosis
- muscular dystrophy
- Parkinson's disease
- polycystic kidneys or
- any other hereditary disorder?

◯ No → go to 9.02

◯ Yes → provide details

◯ Mother ◯ Father ◯ Brother ◯ Sister

Condition	Age diagnosed	Age at death (If applicable)
◯ Mother ◯ Father ◯ Brother ◯ Sister		
Condition	Age diagnosed	Age at death (If applicable)
◯ Mother ◯ Father ◯ Brother ◯ Sister		
Condition	Age diagnosed	Age at death (If applicable)
◯ Mother ◯ Father ◯ Brother ◯ Sister		
Condition	Age diagnosed	Age at death (If applicable)

9.02. Have you ever had, or are you considering having a genetic test?

◯ No → go to 10

◯ Yes → provide details

You do not need to disclose to us any genetic test that was conducted solely for the purpose of a medical research study conducted by an accredited university or medical research institution where;

- the test results are not known by you and will not be provided to you, or
- you have specifically requested not to receive the test results

10. Your medical history

10.01. Regardless of whether you have seen a doctor, required treatment or required any time off work, have you ever in your life had symptoms of or been diagnosed with:

		No	Yes
1	Asthma?	○	○
2	Skin cancer, cyst, mole or lesion?	○	○
3	Raised blood pressure or cholesterol managed with or without medication?	○	○
4	Diabetes managed with or without medication, raised blood sugar levels or sugar in your urine?	○	○
5	Sleep apnoea or sleep disorder?	○	○
6	Anxiety or depression, or have you received any mental health counselling?	○	○
7	Any other mental health condition or disorder? (including post traumatic stress disorder, bipolar disorder, schizophrenia, personality disorder, eating disorder or attention deficit disorder (ADD/ADHD))	○	○

Are you applying for Trauma, TPD, Income Protection, Business expenses or Health events?

○ No → go to 10

○ Yes → go to 8

8	Back or neck pain or a condition affecting your back or neck? (including sciatica, whiplash or trapped nerves)	○	○
9	Joint or muscle pain, any type of arthritis, or a condition affecting your bones, joints, muscles or limbs? (including gout, ligament, tendon and muscle injuries, carpal tunnel syndrome, repetitive strain injuries or fractures)	○	○

If you have answered 'Yes' to any question in 1– 9, you will need to complete the relevant questionnaire/s contained in the 'Underwriting questionnaires' booklet attached to this Application.

If you answer 'Yes' to any of the questions 10–35, you will need to provide details in 10.02 on page 20.

10	Chronic fatigue syndrome (CFS), fatigue, fibromyalgia or persistent tiredness?	○	○
11	Dermatitis, psoriasis, eczema or any other skin condition?	○	○
12	Bronchitis, or any other condition affecting your lungs or breathing? (including chronic obstructive pulmonary disease (COPD) or emphysema)	○	○
13	Cancer, a tumour or a growth of any kind? (including Hodgkin's or non-Hodgkin's lymphoma, or leukaemia)	○	○
14	A heart or artery condition or surgery on your heart or arteries? (including angina or heart attack, angioplasty, stent or bypass, irregular heart beat, heart valve or heart structure abnormalities, or cardiomyopathy)	○	○
15	A stroke, brain haemorrhage or damage or surgery to your brain? (including mini stroke, transient ischaemic attack (TIA) or brain aneurysm)	○	○
16	Any thyroid condition? (including over active or Under active thyroid, Graves' or Hashimoto's disease)	○	○
17	Any condition affecting your kidneys or bladder? (including more than one occurrence of blood or protein in your urine, kidney or bladder stones)	○	○
18	Any condition affecting your bowel or digestive system? (Crohn's disease, colitis, irritable bowel syndrome, gastric banding or sleeve, bowel polyps, hernias or ulcers)	○	○
19	Any condition affecting your liver or pancreas? (fatty liver, hepatitis or an abnormal blood test or scan of your liver)	○	○
20	Epilepsy, multiple sclerosis, Parkinson's disease or any other neurological condition? (including headaches or migraines, motor neurone disease, muscular dystrophy or paralysis)	○	○
21	Numbness, pins and needles, tremor, tingling, muscle weakness or difficulty with coordination?	○	○
22	Anaemia or any other blood condition? (including DVT or pulmonary embolism, haemochromatosis or haemophilia)	○	○
23	A congenital condition? (including a congenital heart or kidney abnormality or cerebral palsy)	○	○
24	Have you ever tested positive for HIV or hepatitis B or C, or are you awaiting the results of such a test (other than as part of this application)?	○	○
25	A needlestick injury? (this is an accidental injury involving a jab by a potentially used intravenous needle)	○	○

		No	Yes
26	Any issue affecting your ears or hearing? (including tinnitus, Meniere's disease or labyrinthitis)	◯	◯
27	Vertigo, balance problems or dizziness?	◯	◯
28	Any issue affecting your eyes or sight? (including blurred, double or impaired vision or optic neuritis)	◯	◯

FEMALE ONLY (Questions 29-32)

29	Are you currently pregnant? ◯ No → go to 30 ◯ Yes → go to 29.01		
	29.01. Are you currently in good health with no complications associated with the pregnancy; and no medical investigations planned other than routine pre-natal screening? ◯ No → please provide details ◯ Yes → go to 30 _____ _____ _____		
30	Are you applying for TPD, income protection, business expenses or Active Health Events cover? ◯ No → go to 31 ◯ Yes → do you intend to return to work for at least 24 hours per week within 12 months following the birth of your baby? ◯ No → provide details of your plans of when you return to work, and how many hours per week you plan to work on return ◯ Yes → go to 31 _____ _____ _____		
31	Have you ever had any abnormal cervical screening test? (including abnormal PAP smear, abnormal HPV test result)	◯	◯
32	Have you ever had any breast lump, cyst or breast abnormality? (including an abnormal mammogram, ultrasound or MRI)	◯	◯

MALE ONLY (Question 33)

33	Have you ever had a prostate condition?	◯	◯

ALL TO ANSWER

Other than for conditions that you already told us about

34	In the last 5 years due to illness or injury have you: • been under follow-up with your GP or a specialist, • been admitted to hospital, • had or were advised to have any medical investigation, treatment or procedure, or • had been unable to work for more than 5 consecutive days?	◯	◯
35	Have you had symptoms for which you: • intend to seek medical advice or a consultation, • are awaiting medical treatment (including surgery), or • are awaiting the results from medical tests or investigations?	◯	◯

Continue filling out this form on the following page ↘

10.02. Did you answer 'Yes' to any of the questions 10–35 in question 10.01?

◯ No → go to 10.03

◯ Yes → provide full details for each 'Yes' response in the table below (more space is available on the next page if required)

	Question no:		**Question no:**	
What is the condition/diagnosis?				
Date of diagnosis	/ /		/ /	
What symptoms have you experienced?				
Date of first/last symptoms	First / /	Last / /	First / /	Last / /
Frequency of symptoms				
What treatment have you received?				
Date of first/last treatment	First / /	Last / /	First / /	Last / /
Frequency of treatment				
Degree of recovery	%		%	
Have you undergone any specific testing or investigations (such as scans or X-rays) for this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Have you taken time off work or are your work duties or lifestyle affected or restricted due to this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Is your usual doctor noted in question 11 of this Application the treating doctor for this condition?	◯ Yes ◯ No → provide details		◯ Yes ◯ No → provide details	
Doctor's/Clinic's name				
Doctor's/Clinic's Address, State and Postcode				
Doctor's/Clinic's Phone number	( )		( )	

	Question no:		Question no:	
What is the condition/diagnosis?				
Date of diagnosis	/ /		/ /	
What symptoms have you experienced?				
Date of first/last symptoms	First / /	Last / /	First / /	Last / /
Frequency of symptoms				
What treatment have you received?				
Date of first/last treatment	First / /	Last / /	First / /	Last / /
Frequency of treatment				
Degree of recovery	%		%	
Have you undergone any specific testing or investigations (such as scans or X-rays) for this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Have you taken time off work or are your work duties or lifestyle affected or restricted due to this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Is your usual doctor noted in question 11 of this Application the treating doctor for this condition?	◯ Yes ◯ No → provide details		◯ Yes ◯ No → provide details	
Doctor's/Clinic's name				
Doctor's/Clinic's Address, State and Postcode				
Doctor's/Clinic's Phone number	( )		( )	

Continue filling out this form on the following page ↘

10.03. As the result of illness or injury, have you ever or are you expecting to claim under any:

- Trauma, Total & Permanent Disability (TPD), Income Protection or Salary Continuance policy
- Workers compensation
- Any other benefits paid due to sickness, disability or injury (other than Health insurance)

○ No → go to 11

○ Yes → provide details

Company/Source

Date / / Period of disability

Cause of claim

11. Doctor's details

11.01 Do you have a doctor/medical centre that you usually attend?

○ No → provide details of the most recent doctor/medical centre

○ Yes → provide details

Doctor's /Clinic's name Name of medical centre

Address of doctor or medical centre

State Postcode Phone number ( )

11.02 When was the last time you saw this doctor and/or clinic? Date / /

11.03 Will this doctor have information about all of your disclosed medical history?

○ No → go to 11.04

○ Yes → go to 11.06

11.04 Which of your conditions will this doctor have information about?

11.05 Are you able to provide details of another doctor who may have details of your disclosed medical history?

○ No → go to 11.06

○ Yes → provide details

Doctor's /Clinic's name Name of medical centre

Address of doctor or medical centre

State Postcode

Phone number ( )

11.06 Is there any additional information you would like to provide to assist Zurich in assessing your application?

○ No

○ Yes → provide details

NEXT STEPS

Complete any of the questionnaires contained in the 'Underwriting questionnaires' booklet attached to this Application that apply to you, then complete the Declaration section on page 23 and continue working through this Application.

ZURICH

Declaration

Declaration/s of the policy owner/s and life insured

I/we declare that I/we:

- am an/are Australian resident/s living in Australia;
- have read the relevant Zurich PDS which was provided to me with this Application form, and apply to Zurich Australia Limited (Zurich) and/or the trustee of the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust for the insurance set out in this Application;
- confirm that the answers to the questions set out in the Application and any annexures attached to the Application (including the Zurich insurance quote and Life Insured's Statement) are true and complete;
- understand that the policy/policies applied for will become effective when this Application is approved by Zurich;
- will inform Zurich of any relevant changes which occur before my/our policy is received;
- have read and understood my/our Duty of disclosure as detailed in this Application, and understand that this duty continues until written notice has been given that the cover has been accepted or declined;
- where this Application for insurance is to replace an existing Zurich policy, I/we confirm that, at the time of applying for cover under the existing policy, the Duty of disclosure was complied with and all matters were completely and accurately represented, and I/we understand that this confirmation is a relevant matter for Zurich in assessing this new Application (if I/we are unsure, I/we have obtained a copy of the original Application form and have checked and confirmed the details or have signed a statement providing further disclosures or corrections attached to this form);
- agree that any policies issued are conditional on the life insured (including any partner under the Home support option) disclosing all matters known to him/her that are relevant to the insurance cover applied for (before the Application is accepted) and that the policy/policies and/or benefits may be cancelled, altered or not paid if this condition is not met;
- have read and understood the Privacy Statement under the Privacy section of the relevant PDS and consent to the collection and use of personal information and sensitive personal information about me/us in the manner described (including discussing any information obtained from me/us and any doctors or accountants with the financial adviser associated with this Application);
- have obtained consents from any identified person I/we have provided (sensitive) personal information about and informed them of the Privacy Statement;
- agree that if I/we make any overpayment of premium that Zurich may retain the overpayment unless it exceeds $5.00; and
- agree that if this Application for insurance is intended to replace any existing policy or policies as referred to in this Application, when Zurich notifies me/us that my/our Application for insurance has been accepted, I/we must cancel such policy or policies. If I/we do not cancel any existing policy or policies as referred to in this Application when notified by Zurich that my/our Application for insurance has been accepted, the insurance applied for and accepted by Zurich will be ineffective and any claim made by me/us, or any other applicable person to Zurich, will be rejected.

Life Insured only

- I confirm that I am not now receiving or considering any medical or surgical attention or treatment other than that shown in the Life Insured's Statement accompanying this Application.
- I understand that the Application will not become effective until it is approved by Zurich.
- In relation to any tax returns submitted in support of this Application, I confirm that these are the tax returns submitted to the Australian Taxation Office and no subsequent adjustments or amendments have been made or are expected.

Life insured – signature

✗ Date / /

Policy owner 1 – signature

✗ Date / /

Policy owner 2 – signature

✗ Date / /

If you have signed on behalf of a policy owner who is a company or trust, also print your name/s and position/s below

Policy owner 1 – name

Position

Policy owner 2 – name

Position

Parent/guardian – signature → of policy owners 10-16 years old

✗ Date / /

Relationship to the life insured

Important notes

If the policy owner/s:

- is/are the individual trustee/s of a superannuation fund: this form is to be signed by all trustees or person/s authorised to sign and enter into the contract of insurance on behalf of the trustee/s in accordance with the fund's Trust Deed and rules.
- is a company: this form is to be signed by two directors, a director and company secretary, or the sole director/company secretary.

Make a copy of this page if more signatures are required.

This page has been left blank intentionally.

Medical release authority

Complete this form to authorise your Doctor to provide your medical details to Unified Healthcare Group, as agent for Zurich Australia Limited.

Dear Doctor

I authorise you to release details of my personal medical history to Unified Healthcare Group Pty Ltd ('UHG') who act as agent on behalf of Zurich Australia Limited ABN 92 000 010 195 ('Zurich'), or directly to Zurich.

A photocopy (or similar) of this authorisation is as valid as the original.

Title Surname First name

Middle name Maiden/Former name

◯ Male ◯ Female Date of birth / /

Signature of life insured

✗ Date / /

This page has been left blank intentionally.

ZURICH

Payment authority 1

If more than one policy is being applied for and different payors apply, complete a second Payment authority (page 29). Copy and complete this page if you require more.

Ensure you have also completed section 2 on this page where different payors apply.

1. Are you paying by rollover (only available for policies owned by the trustee of the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust)?

○ No → go to 2

○ Yes → complete the Zurich Insurance-only Superannuation Plan Membership application on pages 5 and 6. Do not complete this Payment authority.

2. Who is paying for the insurance?

The person paying for the insurance will be nominated as the policy 'payor'. We will send billing details to the person you nominate.

○ Policy owner 1 → go to 3

○ Life insured 1 → go to 3

○ Someone else (such as another individual, a company, trustee or business partner) → provide details below

Title Surname/Company/Trustee of superannuation fund

First name Middle name

Mailing address State Postcode

Contact phone number ( )

3.

3.01. Method of payment (select one only)

○ Direct Debit → go to 3.02

○ BPAY (half yearly/yearly payment) → finish here. Your adviser will contact you with details when payment is required (not available for employer contributions)

The frequency of payment (monthly, quarterly, half-yearly, yearly) will be determined by the Zurich premium quote.

3.02. Direct debit account details

Credit card

○ Visa ○ MasterCard Cardholder's name Expiry date /

Card number

OR

Bank, credit union or building society

Account name

BSB number – Account number

Continue filling out this form on the following page ↘

3.03. How would you like to make your first payment?

You only need to nominate details for your first payment if it will be different to your ongoing method of payment. For example, if you want to make a one-off BPAY payment before your regular direct debit payments begin.

◯ Use details provided in 3.02 → go to 3.04

OR

◯ By BPAY → finish here. Your adviser will contact you with details when payment is required (not available for employer contributions)

◯ Direct debit using different account/credit card → provide details, then go to 3.04

◯ Visa ◯ MasterCard ◯ Amex Cardholder's name Expiry date /

Card number

Account name

BSB number – Account number

3.04. Direct debit declaration

- I/We acknowledge that this direct debit request is governed by the terms of the Direct Debit Request Service Agreement on page 31
- I/We have read the Direct Debit Request Service Agreement and agree with its terms and conditions.
- I/We request and authorise Zurich Australia Limited ABN 92 000 010 195 (User ID – 117) to arrange for funds to be debited from my/our account at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS) including for any amount requested by the trustee of a superannuation fund to pay any premium or other payment due to Zurich in respect of insurance cover held by the superannuation fund trustee on my life.

Name – **Account holder 1/Primary cardholder**

Signature – **Account holder 1/Primary cardholder**

✗ Date / /

Name – **Account holder 2** (if applicable)

Signature – **Account holder 2** (if applicable)

✗ Date / /

ZURICH

Payment authority 2

Only complete a second (or subsequent) Payment authority if more than one policy is being applied for and different payors apply.

1. Are you paying by rollover (only available for policies owned by the trustee of the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust)?

○ No → go to 2

○ Yes → complete the Zurich Insurance-only Superannuation Plan Membership application on pages 5 and 6. Do not complete this Payment authority.

2. Who is paying for the insurance?

The person paying for the insurance will be nominated as the policy 'payor'. We will send billing details to the person you nominate.

○ Policy owner 1 → go to 3

○ Life insured 1 → go to 3

○ Someone else (such as another individual, a company, trustee or business partner) → provide details below

Title Surname/Company/Trustee of superannuation fund

First name Middle name

Mailing address State Postcode

Contact phone number ( )

3.

3.01. Method of payment (select one only)

○ Direct Debit → go to 3.02

○ BPAY (half yearly/yearly payment) → finish here. Your adviser will contact you with details when payment is required (not available for employer contributions)

The frequency of payment (monthly, quarterly, half-yearly, yearly) will be determined by the Zurich premium quote.

3.02. Direct debit account details

Credit card

○ Visa ○ MasterCard Cardholder's name Expiry date /

Card number

OR

Bank, credit union or building society

Account name

BSB number – Account number

Continue filling out this form on the following page ↘

3.03. How would you like to make your first payment?

You only need to nominate details for your first payment if it will be different to your ongoing method of payment. For example, if you want to make a one-off BPAY payment before your regular direct debit payments begin.

◯ Use details provided in 3.02 → go to 3.04

OR

◯ By BPAY → finish here. Your adviser will contact you with details when payment is required (not available for employer contributions)

◯ Direct debit using different account/credit card → provide details, then go to 3.04

◯ Visa ◯ MasterCard ◯ Amex Cardholder's name Expiry date /

Card number

Account name

BSB number – Account number

3.04. Direct debit declaration

- I/We acknowledge that this direct debit request is governed by the terms of the Direct Debit Request Service Agreement on page 31
- I/We have read the Direct Debit Request Service Agreement and agree with its terms and conditions
- I/We request and authorise Zurich Australia Limited ABN 92 000 010 195 (User ID – 117) to arrange for funds to be debited from my/our account at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS) including for any amount requested by the trustee of a superannuation fund to pay any premium or other payment due to Zurich in respect of insurance cover held by the superannuation fund trustee on my life.

Name – **Account holder 1/Primary cardholder**

Signature – **Account holder 1/Primary cardholder**

✗ Date / /

Name – **Account holder 2** (if applicable)

Signature – **Account holder 2** (if applicable)

✗ Date / /

DIRECT DEBIT REQUEST SERVICE AGREEMENT

This agreement sets out the terms and conditions on which the Account Holder has authorised Zurich to debit money from their account and the obligations of Zurich and the Account Holder under this Agreement.

The Account Holder understands and agrees that:

- Direct debiting may not be available on all accounts. The Account Holder is responsible for ensuring the specified account can accept direct debits and there are sufficient cleared funds available in the nominated account to permit payments under the Direct Debit Request on the due date for payments.
- Zurich accepts no responsibility for issues arising where incorrect details have been provided. The Account Holder should check the account details provided to Zurich are correct. If uncertain, check with your financial institution before completing the Direct Debit Request.
- Zurich will debit the account for the sum of the amounts due at the debit date for all specified policies.
- Changes to bank account details must be provided in writing, or by telephoning Zurich (or by such other means as we approve).
- Zurich will give the Account Holder at least 14 days notice in writing if there are any changes to the terms of this Service Agreement.

Zurich agrees that:

- When the due date for payment is not a business day, the debit will be processed on the next business day.
- The Account holder can cancel, change*, defer or suspend the Direct Debit Request on a policy by providing notice to Zurich in writing or by telephone (or by such other means as we approve), or directly with the Account Holder's financial institution (which is required to act promptly on the instructions). Notification must be received by Zurich at least 14 days before the next drawing date in order to process your instructions.

  *The Account Holder's financial institution can "change" the Direct Debit Request only to the extent of advising Zurich of new account details.
- Upon request, Zurich will forward a copy of the current terms and conditions for direct debits, to the Account Holder by post, facsimile or other agreed method.
- Zurich will provide details of this Direct Debit, on request.

Disputes

The Account Holder should give notice of any disputed debit to Zurich. Zurich will respond within 7 working days of receiving your letter. Alternatively, the Account Holder can take it up directly with the Account Holder's financial institution.

Dishonoured debits

If a debit is unsuccessful, Zurich will cancel the payment in respect of the dishonoured debit. In some instances, such as where your account has insufficient funds, Zurich may notify you and attempt a second deduction from your account within 14 days. You should ensure that your account has sufficient funds before any second deduction. If we receive new information from you after a dishonour, Zurich will process a one-off debit to pay the policy up to date. If two consecutive dishonours occur, Zurich may cancel the authority. Zurich may charge a dishonour fee to the relevant policy. Currently the fee is nil. The financial institution may also charge fees relating to the dishonour to the account, which is the Account Holder's responsibility.

Confidential information

Zurich may disclose information about your account to its banker (in connection with a claim made against it relating to an alleged incorrect or wrongful debit made from the account), your financial institution, your adviser, other companies within the Zurich Financial Services Australia Group of companies, service providers engaged by Zurich (including banking gateway providers and credit card transaction processors), and if applicable to Equity Trustee Superannuation Limited and Aon Hewitt Limited, on whose behalf Zurich collects contributions for the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust.

Zurich will not disclose information about you or the account to any other person, except where you have given consent or where the disclosure is required by law.

Notices to Zurich

The Account Holder may give notice to Zurich in writing at the address shown or by contacting Zurich on 131 551. Alternatively, you may write to us at Locked Bag 994, North Sydney NSW 2059.

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This form is dated 2 October 2018

ZURICH

Zurich Insurance

Child Cover Application

Wealth Protection and Active

This form is to be completed by the applicant (parent) on behalf of any children who are being insured under a Zurich Child Cover policy. If you are applying for more than two children to be insured, please copy and complete this page.

Only a child who lives at the same address as the adult life insured at the time of this Application may be covered. A child may only be named on one Zurich Child Cover policy.

Surname First name Middle name

Your date of birth / /

1. Child 1

Details

Surname First name

Primary residential address State Postcode

◯ Male ◯ Female Date of birth / / Place of birth

Relationship details

1. What is your relationship to the child?

2. Does the child live with you?

◯ No → provide details of living situation

◯ Yes

3. Have you cared for this child continually from birth?

◯ No → provide details

◯ Yes

4. Does the child have any existing death or trauma cover?

◯ No

◯ Yes → complete below

Insurer	Cover type	Sum insured	Being replaced? (circle)
		$	Y/N
		$	Y/N

Medical history

5. Has this child

5.01. Ever been admitted to hospital for any reason, had surgical procedures or blood transfusions?

◯ No

◯ Yes → provide details

Continue filling out this form on the following page ↘

5.02. Ever had abnormal blood tests or abnormal investigation results?

◯ No

◯ Yes → provide details

5.03. Been advised to undergo an operation, surgery or investigations in the future?

◯ No

◯ Yes → provide details

5.04. Ever had or is currently being treated for any medical condition, medical disorder or disability?

◯ No

◯ Yes → provide details

5.05. Been infected with or tested positive for AIDS or HIV virus or been infected with or used any drug not prescribed by a medical practitioner?

◯ No

◯ Yes → provide details

6. Has this child's mother, father, brother or sister suffered from diabetes, heart disease, cancer, stroke, mental health condition, multiple sclerosis, blood disorder, kidney disorder, Huntington's disease, muscular dystrophy, Alzheimer's disease or dementia, motor neurone disease, Parkinson's disease or any other hereditary disease?

◯ No

◯ Yes → provide details

Relationship to child	Condition suffered	Age at diagnosis

2. Child 2

Details

Surname First name

Primary residential address State Postcode

◯ Male ◯ Female Date of birth / / Place of birth

Relationship details

1. What is your relationship to the child?

2. Does the child live with you?

◯ No → provide details of living situation

◯ Yes

3. Have you cared for this child continually from birth?

◯ No → provide details

◯ Yes

4. Does the child have any existing death or trauma cover?

◯ No

◯ Yes → complete below

Insurer	Cover type	Sum insured	Being replaced? (circle)
		$	Y/N
		$	Y/N

Continue filling out this form on the following page ↘

Medical history

5. Has this child

5.01. Ever been admitted to hospital for any reason, had surgical procedures or blood transfusions?

◯ No

◯ Yes → provide details

5.02. Ever had abnormal blood tests or abnormal investigation results?

◯ No

◯ Yes → provide details

5.03. Been advised to undergo an operation, surgery or investigations in the future?

◯ No

◯ Yes → provide details

5.04. Ever had or is currently being treated for any medical condition, medical disorder or disability?

◯ No

◯ Yes → provide details

5.05. Been infected with or tested positive for AIDS or HIV virus or been infected with or used any drug not prescribed by a medical practitioner?

◯ No

◯ Yes → provide details

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6. Has this child's mother, father, brother or sister suffered from diabetes, heart disease, cancer, stroke, mental health condition, multiple sclerosis, blood disorder, kidney disorder, Huntington's Chorea, muscular dystrophy, Alzheimer's disease or dementia, motor neurone disease, Parkinson's disease or any other hereditary disease?

◯ No

◯ Yes → provide details

Relationship to child	Condition suffered	Age at diagnosis

This page has been left blank intentionally.

This form is dated 2 October 2018

Zurich Insurance

Home support option

Income Protector/Plus

This form is to be completed by the life insured's partner if the Home support option is being added to a Zurich Income Protector/ Plus policy.

Partner's details

Provide your details

Title | Surname | First name | Middle name

○ Male ○ Female | Date of birth / /

Have you smoked tobacco, or any other substance, or used e-cigarettes or any other nicotine replacement therapies within the past 12 months?

○ Yes

○ No

Complete this section only if your address is different to that of the life insured

Address | State | Postcode

I declare that the answers above are true and complete.

Further, I declare that I have read and understood the Duty of disclosure as detailed in the Life Insured's Statement and in the relevant Zurich PDS, and understand that this duty continues until written notice has been given that the cover has been accepted or declined.

Insured person (partner) – signature

✗ | Date / /

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ZURICH

Adviser's report

The following information is required for underwriting and policy administration, and is to be completed by the financial adviser/s submitting this Application.

1. Client contact

1.01. Zurich would like to make it easier (and in many cases faster) for you by contacting your client directly to obtain missing or additional information over the phone, and organising any medical requirements on your behalf.

If you do not wish to take advantage of this service, opt out by ticking the boxes below:

◯ I do not authorise Zurich to contact my client directly

◯ I would prefer to make arrangements for the medical requirements myself

To minimise any inconvenience for your client, you should await the outcome of the initial underwriting assessment for a complete list, before making arrangements.

1.02. Was the Life Insured's Statement completed by the life insured in their own handwriting?

◯ No → go to 1.03

◯ Yes → go to 1.04

1.03. Has the life insured reviewed and verified the answers provided in the Life Insured's Statement?

◯ No → provide details

◯ Yes

1.04. Was this Application completed and signed in your presence?

◯ Yes

◯ No → provide details

2. Are there any Applications for other life insureds being submitted with this Application?

◯ No → go to 3

◯ Yes → provide details of the life insureds below

Surname First name

Surname First name

Surname First name

3. Has an underwriting pre-assessment been provided for this Application?

○ No → go to 4

○ Yes → provide details

Reference number Details of pre-assessment

Continue filling out this form on the following page ↘

4. Commission

4.01. Provide adviser details and your commission split.

Commission totals (first year/renewal) must add up to 100%

Adviser name 1 Adviser number

Licensee name

Phone number ( ) Fax number ( )

Mobile number

Commission split First year % Renewal %

Adviser name 2 Adviser number

Licensee name

Phone number ( ) Fax number ( )

Mobile number

Commission split First year % Renewal %

4.02. Nominate the servicing adviser

◯ Adviser 1

◯ Adviser 2

5. Is this your first application with Zurich, or have you recently changed licensee?

◯ No

◯ Yes → attach your business card to this Application and provide your ASIC Authorised Rep Number

6. Provide details of changes to the servicing adviser.

If this Application will result in a new servicing adviser on an existing Zurich policy which is being changed or replaced, you must provide us with a completed authority or Change of financial adviser form from your client so that we can pay commission to you.

Tick the box below if you will be sending the form to us as part of this Application:

◯ Authority to change servicing adviser will be provided

7. Provide any additional comments

8. Adviser/s signature

Adviser 1 – signature

✗ Date / /

Adviser 2 – signature (if applicable)

✗ Date / /

Send the completed form to:
Zurich Australia Limited, Locked Bag 994,
North Sydney NSW 2059

For all enquiries:
phone 1800 500 655
www.zurich.com.au

This form is dated 2 October 2018

ZURICH

Underwriting questionnaires

Select and complete the relevant questionnaire as prompted by your previous answers

- ◯ **Asthma questionnaire**
- ◯ **Sleep disorder questionnaire**
- ◯ **Raised cholesterol questionnaire**
- ◯ **High blood pressure questionnaire**
- ◯ **Diabetes questionnaire**
- ◯ **Cyst/Mole/Skin lesion questionnaire**
- ◯ **Mental health questionnaire**
- ◯ **Back/Neck pain questionnaire**
- ◯ **Joint/Musculoskeletal questionnaire**
- ◯ **Activity questionnaires**
  - Diving questionnaire
  - Motor sports questionnaire
  - Aviation questionnaire
  - Other activity questionnaire
- ◯ **Financial questionnaire**
- ◯ **Business Expenses questionnaire**
- ◯ **Bankruptcy questionnaire**

ASTHMA QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When did you have your first symptoms/episode of asthma?

2. When were your most recent symptoms/episodes of asthma?

3. Approximately how many episodes of asthma do you have per year?

4. In the past two years, have you had time off work as a result of asthma?

◯ No

◯ Yes → provide details How much? When?

5. Within the last two years, has your asthma required any of the following:

- More than three scripts of oral steroids
- A hospital stay longer than one night
- More than five continuous days off
- Any heart or lung test that required a specialist or hospital referral

◯ No

◯ Yes → provide details

Name	Dosage	Frequency

6. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's name

Address State Postcode

Phone number ( )

SLEEP DISORDER QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What is the condition/diagnosis? Date diagnosed / /

2. Have you been using a CPAP machine every night for 3 months or more?

◯ No

◯ Yes

3. Have you been using a mouthguard or mandibular splint nightly for the last 3 months?

◯ No

◯ Yes

4. Is your condition fully controlled? (this means that your symptoms have not got worse or more frequent, and your treatment hasn't changed, for at least 6 months)

◯ No

◯ Yes

5. Do you suffer from excessive daytime tiredness? (this means you are likely to fall asleep or feel the urge to sleep when sitting inactive in a public place (e.g. in a theatre or a meeting), watching TV, as a passenger in a car or sitting talking to someone)

◯ No

◯ Yes

6. Does this condition limit your ability to work or carry out the normal duties of your normal daily activities?

◯ No

◯ Yes

7. Unless already provided, please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered

Date when first suffered the symptoms / /

Symptoms

Tests/investigations

Treatment

Time off work Date last had symptoms / /

8. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

RAISED CHOLESTEROL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When were you first diagnosed with this condition? Date / /

2. What was your most recent cholesterol result, and when was this taken?

Result Date / /

3. Have you ever taken medication for this condition?

◯ No → go to 8

◯ Yes → provide details

Treatment/dosage Date commenced treatment / /

Date ceased treatment / /

4. Has your treating doctor advised you that your cholesterol is controlled and within normal limits?

◯ No → provide details

◯ Yes

5. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

HIGH BLOOD PRESSURE QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When were you first diagnosed with this condition? Date / /

2. What was your most recent blood pressure result, and when was this taken?

Result Date / /

3. Is this result consistent with previous blood pressure checks?

◯ No → provide details including your typical blood pressure reading and reason for variance

◯ Yes

4. Have you ever taken medication for this condition?

◯ No → go to 5

◯ Yes → provide details

Treatment/dosage Date commenced treatment / /

Date ceased treatment / /

5. Has your treating doctor advised you that your blood pressure is controlled and within normal limits?

◯ No → provide details

◯ Yes

6. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

DIABETES QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. State the diagnosis relevant to you, e.g. Type I or Type II Diabetes Mellitus, Gestational Diabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose etc.

2. When were you diagnosed with this condition? Date / /

3. How often do you consult with your usual doctor/clinic for monitoring?

4. What was the date of your most recent consult with this doctor/clinic? Date / /

5. Are you currently undertaking treatment for this condition?

◯ No → go to 6

◯ Yes → what type of treatment are you undertaking?

- ◯ Diet
- ◯ Insulin – number of daily units:
- ◯ Oral Drug treatment – medication name and dosage:
- ◯ Other – specify:

6. Has your doctor changed your treatment within the last 2 years?

◯ No

◯ Yes → provide details of previous treatment including type, dosage and frequency (if applicable)

7. Have you ever suffered from the following complications of diabetes:

- problems with your eyes
- high blood pressure or other heart/circulatory problems
- kidney problems, including albumin or protein in the urine or
- numbness or tingling in your feet or legs?

◯ No

◯ Yes → provide details including complication/s, severity, treatment and date

8. Do you know your most recent Blood Glucose result?

◯ No

◯ Yes → Blood Glucose result: Date of reading / /

Continue filling out this questionnaire on the following page ↘

9. Do you know your most recent HbA1C (glycosylated haemoglobin) result?

◯ No

◯ Yes → HbA1C result: Date of reading / /

10. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

11. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

CYST/MOLE/SKIN LESION QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What type of cyst/mole/skin lesion do you, or did you have?

2. What is, or was, the location of the cyst/mole/skin lesion?

3. When was the date of diagnosis? / /

4. Was the cyst/mole/skin lesion removed?

◯ No

◯ Yes → provide date and method of removal

5. Were any special tests, investigations or treatment required?

◯ No

◯ Yes → provide details

Do you have pathology results, if required?

◯ Yes

◯ No

6. Was the cyst/mole/skin lesion malignant or benign?

◯ Benign ◯ Malignant ◯ Unknown

7. Have you, or do you require any further treatment or follow-up since the original removal?

◯ No

◯ Yes → provide details

8. Is your usual doctor the treating doctor for this condition?

◯ Yes

◯ No → provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

MENTAL HEALTH QUESTIONNAIRE

1. Were you advised by your treating practitioner of a diagnosis or name for your condition?

◯ No → go to 3

◯ Yes → please check the following condition(s) you experienced and confirm age or date of diagnosis: (if more than one condition, please check all that apply)

- ◯ Grief reaction, stressful life events or difficulties — Age — OR Date / /
- ◯ Post natal depression — Age — OR Date / /
- ◯ Depression (including major depression or dysthymia) — Age — OR Date / /
- ◯ Anxiety (including panic disorder or generalised anxiety disorder) — Age — OR Date / /
- ◯ Bipolar disorder — Age — OR Date / /
- ◯ Obsessive compulsive disorder (OCD) — Age — OR Date / /
- ◯ Post traumatic stress disorder (PTSD) — Age — OR Date / /
- ◯ Schizophrenia or other psychotic disorder — Age — OR Date / /
- ◯ Dissociative disorder (Including dissociative identity disorder) — Age — OR Date / /
- ◯ Eating disorder (including anorexia or bulimia) — Age — OR Date / /
- ◯ Attention Deficit or Hyperactivity Disorder (ADD/ADHD) — Age — OR Date / /
- ◯ Personality disorder (including Borderline personality disorder) — Age — OR Date / /
- ◯ Any other mental health condition not already mentioned.
  What name was given to your condition — Age — OR Date / /

2. Have you experienced any of these conditions more than once?

◯ No

◯ Yes → which condition did you experience more than once, and when did this happen?

3. When did you first experience symptoms relating to your mental health? Age — OR Date / /

4. How have you been affected by your mental health?

Please select each which apply

◯ Have taken time off work under the care of a doctor

When was the last time you were unable to work due to your mental health? Age — OR Date / /

What is the longest number of consecutive days you have been off work due to your mental health?

◯ Have taken time off work under personal or employer sponsored leave

When was the last time you were unable to work due to your mental health? Age — OR Date / /

What is the longest number of consecutive days you have been off work due to your mental health?

◯ My work or social relationships have been negatively impacted

When was the last time you were impacted in this way? Age — OR Date / /

◯ My ability to engage in my usual work and social activities have been negatively impacted

When was the last time you were impacted in this way? Age — OR Date / /

◯ My ability to function has been impacted by my mental health in other ways

Please describe how you have been impacted by your condition:

When was the last time you were impacted in this way? Age — OR Date / /

◯ My mental health has never impacted my ability to function or my relationships

When was the last time you were impacted in this way? Age — OR Date / /

5. Have you ever taken or been prescribed any medication for your mental health condition?

◯ No → go to 6

◯ Yes → please complete below (please check all that apply)

Medication Type	Date First Prescribed	Are you still taking this?	Has this been prescribed more than once?
◯ Antidepressants (e.g. Zoloft, Cipramil, Effexor, Lovan, Aropax)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Mood stabilisers (e.g. Lithium)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Antipsychotics (e.g. Clozaril, Seroquel, Zyrprexa, Risperdal)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Anticonvulsants (e.g. Epilim, Tegretol, Lamictal)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Sedatives / Hypnotics (e.g. Normison, Diazepam)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Stimulants (e.g. Ritalin, Concerta, Provigil)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Substance abuse related medications (e.g. Campral, Naloxone, Suboxone, Methadone)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name:	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name:	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes

6. Have you ever received or been recommended any talk-based therapy such as counselling, CBT, other forms of mental health treatment or been referred to a psychiatrist?

◯ No → go to 7

◯ Yes → please complete below (please check all that apply)

Treatment Type	Date Commenced/ Recommenced	Are you still attending?	Date Ceased (if applicable)
◯ General counselling	/ /	◯ No ◯ Yes	/ /
◯ Cognitive behaviour therapy (CBT) or Dialectical behaviour therapy (DBT))	/ /	◯ No ◯ Yes	/ /
◯ Other forms of talk-therapy Please specify:	/ /	◯ No ◯ Yes	/ /
◯ Consultation with a psychiatrist	/ /	◯ No ◯ Yes	/ /

7. Have you ever been treated in hospital for your mental health condition?

◯ No → go to 8

◯ Yes → when did this happen, what is the name of the hospital where you stayed, and how long was your admission

Continue filling out this questionnaire on the following page ↘

8. Have you ever thought of hurting yourself?

◯ No → go to 9

◯ Yes → when did you last have these thoughts? Age OR Date / /

Had you experienced these feelings previously?

◯ No

◯ Yes → please describe how often you had experienced these feelings previously, and when you first had these thoughts

Have you ever acted on those thoughts?

◯ No

◯ Yes → please provide details including when this has happened

9. Provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / Most recent / /

10. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

BACK/NECK PAIN QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Which part of your back/neck is, or was affected? Select all that apply

◯ Neck (Cervical spine) ◯ Upper/Middle (Thoracic spine) ◯ Lower (Lumbar-sacral spine)

2. When did you first experience back/neck symptoms?

3. Have you ever experienced any symptoms of sciatica, numbness or pins and needles?

◯ No

◯ Yes → provide details including dates

4. Do you continue to experience symptoms?

◯ No → when did you last experience any symptoms of this condition? / /

→ how many episodes of back/neck symptoms have you experienced, and how long did the symptoms last for?

◯ Yes → what was the date of your most recent symptoms? / /

→ how many episodes of back/neck symptoms do you experience per year?

→ how long do the symptoms normally last for?

5. Have you made a complete recovery?

◯ No

◯ Yes → how long have you been free of all symptoms?

6. Are you currently undertaking treatment/therapy for this condition?

◯ No → Have you ever undertaken treatment/therapy for this condition?

◯ No

◯ Yes → provide details

◯ Yes → provide details of treatment/therapy below

Type of treatment		**Date commenced**	**Date ceased** (if applicable)
◯ Medication			
Name	Dosage	/ /	/ /
Name	Dosage	/ /	/ /
◯ Physiotherapy		/ /	/ /
◯ Chiropractor/Osteopath		/ /	/ /
◯ Surgery		/ /	/ /
Details			
◯ Other – advise		/ /	/ /

Continue filling out this questionnaire on the following page ↘

7. Does this condition interfere with or restrict your lifestyle activities or normal occupational duties?

◯ No

◯ Yes → provide details

8. Have you ever taken time off work as a result of your back/neck condition?

◯ No

◯ Yes → advise when and for how long

9. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

10. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

If you need more space to provide your answers, attach a separate sheet signed and dated by you.

JOINT/MUSCULOSKELETAL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Which joint/s or area/s of the body is/are affected?

2. When did you first experience symptoms?

3. What is, or was the cause of your symptoms/condition?

4. Have you made a complete recovery?

◯ No

◯ Yes → for how long have you been free of all symptoms?

5. Are you currently undertaking treatment/therapy for this condition?

◯ No → have you ever undertaken treatment/therapy for this condition?

- ◯ No
- ◯ Yes → provide details below

◯ Yes → provide details of treatment/therapy below

Type of treatment		**Date commenced**	**Date ceased** (if applicable)
◯ Medication			
Name	Dosage	/ /	/ /
Name	Dosage	/ /	/ /
◯ Physiotherapy		/ /	/ /
◯ Chiropractor/Osteopath		/ /	/ /
◯ Surgery		/ /	/ /
Details			
◯ Other – advise		/ /	/ /

6. Does this condition interfere with or restrict your lifestyle activities or normal occupational duties?

◯ No

◯ Yes → provide details

7. Have you ever taken time off work as a result of this condition?

◯ No

◯ Yes → advise when and for how long

Continue filling out this questionnaire on the following page ↘

8. Is your usual doctor the treating doctor for this condition?

◯ Yes

◯ No → provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

9. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

ACTIVITY QUESTIONNAIRES

DIVING QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Are you amateur, professional and/or an instructor? ◯ Amateur ◯ Professional/Instructor

2. Do you have a current diving qualification?

◯ No

◯ Yes → provide details

3. What type of diving do you do? Tick all that apply

◯ Scuba ◯ Snorkeling ◯ Skin diving ◯ Free diving ◯ Wreck diving ◯ Cave/Pothole diving

4. What depths do you dive, and how often (per annum)?

	Average	Maximum
Depth	m	m
Number of dives at this depth	p.a.	p.a.

5. Have you ever been injured, or had an accident while diving?

◯ No

◯ Yes → provide details

Continue filling out this questionnaire on the following page ↘

MOTOR SPORTS (CAR/CYCLE) QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Are you amateur or professional or competitive? ◯ Amateur ◯ Professional ◯ Competitive

2. What types of events do you participate in, and how often per year, e.g. drag racing, speedway, rally driving?

Type and location of event	Number of events per annum

3. What type of vehicles do you drive/ride?

Vehicle type	Engine type/size	Max. racing speed

4. Have you ever been injured, or had an accident while participating?

◯ No

◯ Yes → provide details

Continue filling out this questionnaire on the following page ↘

AVIATION QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Do you hold a Civil Aviation Authority licence?

○ No

○ Yes → state the type and period held

2. Do you intend to change the scope of this licence, including engaging in any other form of aviation?

○ No

○ Yes → provide details

3. Have you ever had an accident or been charged with violating Civil Aviation Authority regulations?

○ No

○ Yes → provide details

4. Complete the following schedule

Category	Flight hours in past 12 months	Flight hours future annual average
Commercial airline		
Charter		
Private		
Aero club/Flying school		
Agriculture		
Helicopter		
Ultralight/Microlight		

OTHER ACTIVITY QUESTIONNAIRE

1. What is the activity?

2. On what basis do you participate in this activity? ○ Amateur/Recreational ○ Competitive ○ Professional

3. How often do you participate in this activity? Events/Hours per year

4. Provide details of the level at which you participate in this activity. e.g. maximum depths, heights, speeds, or grades?

5. Provide details of any injuries you have sustained from this activity

FINANCIAL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

SECTION 1 – PERSONAL FINANCIAL POSITION

1.1. Provide details of your assets and liabilities.
This includes any asset or liability that you directly or indirectly have ownership interest in and/or control over, including those which are not held in your personal name (e.g. those held in your spouse's name).

Assets		**Liabilities**	
Primary residence/farm property	$	Primary residence loan balance	$
Motor vehicle/boat etc.	$	Car loan balance	$
Investment property	$	Credit card balance	$
Investment – shares etc.	$	Personal loan balance	$
Business/es	$	Investment property debt/s	$
Other assets (specify):		Other Investment debt/s	$
	$	Business/es debt/s	$
	$	Other liabilities (specify):	
	$		$
	$		$
Total assets	**$**	**Total liabilities**	**$**

1.2. Do you have any financial dependants?

○ No

○ Yes → provide clarification including the age of each dependant, their relationship to yourself (the life insured), and the length of time they will be dependent on you

1.3. Do you receive or expect to receive net income from other sources such as rental income, dividends etc.?

○ No

○ Yes → provide clarification, including details of the source of the income, the amount of annual net income from this source, and how long this would continue

1.4. Are you applying for (if more than one applies, tick and complete all sections)

○ Business loan cover → complete section 2

○ Business key person cover → complete section 3

○ Business buy/sell cover → complete section 4

○ Personal cover → provide a summary of how the sum insured has been calculated for any personal life, trauma, TPD or Active Health Events cover including details of any formulas/methodologies used or other factors relevant to your situation considered

(If only personal cover is ticked, end here)

Continue filling out this questionnaire on the following page ↘

SECTION 2 – BUSINESS LOAN COVER

2.1. Provide details of the loan/s this cover relates to in the table below

	Lender	Amount	Term	Interest rate	Drawdown date	Repayment method
1		$		%	/ /	
2		$		%	/ /	
3		$		%	/ /	
4		$		%	/ /	

2.2. What is the purpose of the loan/s and what is your share?

2.3. Are there joint and several guarantees?

◯ No

◯ Yes → outline who the other person/s are

2.4. Is insurance a requirement of the lender in providing the loan/s?

◯ No

◯ Yes

SECTION 3 – BUSINESS KEYPERSON COVER

3.1. What is your position in the business?

3.2. What are the duties, special skills, knowledge, expertise, qualifications, contacts or other factors that contribute to make you a key person?

3.3. What proportion of business net profit can be directly attributed to you (the life insured)? %

Clarify how this percentage has been determined

3.4. Outline the calculation methodology showing how the level of key person cover was determined

3.5. What are the roles and duties of other shareholders/trustees and key personnel in the business, and how much do they contribute to income generation in the business?

	Role/Duties	Contribution	Position	Value policies in force
1		%		$
2		%		$
3		%		$
4		%		$

3.6. Is cover in force or being effected on the lives of any other persons in the business?

◯ No

◯ Yes → provide details of on whom, their role/duties and how much

Continue filling out this questionnaire on the following page ↘

SECTION 4 – BUSINESS BUY/SELL COVER

4.1. Has an independent valuation been completed?

◯ No

◯ Yes → are you able to provide a copy of the valuation?

- ◯ No
- ◯ Yes

4.2. Provide a detailed outline of the calculation methodology showing how the cover was calculated

_____

_____

_____

4.3. Has a Partnership, Share Purchase and/or Buy/Sell Agreement been put in place?

◯ No

◯ Yes → are you able to provide a copy of the Partnership, Share Purchase and/or Buy/Sell Agreement?

- ◯ No
- ◯ Yes

4.4. Is cover in force or being effected on the lives of all business partners or shareholders?

◯ No → provide details as to why not

_____

_____

_____

◯ Yes → are the business partners/shareholders also applying for cover with Zurich?

- ◯ No → what levels of cover are being applied for, and with which insurer?

  _____

- ◯ Yes → confirm the names of the other business partners/shareholders applying for cover with Zurich

  _____

BUSINESS EXPENSES QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

SECTION 1 – BUSINESS DETAILS

1.1. When did your business commence? / /

1.2. What are the principal business activities?

1.3. Describe what you would expect to happen to your business in the event of your disability and over what timeframe.
Include details of any contingencies (including use of a locum) that may be in place

1.4. What proportion of total business expenses are you responsible for? %

1.5. Provide the following details for all income generating employees and business owners/partners

Name of employee or business owner/partner	% of income generated	Role/duties	Annual salary	% interest in the business (if any)
	%		$	%
	%		$	%
	%		$	%
	%		$	%

1.6. Are you applying for:

◯ Keyperson replacement cover → complete section 2

◯ Ongoing fixed expenses cover → complete section 3

SECTION 2 – KEYPERSON REPLACEMENT COVER

2.1. What is your position in the business?

2.2. What are the duties, special skills, knowledge, expertise, qualifications, contacts or other factors that contribute to make you a key person that would require the business to get a replacement in the event of your disability?

2.3. What proportion of the business net profit can be directly attributed to you (the life insured)? %

2.4. What would a replacement cost at market rates? $ per month

2.5. Outline the basis on which the replacement cost was determined?

2.6. Clarify how long it would most likely take to source a replacement

Continue filling out this questionnaire on the following page ↘

SECTION 3 – ONGOING FIXED EXPENSES COVER

Enter your share of average monthly business expenses (that you are responsible for). Some expenses are not eligible for this insurance, e.g. partner share of expenses and salaries. Refer to the relevant PDS for a list of business expenses that we will cover.

Accounting and auditing fees (regular only)	$
Bank fees and charges	$
Cleaning costs (regular only)	$
Electricity, gas and water	$
Fees for professional associations	$
Insurance premiums (excluding this policy and income protection policies)	$
Interest payments on business loans	$
Leasing/Hire purchase of office equipment, machinery or motor vehicles	$
Minimum loan repayments of business capital/principal loan	$
Locum cover (less earnings generated by locum)	$
Motor vehicle fixed business related costs (registration etc.)	$
Payroll tax for employees not directly involved in revenue generation	$
Printing postage and stationery	$
Property rates/taxes	$
Rent/Leasing fees (business premises)	$
Repairs and maintenance	$
Salaries of employees not directly involved in revenue generation (excluding income splitting)	$
Security costs	$
Subscriptions/fees for business related associated memberships	$
Superannuation contribution for employees not directly involved in revenue generation (excluding income splitting)	$
Telephone	$
Other expenses (specify the nature of the expense) Expense:	$
Expense:	$
Expense:	$
Total	**$**

BANKRUPTCY QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What date were you declared bankrupt? / /

2. Has your bankruptcy been discharged?

◯ No
◯ Yes → when was it discharged? / /

3. Was this bankruptcy:

◯ Voluntary?
◯ Forced?

4. Provide a detailed description of the reason for and the circumstances under which you were declared bankrupt on the above occasion

5. At the time of your bankruptcy, were you an employee only with no ownership (directly or otherwise) in the business you were working in?

◯ No → detail how the bankruptcy affected your business structure, trading operation and/or management of the business at the time

◯ Yes → detail how the bankruptcy affected your employment situation

6. Apart from any original creditor's petition, were any legal proceedings instigated against you arising from this bankruptcy?

◯ No
◯ Yes → provide details, including whether any proceedings are still in place

7. Have you ever been declared bankrupt prior to this bankruptcy?

◯ No
◯ Yes → provide full details, including date of discharge

8. Has any entity you have been associated with been placed into receivership, liquidation or administration?

◯ No
◯ Yes → provide details

9. Do you still have financial commitments to any other parties involved?

◯ No
◯ Yes → provide details

10. Did you suffer from any health problems at the time of bankruptcy, e.g. stress, anxiety or high blood pressure?

◯ No
◯ Yes → provide details

Notes

Notes

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