

# Voluntary insurance cover

## This form is for members of the LGS Accumulation Scheme

Use this form if you want to apply for or alter your voluntary insurance cover. For your application to be considered, you must complete all sections of this form.

Please use a black pen and CAPITAL letters or type directly into this form online, print it and send it to us. Use (X) to mark boxes.

Before completing this form, please ensure you read the relevant Product Disclosure Statement (PDS) available at [lgsuper.com.au/PDS](http://lgsuper.com.au/PDS)

These amounts must be multiples of \$1,000 with a minimum of \$50,000. There is no maximum for Death cover, however there is a maximum of \$3,000,000 for Total and Permanent Disability.

Cover is available in multiples of \$100 with a minimum cover of \$1,000 per month. The highest cover you can apply for is \$25,000 per month with a waiting period of either 30, 60 or 90 days. This monthly benefit must not exceed 75% plus a Superannuation Contribution Benefit of 10% of your declared earned income.

### IMPORTANT

Accident cover applies for a maximum of 90 days after we receive this form. It is therefore important that you forward this application to us promptly.

## 1. Your details

Member no.	<input type="text"/>	Date of birth	<input type="text"/>	Title	<input type="text"/>
Given name/s	<input type="text"/>				
Family name	<input type="text"/>				
Email address	<input type="text"/>				
Phone (home)	<input type="text"/>	Phone (work)	<input type="text"/>		
Phone (mob)	<input type="text"/>				
<b>Postal address</b>					
No./Street	<input type="text"/>				
Suburb/Town	<input type="text"/>	State/Territory	<input type="text"/>	Postcode	<input type="text"/>
Residential address <input checked="" type="checkbox"/> select if same as postal address above					
No./Street	<input type="text"/>				
Suburb/Town	<input type="text"/>	State/Territory	<input type="text"/>	Postcode	<input type="text"/>

## 2. Insurance level

I wish to apply for (or increase my level of voluntary insurance cover to):

<input checked="" type="checkbox"/> Death cover in the amount of:	\$	<input type="text"/>
<input checked="" type="checkbox"/> Death and Total and Permanent Disability cover in the amount of:	\$	<input type="text"/>
<input checked="" type="checkbox"/> <b>Salary Continuance Cover:</b>		
Short term (two-year benefit period) in the monthly amount of:		\$
Long term (to age 65 benefit period) in the monthly amount of:		\$
Monthly Income Benefit Waiting Period	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days
	<input type="checkbox"/> 90 days	

## 3. Occupation details

3.1	<input type="checkbox"/> Self employed	<input type="checkbox"/> Employee	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="text"/>	hrs/wk	<input type="text"/>	weeks/year
3.2	Your occupation	<input type="text"/>		Industry	<input type="text"/>			
3.3	Duties performed <input type="text"/>							
3.4	Annual salary	\$	<input type="text"/>					
	(includes items such as your super contributions, but excludes bonuses/commission)							

## 4. Group medical requirements

### Death and Total Permanent Disability levels of cover and initial requirements for members under 45 years of age.

Level of cover	Initial requirements
Up to \$2,500,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (refer to question 7)</li> </ul>
\$2,500,001 to \$3,000,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (refer to question 7)</li> <li>● Blood Tests (upon receipt of your application, you will be notified if these are required)</li> <li>● Fast Check Medical (upon receipt of your application, you will be notified if these are required)</li> </ul>
Over \$3,000,000	<ul style="list-style-type: none"> <li>● Personal Medical Attendant's Report from your Doctor</li> <li>● Please contact us for requirements</li> </ul>

### Death and Total Permanent Disability levels of cover and initial requirements for members aged 45 years and over.

Level of cover	Initial requirements
Up to \$1,500,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> </ul>
\$1,500,001 to \$2,000,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Blood Tests (as above)</li> <li>● Fast Check Medical (as above)</li> </ul>
\$2,000,001 to \$3,000,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Blood Tests (as above)</li> <li>● Fast Check Medical (as above)</li> </ul>
Over \$3,000,000	<ul style="list-style-type: none"> <li>● Personal Medical Attendant's Report from your Doctor</li> <li>● Please contact us for requirements</li> </ul>

### Group Salary Continuance monthly benefit levels and initial requirements for members aged under 45.

Monthly benefit	Initial requirements
Up to \$12,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> </ul>
\$12,001 to \$15,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Blood Tests (as above)</li> </ul>
\$15,001 to \$20,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Fast Check Medical (as above)</li> <li>● Blood Tests (as above)</li> </ul>
\$20,001 to \$25,000	<ul style="list-style-type: none"> <li>● Please contact us for requirements</li> </ul>

### Group Salary Continuance monthly benefit levels and initial requirements for members aged 45 and over.

Monthly benefit	Initial requirements
Up to \$12,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> </ul>
\$12,001 to \$15,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Personal Medical Attendant's Report from your Doctor</li> <li>● Blood Tests (as above)</li> </ul>
\$15,001 to \$20,000	<ul style="list-style-type: none"> <li>● Member's Personal Statement (as above)</li> <li>● Fast Check Medical (as above)</li> <li>● Blood Tests (as above)</li> <li>● Personal Medical Attendant's Report from your Doctor</li> </ul>
\$20,001 to \$25,000	<ul style="list-style-type: none"> <li>● Personal Medical Attendant's Report from your Doctor</li> <li>● Please contact us for requirements</li> </ul>

Complete this section if you want to make an insurance cover transfer application from your previous account to your LGS account.

## 5. Insurance transfer application

Death Sum Insured \$  TPD Sum Insured \$

Monthly Income Benefit \$  Benefit Period

Monthly Income Benefit Waiting Period  30 days  60 days  90 days

5.1 Is this an increase?  No  Yes

5.2 Have you ever held or applied for any life, disability, accident and sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused?  No  Yes

5.3 Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party?  No  Yes

5.4 Do you have, or are you applying for, any other life or disability cover?  No  Yes

If Yes to 5.2, 5.3 and/or 5.4, please provide full details below:

Name of company	Cover type	Sum insured/ monthly benefit	Date of application or claim	Accepted/ Loaded Exclusion/ Declined	To be replaced?
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> DD/MM/YYYY	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> DD/MM/YYYY	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> DD/MM/YYYY	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

## 6. Habits and activities

6.1 Do you drink alcohol?  No  Yes

If Yes, state type, number of standard drinks per day and number of days per week when alcohol is consumed.

6.2 Have you smoked in the past 12 months?  No  Yes

If Yes, state form and daily quantity

6.3 Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs?  No  Yes

If Yes, state type and daily quantity

6.4 Do you currently, or do you intend to engage in, any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding, or rock climbing? If Yes, please complete a sports and pastimes statement  No  Yes

6.5 Do you intend travelling outside Australia within the next two years?  No  Yes

If Yes, please provide details below (where, when, duration and reason)

6.6 Are you an Australian Citizen or do you have an Australian Permanent Resident's Visa?

No  Yes

If No to 6.6, please advise type of visa and expiry date, plans for applying for permanent residency and nationality/current citizenship:

## 7. Personal statement

7.1 Please state your: height  cm weight  kg

### 7.2 Name and address of your usual doctor

Doctor's name   
 No./Street   
 Suburb/Town  State/Territory    Postcode      
 Country  Phone

### 7.3 Details of last medical consultation with your usual doctor

Date     Reason   
  
 Outcome/results

### 7.4 If you have attended that doctor for less than 12 months, please state the name and address of your previous doctor

Doctor's name   
 No./Street   
 Suburb/Town  State/Territory    Postcode      
 Country  Phone

- 7.5 a) Within the LAST THREE YEARS have you consulted, been examined,  No  Yes treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquillisers?
- b) Have you EVER had an ECG, ultrasound, X-ray, transfusion,  No  Yes mammogram or any other investigation?
- c) Have you EVER had any blood tests which revealed an abnormality  No  Yes e.g. raised blood sugar, liver function, kidney function results or anaemia, etc?
- d) Do you contemplate seeking any medical examination, advice, treatment  No  Yes or surgery for any other current health condition in the future?

Please provide full details for all Section 7.5 'Yes' answers:

Question	Dates (From/To)	Name and address of doctor, hospital or clinic	Condition, medications, treatment and time off work	Recovery %
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

7.6 Have you ever had, been advised that you had, or received advice or treatment for any of the following:

- a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder?  No  Yes
- b) Bowel, stomach or intestinal problem, gallbladder, hepatitis or liver disease?  No  Yes
- c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks?  No  Yes
- d) Depression, anxiety, panic attacks, stress, chronic fatigue, fibromyalgia or any mental or nervous condition?  No  Yes
- e) Diabetes, sugar in urine, pancreatic or thyroid problems?  No  Yes
- f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind?  No  Yes
- g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis?  No  Yes
- h) Impairment of sight, hearing or speech?  No  Yes
- i) Asthma, bronchitis, sleep apnoea, or any lung complaint?  No  Yes
- j) Leukaemia, haemochromatosis, anaemia, or any blood problems?  No  Yes
- k) Kidney, prostate, or bladder problems?  No  Yes
- l) Psoriasis, eczema, or any skin problems?  No  Yes
- m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury?  No  Yes
- n) To the best of your knowledge do you, or any of your current or past sexual partners, have HIV/AIDS, or do you/have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus?  No  Yes

**Females only**

- o) Have you ever had any gynaecological conditions (e.g: endometriosis, abnormal pap smear, etc.)?  No  Yes
- p) Have you ever had any complications of pregnancy or childbirth?  No  Yes
- q) Are you currently pregnant? If Yes, what is the expected delivery date?
- r) Have you ever had a breast lump (even if you have not seen a doctor about it)?  No  Yes

**7.7 Family history**

Relationship to member	Current age	Medical Condition (e.g. breast cancer, heart attack, Type 2 diabetes)	Age when diagnosed	Age at death (if applicable)

Please provide details of your family medical history.

7.8 Has any of your immediate family (mother, father, brother or sister) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's disease or any other hereditary disease?

If Yes, please provide details:

Please provide full details for all 'Yes' answers in Section 7.6. Please continue on a separate sheet if required.

## 8. General medical questionnaire

	Question <input type="checkbox"/> Specific Condition	Question <input type="checkbox"/> Specific Condition	Question <input type="checkbox"/> Specific Condition	Question <input type="checkbox"/> Specific Condition
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				
H. What advice/treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
J. Date treatment/medication ended.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)				
M. Please supply the name and address of all documents, hospitals or other practitioners consulted.				

## 9. Your declaration

### IMPORTANT

From 1 July 2019, legislation requires that your insurance be cancelled if your account becomes inactive (i.e. has not received contributions for 16 months or more).

From 1 April 2020, in accordance with the Putting Members' Interests First (PMIF) legislation, new members joining the Fund must be at least 25 years of age and have a super balance of at least \$6,000 to obtain automatic insurance cover.

You must mark the following box if you do not wish your insurance to be cancelled, if your account becomes inactive or if you wish to obtain basic cover before you become eligible for automatic insurance cover.

To **obtain and keep ALL** your insurance cover:

I elect to **obtain and keep my insurance cover** even if:

- I am under the age of 25 and/ or
- My super account balance is under \$6,000; or
- My account becomes inactive in the event of not receiving any contribution or rollovers for 16 months or more.

I acknowledge that I have read the Duty of Disclosure below and I am aware about the consequences of non-disclosure. I understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting or typed online and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or Personal Statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Applicant, authorise and direct any medical or other practitioner to divulge at any time to the Insurer or to any lawfully constituted tribunal any and all information concerning my state of health and medical history acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by the Trustee and the Insurer or its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information the Insurer collects on this form or future forms in relation to this insurance.

I

hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written or typed online by me or by any person on my behalf. I also declare that I have read and understood the Product Disclosure Statement and the 'Insurance in your super' fact sheet.

Signed

Date

## 10. Medical authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of member

Signature of member  Date

### Your Duty of Disclosure

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know that may affect their decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell the insurer anything that:

- reduces the risk they insure you for; or
- is common knowledge; or
- they know or should know as an insurer; or
- they waive your duty to tell them about.

### If you do not tell the insurer something

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

If you do not tell the insurer anything you are required to, and they would not have insured you if you had told them, they may avoid the contract within three years of entering into it.

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

If the insurer chooses not to avoid the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

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

### Payment of invoice

Please have any invoices made out to TAL Life Limited.

## Please return your completed form to:

Mail: Local Government Super  
PO Box N835  
Grosvenor Place NSW 1220

Email: [admin@lgsuper.com.au](mailto:admin@lgsuper.com.au)

### Privacy Collection Statement

The information provided on this form is collected by LGSS Pty Limited (ABN 68 078 003 497) as Trustee for Local Government Super (ABN 28 901 371 321) for the purposes of administering accounts and providing services to you associated with fund membership. If you do not provide the requested information, LGS may not be able to perform these services. Your personal information may be shared with our administrator, other superannuation trustees and other services providers, in order to be able to provide our services to you. We may provide information to government, regulatory or other bodies if required by law. For further information about how we manage and protect personal information, please refer to our privacy policy available at [lgsuper.com.au/privacy-policy](http://lgsuper.com.au/privacy-policy) or by calling us on 1300 LGSUPER (1300 547 873). It sets out how we use the information we hold about you, how you can access and correct the information, how you may complain about a breach of privacy and our process for resolving privacy related enquiries and complaints.

Issued by LGSS Pty Limited (ABN 68 078 003 497) (AFSL 383558), as Trustee for Local Government Super (ABN 28 901 371 321).

Enquiries Phone: 1300 LGSUPER (1300 547 873), 8.30am–5.00pm, Monday to Friday Web: [lgsuper.com.au](http://lgsuper.com.au)