



Application for

# Income Protection Insurance

Complete this form if you wish to apply for income protection insurance. You must be a permanent employee working at least 15 hours per week to apply. Income protection insurance is not available to casual employees or Spouse members.

## PART A Your personal details

Title (please tick):  Dr  Mr  Ms  Mrs  Miss      Membership no.:

Given name:       Surname:

Home address:

Telephone: (    )       Date of birth:    /    /

## PART B Your insurance choice

If you would like to purchase income protection insurance, please tick the box below.

Yes, I wish to apply for income protection insurance through IPE Super.

## PART C Declaration

I acknowledge the following:

- I have received and understood the Product Disclosure Statement for IPE Super for my category of membership.
- I understand that my application for income protection insurance cover is dependent upon me completing the insurer's Application for Insurance and providing any medical or other evidence requested by the insurer. Further, cover will only commence if it is accepted by IPE Super's insurer, and will be subject to any terms and conditions imposed by the insurer.
- I authorise the Trustee to deduct the cost of income protection insurance from my IPE Super account.
- I acknowledge that I have received and understood a summary of the *Privacy Policy* of IPE Super as set out in the Product Disclosure Statement, and I agree to the use and disclosure of my personal information as disclosed therein.

Signature:       Date:    /    /

You should also complete the insurer's Application for Insurance (attached). For more information, see the Fund's website at [www.ipesuper.com.au](http://www.ipesuper.com.au) or call 1800 257 135.

Return all completed forms to:

The Fund Administrator, IPE Super, PO Box 1442, Parramatta NSW 2124



# Application for Insurance

## MetLife

### About the Application

- This application needs to be completed by the person to be insured.
- Please complete the application in BLACK ink pen only.
- Any changes made to this application are to be initialled by the person to be insured.
- Please answer all the questions as accurately as possible and provide additional information wherever requested.
- As part of your application, you may be required to undergo additional medical tests.
- As part of the overall assessment process MetLife will contact you on your preferred phone number if further information is required.

### Privacy - Use and Disclosure of personal information

#### Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' and the 'Insurer')

The personal information you provide in this form is necessary for us to provide you with the products and services you have requested from us, and to manage your claims. You do not have to provide us with your personal information, but if you do not do so we may not be able to provide you with our products or services.

MetLife Insurance Limited complies with the Privacy Act 1988 and the principles laid out in its privacy policy which details information about how you may access or seek correction of your personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at [www.metlife.com.au/privacy](http://www.metlife.com.au/privacy).

Name of Scheme or Superannuation Fund: \_\_\_\_\_

### About You

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Residential Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Date of Birth (dd/mm/yyyy) \_\_\_\_\_ Gender \_\_\_\_\_ Email Address \_\_\_\_\_  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female

Contact Number Preferred \_\_\_\_\_ Contact Number Other \_\_\_\_\_ Preferred Time of Contact \_\_\_\_\_  
\_\_\_\_\_  Morning (9am-12pm)  Afternoon (12-6pm)

Are you a permanent resident of Australia?  Yes  No

### About Your Insurance Needs

Total Required Cover:

	Death Cover	Total & Permanent Disability Cover	Income Protection
Existing Policy Cover (if known)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> per month
Additional Policy Cover Requested	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> per month
Total Cover Requested (= Existing + Additional Policy Cover Requested)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> per month

## About Your Work

1. What industry do you work in?  
(eg. banking, agriculture, education)

What is your current occupation?

What is your current gross annual salary?

2. Do you work more than **15 hours** per week?

Yes  No

## About Your Insurance History

3. Has an application for Life, Trauma, TPD or Disability Insurance on your life ever been declined, deferred or accepted with a loading or exclusion or any other special condition or terms?

Yes  No

4. Have you ever made a claim for or received sickness, accident or disability benefits, Workers' Compensation, or any other form of compensation due to illness or injury?

Yes  No

5. Do you currently have or are you applying for insurance with MetLife (in addition to this application) or any other insurance company or superannuation fund?

Yes  No

If "Yes", please give details in the table below.

Product/Type	Total Amount of Cover	To be replaced by this cover?
Life Insurance	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total & Permanent Disability	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
Income Protection	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

## About Your Health

6. What is your height?

What is your weight?

\_\_\_\_\_ cm

\_\_\_\_\_ kg

7. Have you smoked in the last 12 months?

Yes  No

8. In the last **3 years** have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?  
Please tick all boxes that apply.

Headache or Migraine (eg. tension or cluster headaches or migraines)

Lung or Breathing Conditions (eg. asthma, sleep apnoea)

Eyesight Conditions (does not incl. contact lenses or glasses for near or far sightedness)

Ear or Hearing Conditions (eg. hearing loss, tinnitus or swimmer's ear)

Muscle, Tendon or Ligament Problems

Trapped Nerves (eg. carpal tunnel syndrome, pinched nerve, tennis elbow)

Infectious Diseases (excl. cold & flu)

Gout

None of the above conditions

If you have selected any of the above conditions in question 8, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

9. In the last **5 years** have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?  
Please tick all boxes that apply.

- High Blood Pressure
  High Cholesterol
  Chronic Fatigue / Fibromyalgia  
 **None of the above conditions**

If you have selected any of the above conditions in question 9, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

10. Have you **ever** suffered from, been diagnosed with or sought medical advice or treatment for any of the following?  
Please tick all boxes that apply.

- Bone, Joint or Limb Conditions
  Back or Neck Pain
  Digestive Conditions  
 Brain or Nerve Conditions (incl. stroke)
  Psychological or Emotional Conditions
  Cancer, Cyst, Growth, Polyps or Tumour  
 Thyroid Conditions
  Skin Disorder
  Genitourinary Conditions  
 Autoimmune Diseases
  Heart Related Conditions
  Kidney or Liver Conditions  
 Diabetes
  Blood Conditions  
 None of the above conditions

If you have selected any of the above conditions in question 10, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

11. Are you currently pregnant? (Females Only)  Yes  No

12. What is the name of your usual doctor/medical centre? \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Contact Number: \_\_\_\_\_

## About Your Family History

13. Has your mother, father, any brother or sister been diagnosed under the age of 55 years, with any of the following conditions: Alzheimer's Disease, Cancer, Dementia, Diabetes, Familial Polyposis, Heart Disease, Huntington's Disease, Polycystic Kidney Disease, Multiple Sclerosis, Muscular Dystrophy, Stroke or any inherited or hereditary disease?

Note: You are only required to disclose family history information pertaining to first degree blood related family members, living or deceased.

- Yes  No  Unknown

If "Yes", please give details in the table below.

Relationship to proposed insured	Age at diagnosis	Specific condition(s)

## About Your Lifestyle

14. Do you have firm plans to travel or reside in another country **other than** New Zealand, America, Canada, the United Kingdom or Europe?  Yes  No

If "Yes", please give details in the table below.

Country	Length of stay

15. Do you regularly engage in or intend to engage in any of the following activities? Please tick all boxes that apply.

- Water Sports** (eg. underwater diving, rock fishing)
  **Motor Sports** (eg. motorcycle, auto, motor boat)
  **Sky Sports** (eg. skydiving, hang gliding, parachuting, ballooning)
- Aviation** (other than as a fare paying passenger on a commercial airline)
  **Horse Sports** (eg. polo, horse riding, rodeo, dressage, jumping)
  **Combat Sports or Martial Arts** (eg. martial arts, boxing, fencing)
- Field Sports** (eg. hockey or football including touch or tag and soccer)
  **Hunting** (of any kind)
  **Any activity not mentioned** (eg. base jumping, caving, outdoor rock climbing)
- None of the above activities**

Please provide details for any activities you have selected above:

Activity	Details

16. Have you within the last **5 years** used any drugs that were not prescribed to you (other than over the counter drugs) or have you exceeded the recommended dosage of **any** medication?  Yes  No

If "Yes", please give details in the table below.

Drug/Medicine	Reason for Use

17. On average, how many standard alcoholic drinks do you consume each week (a standard drink is equivalent to either 125ml glass of wine, a schooner of light beer, a middy/pot of full strength beer or a 30ml shot of spirits)? \_\_\_\_\_ / week

18. Have you ever been advised by health professional to reduce your alcohol consumption?  Yes  No

19. Do you currently have HIV (Human Immunodeficiency Virus) that causes AIDS (Acquired Immune Deficiency Syndrome)?  Yes  No

If "No", are you in a high risk category for contracting HIV?  Yes  No

20. Other than already disclosed in this application, do you presently suffer from any condition, injury or illness, which you suspect may require medical advice or treatment in the future?  Yes  No

If "Yes", please provide details below.

Condition	Details

## YOUR DUTY OF DISCLOSURE

Before you enter into a contract of insurance with an Insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the Insurer every matter that you know or could reasonably be expected to know is relevant to the Insurer's decision whether to accept the risk of the insurance and if so, on what terms. You have the same duty to disclose those matters to the Insurer before you extend, vary or reinstate a contract of life insurance.

This duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the Insurer;
- that is common knowledge;
- that the Insurer knows or, in the ordinary course of his/her business, ought to know; and
- as to which compliance is waived by the Insurer.

## NON-DISCLOSURE

If you fail to comply with this Duty of Disclosure and we, MetLife would not have entered into the contract on any terms if the failure had not occurred, we may avoid the contract within 3 years of entering into it. For applications accepted from 28 June 2014 onwards, we can exercise the right to avoid the contract even if it would have provided you with cover on different terms.

If the non-disclosure is fraudulent, we may avoid the contract at any time.

An Insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

We have the same rights if you make a misrepresentation to us.

We are required to treat some policies as comprising 2 or more separate conflicts of life insurance and elect whether to apply its rights to each contract separately. For example, TPD and income protection benefits may be treated as separate contracts. Additionally, default cover and any additional cover will also be treated separately.

## ADDITIONAL RIGHTS FROM 28 JUNE 2014

For all cover except death cover received by members from 28 June 2014, we have the following additional rights if you fail to comply with your duty of disclosure or make a misrepresentation to us:

- Elect to reduce the sum insured according to a formula prescribed by the law at any time;
- If we have not avoided the contract or varied the sum insured, we can vary the contract in a way that places us in the same position we would have been if the non-disclosure or misrepresentation had not occurred.

We also have these additional rights for policies issued before 28 June 2014 if it agrees to:

- increase the sum insured; or
  - provide additional kinds of insurance cover
- but only to the extent of the variation.

## DECLARATION

- I have read and understand my Duty of Disclosure and understand that this duty applies until formal notification of acceptance.
- My answers to the questions are true, and I have not deliberately withheld any information or material to the proposed insurance.
- I agree to be bound by the terms and conditions set out in the insurance policy document.
- I consent to the collection, use and disclosure of personal information by MetLife and its service providers in order to assess my application and any claim under the policy.
- I have read and understood the Privacy Disclosure Statement contained in the section head "Privacy - Use and Disclosure of personal information." I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement above and MetLife's Privacy Policy.
- I consent to MetLife seeking medical information from any doctor/hospital/health care professional whom I have consulted.
- I understand that cover under a policy does not begin until acceptance by the insurer, of which I will be notified in writing.
- I have read the insurance section of the current Product Disclosure Statement.

MET0401 05/14 RDA4674

## Signature

Signature of Applicant

Date

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

- Please return completed form to MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001 or [auseservices@metlife.com](mailto:auseservices@metlife.com)

MetLife Insurance Limited  
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