

Important notice

ING Life Limited (ING Life) is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposed to become an insured member under the policy and your benefits are subject to assessment by ING Life
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by ING Life.

ING Life requires this personal statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement on page 40.

You may wish to seal it in an envelope and send it to:

ING Life Limited
GPO Box 4129
Sydney NSW 2001

Your duty of disclosure

You have a duty under the Insurance Contracts Act 1984 (Cth.) 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 insurance and, if so, on what terms.

Your duty of disclosure applies even after your application is completed and until the insurer has assessed and accepted your application for insurance cover, or an increase in cover.

You have the same duty to disclose those matters to the insurer before you change your insurance cover or apply for new cover. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by the insurer
- is of common knowledge
- the insurer knows, or in the ordinary course of business, ought to know or
- the insurer has waived.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

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

Group Risk

ING Life Limited

ABN 33 009 657 176

Australian Financial Services Licence 238341

GPO Box 4129

Sydney NSW 2001

347 Kent Street

Sydney NSW 2000

Tel 133 667

Fax 02 9234 8970

Group Risk

Personal Statement



> INVESTMENT > INSURANCE
> SUPERANNUATION

Dated 11 March 2004

Type of Fund/Plan

Please tick the appropriate box Group Life Group Salary Continuance

Policy Number (if known)

Name of Fund/Plan

Name of Intermediary

Type of cover

Death Only

Death and Total and Permanent Disablement (TPD)

Group Salary Continuance (monthly benefit)

Amount of benefit/cover

\$

\$

\$

1. Personal details

Title Mr Mrs Miss Ms Dr Other

Surname

First name(s)

Date of birth D D M M Y Y Y Y Sex M F

Occupation

Occupation duties

(include the percentage of time spent in each)

2. Insurance details

1. Have you previously applied to ING Life Limited or are other applications being submitted? Yes No

If **yes** provide Application No. or Policy No.

2. Have you any Life, Disability and/or Trauma cover with us or any other company or as a part of your employment, or have you recently proposed with any other company for such cover? Yes No

If **yes**, please provide details of cover.

Name of Company	Type of Cover	Sum Insured	Date Commenced
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. If this application is accepted, do you intend this cover to replace any cover mentioned above? Yes No

4. Have you ever had an application on your life declined, postponed, accepted with a higher than normal premium or otherwise than as submitted? Yes No

If **yes**, provide name of company, alteration, date and reason, if known.

5. Have you ever made a claim for or received sickness, accident, disability, Veterans Affairs benefits, workers' compensation, unemployment benefits or **any** other similar compensation? Yes No

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

3. General details

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

2. How long have you lived in Australia?

3. Do you have any intention to travel outside Australia within the next two years? Yes No

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

Date of departure Duration of stay

Destinations

4. What is the purpose of your stay? Holiday Business Residing Other

If **other**, please specify

4. Usual doctor or medical centre details

1. Full name of usual doctor

Phone number

2. a. Full address of usual doctor

Street address

State Postcode

b. How many years have you been attending this doctor? years months

3. If known for less than 12 months, please advise name and address of the doctor who has details of your medical history.

Name

Phone number

Street address

State Postcode

4. a. If you have more than one usual doctor, please provide details of additional doctors below.

Name

Phone number

Street address

State Postcode

b. How many years have you been attending this doctor? years months

5. Please give details of your last consultations with ANY doctors, and if applicable, outcome or degree of recovery.

Doctor's name and address	Date	Reason for consultation	Outcome

If more space is required, attach an additional page.

5. Personal health statement

If a medical examination is required, or if you are completing a Paramedical Report, please go to section 9 on page 7. Otherwise, please complete sections 5, 6, 7 and 8.

1. What is your current height and weight? Height cm Weight kg
2. Has your weight varied by more than 10 kg during the past 12 months? Yes No
If yes, please provide details.
3. During the past 12 months have you smoked tobacco or any other substance? Yes No
If yes, please state type and quantity per day.
4. Non-smokers – Have you ever smoked regularly in the past? Yes No
If yes, please state type, date ceased and quantity per day.
5. Do you consume alcohol? Yes No
If yes, state type and quantity per day (the word 'social' is not sufficient).
6. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? Yes No
If yes, please provide full details.

6. Family history – to be completed in respect of relatives related by blood

1. Have any of your parents, brothers or sisters (living or dead) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary or familial disorder?
 Yes No If yes please complete the following:

Relation	Condition (disorder)	Age diagnosed

2. Have any of your parents, brothers or sisters (living or dead) been diagnosed prior to age 60 with any of the following conditions: diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease?
 Yes No If yes, please complete the following:

Relation	Condition (disorder)	Age diagnosed

7. Health history

To the best of your knowledge, have you ever had any of the following?

Please tick appropriate box.

If the answer is YES please circle the specific conditions and follow the instructions in the box below.

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| 1. <u>Asthma</u> , sleep apnoea, bronchitis, persistent cough or any other chest or lung troubles or allergy? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Heart trouble, murmur, <u>high blood pressure</u> , <u>high cholesterol</u> , <u>chest pain</u> , rheumatic fever, palpitations, stroke or vascular disorder? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. <u>Diabetes</u> , thyroid or glandular trouble? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. <u>Ulcers</u> , bowel trouble or recurring indigestion? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. <u>Epilepsy</u> , fits or dizziness of any kind or persistent headaches? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. <u>Stress</u> , <u>anxiety</u> , <u>depression</u> , <u>mental</u> or <u>nervous disorders</u> ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. Kidney or bladder problems, renal colic or stones, nephritis, pyelitis or cystitis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. <u>Back</u> , <u>neck</u> , <u>shoulder</u> or <u>knee</u> pain or strain, sciatica or any other disorder of the spine or neck, any disorder of the joints, muscles, ligaments, cartilage or limbs, including broken bones? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. <u>Arthritis</u> , <u>gout</u> , fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. Cancer, tumour, cyst, growths of any kind or breast lumps (even if you have not seen a doctor)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. Varicose veins, hernia or skin trouble? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. Any abnormality affecting eyesight, hearing, speech or physical mobility? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. Anaemia, haemophilia or any other disease of the blood? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. Bowel, liver or gall bladder disease, or hepatitis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. Coughing of blood, passing of blood from the bowel or in the urine? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. Any sexually transmittable disease including but not limited to AIDS or its positive antibodies, gonorrhoea or syphilis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 17. Within the last five years, have you had any other illness, injury, operation, -ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 18. Due to injury or illness have you ever been off work for more than seven consecutive days?
(for a condition not already mentioned) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 19. Do you currently have any symptoms of ill health or disability? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 20. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation in the future? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 21. Do you take, or have you EVER taken, drugs, tablets or any medications on a regular or ongoing basis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 22. Have you EVER used or injected any drugs not prescribed by a medical attendant? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 23. AIDS Statement | | | | |
| (i) Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (ii) Have you EVER worked as, or engaged in sexual activity with, a prostitute, or engaged in anal sexual activity? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (iii) Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 24. Females only – Have you ever had any complications with pregnancy or childbirth? | | | | |
| – Are you currently pregnant? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| – Have you ever had an abnormal pap smear, breast ultrasound or mammogram? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

For any yes answer above:

If a condition is underlined please complete Additional Medical Questionnaire in section 8 on page 36.

Otherwise, complete the following table and include full details. If insufficient space, please attach an additional statement.

This does not mean that insurance is not available, but we may require additional information from you to assess your application.

Question No. _____ Illness, injury or tests _____ Date commenced _____ Time off work _____ Degree of recovery (%) _____ Full details of treatment _____ _____ Date of last symptom _____ Full name and address of doctor or hospitals consulted _____ _____ _____ Other information _____	Question No. _____ Illness, injury or tests _____ Date commenced _____ Time off work _____ Degree of recovery (%) _____ Full details of treatment _____ _____ Date of last symptom _____ Full name and address of doctor or hospitals consulted _____ _____ _____ Other information _____
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8. Additional medical questionnaire – to be completed if you have or have had a condition as underlined in section 7.

1. Please name the condition from section 7. _____

2. What were the main symptoms and/or what caused the condition? _____

3. Date symptoms commenced Date symptoms ceased

4. Time off work _____

5. Did the condition recur? Yes No If **'Yes'**, please complete the rest of this question.
 Date condition recurred Date condition lasted until
 Time off work _____

6. Have you fully recovered from the condition? Yes No

7. If **'Yes'**, when did you fully recover from the condition? Date

8. What test/treatment/medication have you had for this condition? Please give details.
 Test/treatment/medication _____ Date

9. Which doctor did you last consult about this condition and what was the date of that consultation?
 Doctor's name _____ Date

10. Does your usual doctor have details of this condition? Yes No

11. Has further treatment been recommended by your doctor for this condition? Yes No
 If **'Yes'**, please give details. _____

9. Sports and pastimes

Have you any prospect, or intention, of engaging in:

1. Aviation, other than as a fare-paying passenger? Yes No
2. Any hazardous activities or sports, e.g. motor or water sports (e.g. scuba, skin diving), football, parachuting, gliding, recreations involving heights, underground sports, underwater sports, caving, body contact sports, hang gliding etc? Yes No
3. Motorcycle riding/motor racing other than as a means of transportation to and from work? Yes No

If you have answered 'No' to all of the questions (1), (2) and (3) above, please proceed to Section 10.

If you answered 'Yes' to any of the questions (1), (2) and (3) above, please continue completing Section 9 below for any relevant activities. If necessary, please elaborate on any 'Yes' answers, i.e. type of sport, time spent training and participating, number of times per annum, receipt of fees or payments, any injuries sustained, in the following pages.

Only complete if directed to do so above.

Sports and pastimes

Motorcycle/Motor racing

Yes* No

Vehicle type Races per annum
Engine size Maximum speed (km/h)
Class Professional/amateur
Competitive/recreational

Scuba/Skin Diving

Yes* No

Average depth (m) Maximum depth (m)
Dives per annum Do you use explosives?

If you dive in caves or potholes, give details.

Football/Soccer/Aussie Rules, etc.

Yes* No

Code played and grade
Games per annum Professional/amateur
Competitive/recreational

If you are a member of a club, give details.

Do you receive any income from participating in football/soccer/Aussie Rules etc.? Yes* No

If yes, provide amount and details.

Aviation/Flying – Civil Aviation Safety Authority (CASA)

Do you hold a CASA licence? Yes No

If yes, state type and period held.

Do you intend to change the scope of your present licence?

Yes No

Have you ever had an accident or been charged with violating CASA Regulations?

Yes No

Do you always use authorised landing areas?

Yes No

Please complete the table below:

Type of aircraft	Number of hours flown			
	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Other activities

Do you intend to engage in any form of aviation other than the above categories? (e.g. ballooning, aerobatics, parachuting, paragliding, etc.)

Yes No

If yes, provide amount and details.

Other sports or pastimes

Yes* No

a. Do you currently, or intend to, participate in other sports or pastimes?

(e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.)

If yes, provide amount and details.

b. On what basis do you consider that you partake in this activity?

Professional/amateur

Competitive/recreational

*** If necessary, please elaborate on any YES answers below, i.e. type of sport, time spent training and participating, number of times per annum, receipt of fees or payments, any injuries sustained.**

10. Declaration by the Life Insured or Applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to ING Life Limited and/or the Medical Examiner are true and correct.
- I authorise the collection, use and disclosure of my personal information for the purposes of administration and maintenance of this policy, as outlined in the Privacy Statement on page 40. I understand that ING Life Limited will not be able to process a claim or administer this policy without this consent.
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I declare that I have been clearly informed in writing of the general nature and effect of the duty of disclosure.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to ING Life Limited in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received a copy of the Group Risk Product Disclosure Statement(s) (PDS) and Plan Summary for the type(s) of cover for which I am applying.

Signature of Life to be Insured

Date

11. Doctor's authorisation

To be completed and signed by the applicant.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 or any organisation duly appointed by ING.

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

My name

Date of birth

Signature of applicant

Dated this day of 20

Address

State

Postcode

Doctor's authorisation

To be completed and signed by the applicant.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 or any organisation duly appointed by ING.

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

My name

Date of birth

Signature of applicant

Dated this day of 20

Address

State

Postcode

Privacy Statement

ING is committed to ensuring the confidentiality and security of a member's personal information. The ING Privacy Policy detailing our handling of personal information is available upon request or may be downloaded from www.ing.com.au. Members may request access to information held by us about the member, the policy or scheme of which the member is an insured member, and any other ING products or services which the member may hold by contacting the ING Privacy Officer at the address below. The member may assist us by contacting ING Customer Services if any of their personal information is incorrect, has changed or requires updating.

Where the member's employer or superannuation fund trustee (fund) has established a Group Life Policy, it may be necessary for us to:

- collect personal information from the member
- collect some personal information about the member from the employer/fund
- disclose some of the member's personal information to the employer/fund in order to undertake the management and administration of the Group Life Policy.

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose the member's personal information to certain third parties. Unless the member consents to such disclosure we will not be able to process the application, administer the insurance, process a claim or provide the relevant ING products or services. The types of organisations to whom we may routinely disclose the member's personal information include:

- doctors, medical services or other organisations providing services in the collection, collation or assessment of personal information (including health information) for the purpose of underwriting or assessing your application or assessing any claims
- reinsurance organisations for the purpose of underwriting your application or assessing claims
- organisations undertaking compliance reviews of our financial advisers or reviews of the accuracy and completeness of our information
- organisations maintaining our information technology systems and providing information technology services
- organisations providing analysis and research
- authorised financial institutions, such as banks, credit unions and building societies, providing account details as a mechanism for providing payments or receipt of payments
- organisations providing mailing services and undertaking the printing of our standard documents and correspondence
- Trustees of the member's superannuation fund (if the insurance is linked to such a fund), or their appointed administration company who administers your insurance on their behalf.

We will disclose the member's personal information to these organisations to enable them to undertake specified management and administration services.

For life risk products (including Group Life) we collect health information with the member's consent. A member's health information will only be disclosed to service providers such as doctors, reinsurers and assessors who are directly involved in collecting, collating or assessing such information for the purpose of underwriting or assessing the application or assessing any claim. Where the member's insurance forms part of a superannuation fund, we may also be required to provide copies of the member's health information to the Trustees of the fund (or their appointed administrator who administers the insurance cover on their behalf) for purposes such as verifying a decision made by us in accordance with obligations imposed by law). A member's health information will not be disclosed by ING for any other purpose.

We will also disclose a member's personal information in circumstances where we are required by law to do so.

Please note amendments to the Family Law Act 1975 commenced on 28 December 2002 enabling certain persons to request information about a member's interest in a superannuation fund. The policy owner may, if requested, be required to provide information about the member's interest in a superannuation fund to their spouse or a person who intends to enter into an agreement with the member about splitting their superannuation interests in the event of separation of marriage. The request must be in a form prescribed by law.

Where the member's employer (or former employer) has appointed a financial adviser or other intermediary to arrange and/or administer the Group Life Policy on their behalf, we will provide the member's personal information to the financial adviser/intermediary in order to undertake the management and administration of the policy. Where the member wishes to authorise any other parties to act on the member's behalf, to receive information and/or undertake transactions, the member should notify us in writing. If you have any further questions you would like answered about privacy, please write to us or contact us at:

ING Privacy Officer
347 Kent Street
Sydney NSW 2000
Phone 02 9234 8111
Fax 02 9299 3979
Email privacy@ing.com.au



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