

Step 2 – Choose level of cover

I wish to change the number of units of insurance cover I have under the Fund to: **(Select one option only)** ✓

- | | |
|-------------------------------|--------------------------------|
| <input type="radio"/> 1 unit | <input type="radio"/> 6 units |
| <input type="radio"/> 2 units | <input type="radio"/> 7 units |
| <input type="radio"/> 3 units | <input type="radio"/> 8 units |
| <input type="radio"/> 4 units | <input type="radio"/> 9 units |
| <input type="radio"/> 5 units | <input type="radio"/> 10 units |

I confirm I am employed as:

- Full-time (15 hours or more per week)
 Part-time/Casual (less than 15 hours per week)

If you are increasing cover you will need to complete the attached health statement, and be accepted by the Fund Insurer, before cover commences.

The cost of cover is deducted from your employer's contribution. Please refer to the Product Disclosure Statement for full details of insurance cover.

Step 3 – Sign the form

If my request is agreed to, I understand that:

- provision of any higher insurance cover will be subject to the provision of satisfactory evidence of good health to the insurer and will not be provided until the Trustee has advised me in writing of its acceptance of the increased insurance cover
- any reduction from my existing insured benefit will take effect from the date the Trustee receives my request
- a total and permanent disablement benefit will be payable if I am assessed as totally and permanently disabled by the Trustee and the Fund's insurer
- this request replaces any previous instruction by me
- the information on this form will be handled by the Trustee to process my insurance choice
- to process my request, the Trustee may disclose or make accessible my personal information to the administrator, insurer, my employer or any other party necessary
- to access my personal information I can contact the Fund's Privacy Officer
- by signing this form I consent to this handling of my personal information.

Signature

X

Date

/ /

Please return your completed form to the Fund Administrator, REI Super, GPO Box 4303, Melbourne, VIC 3001.



Standard Personal Statement and Declaration of Health



MetLife®

Duty of Disclosure (Insurance Contracts Act 1984)

Your Duty of Disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that 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 vary or reinstate a contract of life insurance.

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

- that diminishes the risk to be undertaken by the insurer;
- that is common knowledge;
- that your insurer knows or, in the ordinary course of the insurer's business as an insurer, ought to know; OR
- where compliance with your duty is waived by the insurer.

Non-disclosure

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

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

Please note: Your Duty of Disclosure continues until an insurance cover has been accepted by MetLife.

Privacy Statement

MetLife is subject to the National Privacy Principles under the Privacy Act 1988 and has a Privacy Statement that explains how we handle the information we collect about you. For a copy of the MetLife Privacy Statement, please refer to the Product Disclosure Statement which was provided to you or contact MetLife Customer Service on **1300 555 625**.



MetLife Insurance Limited
ABN 75 004 274 882
AFSL No. 238096

Standard Personal Statement and Declaration of Health

To be completed by the person whose life is to be insured.

If space is insufficient, please attach an extra sheet of paper.

Please complete the questionnaire in **BLACK** ink pen only.

Any changes made to this questionnaire to be initialled by the person whose life is to be insured.

Please answer all questions to the best of your ability as omissions will delay issue of your cover.

Preliminary - For the Administrator of the scheme or superannuation fund to complete:

Name of Scheme or Superannuation Fund:

Number of Scheme or Superannuation Fund:

For Completion by the Life Insured

Name of Employer and/or Member Number:

Your Personal Details

Name:

Date of Birth:

 / /

Address:

State:

Postcode:

Contact Number(s):

Gender:

 Male Female

Preferred:

Other:

Preferred Contact Time?

 Morning (9-12am) Afternoon (12-6pm)

Occupation Details

1 What is your current occupation?

2 Please provide details of duties (e.g. types of clerical, manual work etc) and qualifications/trade certificates if applicable.

3 What is your current annual salary?

710101

Insurance History

4 How much cover do you have with this fund?

Death:

TPD:

IP:

Trauma:

5 How much extra cover are you applying for?

Death:

TPD:

IP:

Trauma:

6 Has an application for Life, Trauma, TPD or Disability Insurance on your life ever been declined, deferred or withdrawn by any company, or accepted with a loading or exclusion or any other special condition or terms? Yes No

If "Yes", please give details.

7 Do you have or are you applying for any Life, Trauma, TPD or Disability Insurance policies with MetLife or any other company (Apart from this application)? Yes No

If "Yes", is this application replacing existing cover? Yes No

If you have answered "Yes" to Question 7, please give details.

Company Name	Type of Cover	Sum Insured or Monthly Benefit	Waiting Period	Benefit Period	Is this Cover to be replaced
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>

Important Notice: If this application for insurance is intended to replace an existing policy or policies indicated in the table above, you must cancel such policies upon notice from MetLife that your application has been accepted. If you do not cancel the existing policy or policies indicated in the table above, MetLife may avoid the contract and no claim would be payable.

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

If "Yes", please give details.

Residence and Travel Details

9 Do you plan to travel, reside or work overseas in the next 12 months? Yes No

If "Yes", please advise where, for how long and for what reason.

Sports and Pastimes

10 Have you, do you currently, or do you intend to take part in any of the following activities?

(a) Aviation other than as a fare paying passenger

Yes No

(b) Motor sports or racing

Yes No

(c) Scuba/Skin Diving

Yes No

(d) Mountaineering or rock climbing

Yes No

(e) Football (all codes)

Yes No

(f) Other hazardous activities: e.g hang gliding, parachuting, ocean racing, etc.

Yes No

If you have answered "Yes" to any of the above questions, please complete the Pastimes and Activities Questionnaire in Question 20.



Habits

11 Have you smoked tobacco or any other substance(s) in the last 12 months?

Yes No

If "Yes", what type and average daily quantity?

12 Do you drink alcohol?

Yes No

If "No", have you ever consumed alcohol in the past? If "Yes", please give details including form and average daily intake.

Doctor Details

13 What is the name of your usual Doctor?

Address:

State:

Postcode:

How long has he/she known you?

 years months

Date you last consulted him/her:

 / /

Reason for your last consultation

Result of your last consultation

Your Health History

14 (a) What is your height?

 cms

(b) What is your weight?

 kgs

Your Health History (cont.)

15 Have you ever had or sought advice or treatment for:

- | | | |
|--|------------------------------|-----------------------------|
| (a) Chest pain, high blood pressure, heart or circulatory disorder, stroke or vascular disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Asthma, bronchitis or any other lung complaint? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Gastric or duodenal ulcer, or persistent indigestion? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Thyroid disorder, diabetes or other pancreas disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Epilepsy, fainting or fits? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Cancer, tumour, cyst or skin lesion? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Disease (e.g. arthritis, gout) or injury to the muscles, tendons, bones, or joints, including the neck and back? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Mental or nervous disorder including depression, anxiety, stress, chronic tiredness or fatigue? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered "Yes" to any part of Question 15 above, you will also need to complete the 'Supplementary Risks Questionnaire' in Question 19.

16 Have you ever had or sought advice or treatment for:

- | | | |
|--|------------------------------|-----------------------------|
| (a) Stomach, intestinal or rectal disorder, gall bladder or liver disorder, including hepatitis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Paralysis or disorder of the brain or spinal cord, multiple sclerosis or any other neurological disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Any skin disorder (e.g. dermatitis, eczema or psoriasis)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Kidney disease (e.g. renal colic), bladder disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Any defect in sight, hearing or speech, or any other physical deformity or abnormality? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Any blood disorder (e.g. leukaemia, haemophilia or anaemia)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Drug or alcohol dependence, or used any drug not prescribed by a doctor (other than over-the-counter medicines for colds etc)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Other than already stated, within the last five years, have you: | | |
| - received or had any other medical examinations, advice, treatment, operation or been in hospital? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| - taken any prescribed medication on a regular basis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| - had an ECG, x-ray or other tests, including blood tests, for which you have received a consultation (excluding ailments such as cold and flu)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (i) Do you intend to seek medical advice/treatment, or have you ever been advised to have or do you contemplate surgery in the near future? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (j) Females only: | | |
| i) Are you currently pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If "Yes", when is the due date?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------

Your Health History (cont.)

- ii) Have you ever had an abnormal pap smear, breast ultrasound/mammogram or breast lump (even if you have not consulted a doctor)?

Yes No

If you have answered "Yes" to any part of Question 16, please complete the table below.

Question Reference	Illness, Injury or tests	Date Commenced	Reason for and type of treatment	Time off work	Date of last symptoms	Degree of recovery	Full name and address of doctor or hospital (if any)
		/ /			/ /	%	
		/ /			/ /	%	
		/ /			/ /	%	

Family History

- 17 Has any 1st degree relative suffered from diabetes, heart disease, cancer, stroke, kidney disease, mental illness, haemophilia, Huntington's chorea or any inherited or hereditary disease?

Yes No

If "Yes", please fill in the following schedule of family history.

Relationship	Condition (If cancer, please specify site and type)	Age at Diagnosis	Age at Death (If applicable)

AIDS Statement

- 18 This must be completed in **all** circumstances.

- (a) Have you any reason to believe that you are suffering from Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related illness, or that you are carrying the virus that causes AIDS, or that your spouse or any sexual partner is suffering from AIDS or carrying the virus that causes AIDS?

Yes No

- (b) Since 1980, have you:

- i) engaged in male to male anal sexual activity?
- ii) injected yourself with any drug not prescribed by a medical practitioner?
- iii) worked as or engaged in sexual activity with a prostitute?

Yes No

Yes No

Yes No

If you have answered "Yes" to any of the questions above, please provide details.

(Please note: a confidential questionnaire may be sent to you for completion and return).

Supplementary Risks Questionnaire

- 19 To be completed for any "Yes" answer to Question 15.

Please answer fully. If there is insufficient space or more than two conditions/illnesses, please attach a separate page with this information.

Condition/Illness 1

- (a) Specify illness, injury or complaint

Supplementary Risks Questionnaire (cont.)

(b) Which parts of the body were affected and which side (left/right) if applicable?

(c) Date the symptoms first started

 / /

(d) Describe the symptoms

(e) How many times have you suffered from this condition?

(f) What was the average duration of each attack/symptom?

(g) What was the duration of the most recent attack/symptom?

(h) Date of last attack/symptom

 / /

(i) How severe are attacks/symptoms?

Mild Moderate Severe

(j) Did the attacks/symptoms necessitate you being off work?

Yes No

If "Yes", for how long?

 days

(k) Did you ever require hospitalisation?

Yes No

If "Yes", where?

and how long?

 days

(l) Were any tests conducted?

Yes No

If "Yes", what were the tests and results?

Date	Test	Result
/ /		
/ /		

(m) What treatment or medication was given/prescribed?

Treatment/Medication	Dosage	Frequency

(n) Are you on treatment or still being treated?

Yes No

If "Yes", please describe the treatment(s).

(o) Degree of recovery

 %

(p) State name and address of doctor(s) consulted and date of last consultation.

Last consultation	Name	Address
/ /		
/ /		

Condition/Illness 2

(a) Specify illness, injury or complaint

(b) Which parts of the body were affected and which side (left/right) if applicable?

(c) Date the symptoms first started

 / /

(d) Describe the symptoms

(e) How many times have you suffered from this condition?

(f) What was the average duration of each attack/symptom?

(g) What was the duration of the most recent attack/symptom?

(h) Date of last attack/symptom

 / /

(i) How severe are attacks/symptoms?

Mild Moderate Severe

(j) Did the attacks/symptoms necessitate you being off work?

Yes No

If "Yes", for how long?

 days

(k) Did you ever require hospitalisation?

Yes No

If "Yes", where?

and how long?

 days

(l) Were any tests conducted?

Yes No

If "Yes", what were the tests and results?

Date	Test	Result
/ /		
/ /		

(m) What treatment or medication was given/prescribed?

(n) Are you on treatment or still being treated?

Yes No

If "Yes", please describe the treatment(s).

(o) Degree of recovery

 %

Supplementary Risks Questionnaire (cont.)

(p) State name and address of doctor(s) consulted, and date of last consultation.

Last consultation	Name	Address
/ /		
/ /		

Pastimes and Activities Questionnaire

20 To be completed if answering "Yes" to Question 10.

(a) Scuba/Skin Diving

Yes No

What type of diving do you engage in? (e.g. scuba, snorkel, hookah etc.)

Professional/Amateur

Where do you usually dive? (including any cave or wreck diving)

Qualifications

How many times per year?

Average depth

Maximum depth and number of times at this depth

(b) Aviation

Yes No

If you are a pilot, what type of licence do you hold?

Pilot Passenger

Please indicate type of aircraft you fly or are a passenger of and type of aviation you are involved in. (e.g. Commercial, Private, Agricultural, Aero Club, Helicopter, Ultralight Aircraft).

Number of hours flown last year

Anticipated hours in the next year

(c) Motor Racing

Yes No

What type of license do you hold?

If CAMS, state classification

Vehicle type

Engine size/capacity

Pastimes and Activities Questionnaire (cont.)

Maximum speed

Times per year

Professional/Amateur

Type of racing/event(s)

(d) Football/Soccer/Australian Rules/Rugby

Yes No

Professional/Amateur

Number of times per year

If Professional, please indicate annual amount (\$) received

\$

(e) Other. (e.g. Boxing, Mountain Climbing/Abseiling, Competition Sports etc)

Yes No

Activity

Professional/Amateur

Please provide full details including number of times per year, locations, heights, are activities undertaken individually or in a group/club etc.

Declaration

- I have read and understand my Duty of Disclosure and understand that this duty applies until formal notification of acceptance.
- The answers to the questions are true, and I have not deliberately withheld any information 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 and service providers in order to assess my application and any claim under this policy.
- I have read and understood the Privacy Statement and agree to the collection, use and disclosure of personal information as described.
- I consent to MetLife seeking medical information from any doctor who I have consulted.
- I understand that cover under any policy does not begin until acceptance by the Insurer of which I will be notified in writing.

Signature of the person whose life is to be insured:

Date:

x

/ /

Full Name:

Products are offered by MetLife Insurance Limited, which is an affiliate of MetLife, Inc. (Incorporated in the USA) and operates under the "MetLife" brand. None of the obligations of MetLife Insurance Limited are guaranteed by MetLife, Inc. or any other member of the MetLife group. Prepared October 2008.

PEANUTS © United Feature Syndicate, Inc.

710109