

## voluntary insurance application

All accumulation members may apply for AvSuper voluntary insurance cover, although some eligibility and age restrictions apply. Please refer to the **AvSuper member insurance guide** for details of cover. You can make this application online via AOL. If you need assistance with completing this form or to change existing cover to 'fixed cover' please contact AvSuper on 1300 128 751.

**Please send your completed form to AvSuper Admin, PO Box 1140, Wollongong DC NSW 2500.**

### Personal details

Surname		Mr/Mrs/Ms/Miss	
<input type="text"/>		<input type="text"/>	
Given names			
<input type="text"/>			
Address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Telephone (daytime)	Mobile	AvSuper member number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email	Date of birth		
<input type="text"/>	<input type="text"/>		

### Insurance details

All **insurance fees** are listed on our website. I wish to increase my level of voluntary cover (including Automatic Cover) to:

<input type="checkbox"/>	Death only cover in a total of	<input type="text"/>	units* or \$	<input type="text"/>	fixed cover <sup>#</sup>
<input type="checkbox"/>	Death and Total and Permanent Disablement (TPD) cover in a total of	<input type="text"/>	units* or \$	<input type="text"/>	fixed cover <sup>#</sup>
<input type="checkbox"/>	Income protection cover <sup>^</sup> (a minimum of \$1,000 in multiples of \$100 per month to a maximum of 75%** of your salary)				
	Short-term	\$	<input type="text"/>	per month of benefit, with a	<input type="text"/> 30 day / <input type="text"/> 90 day / <input type="text"/> 180 day waiting period.
	Long-term	\$	<input type="text"/>	per month of benefit, with a	<input type="text"/> 30 day / <input type="text"/> 90 day / <input type="text"/> 180 day waiting period.

\* AvSuper fixed premium insurance is based on units of cover relating to your age and occupation such that cover reduces annually for the same number of units.

<sup>#</sup> AvSuper fixed cover is based on your age and occupation with premiums increasing each year.

\*\* Or 85% if you wish to include a superannuation contribution component.<sup>^</sup>

<sup>^</sup> Corporate members are welcome to apply for voluntary cover at any time but Corporate TTD cover ends if Income Protection cover is obtained.

### Authorisation

- I have read and understand the general terms and conditions for cover as described in **AvSuper's member insurance guide** and on your website.
- I understand that I have a current and ongoing duty to disclose anything that may influence the insurer's decision about my cover. I have read the **full duty of disclosure** on AvSuper's website.
- I acknowledge that cover is subject to me satisfying the insurer's requirements, including completing the attached personal statement and providing any requested evidence of health, and written acceptance of my application for cover by the insurer. Any Automatic Cover I may have will not be affected by the outcome of this application.
- I have not made, nor am currently eligible to make, a Total and Permanent Disablement (TPD) claim.
- I have read and understood the AvSuper privacy notice (available from **www.avsuper.com.au** or by phoning 1300 128 751).

Member's signature

Date



**Interim accident cover may apply to some or all of the cover that you are applying for from the date this form reaches the insurer. Therefore it is important that you forward this application to us promptly.**

## Insurance Application / Personal Statement

All questions on this Personal Statement are relevant as to whether or not **Hannover Life Re of Australasia Ltd (HLRA)** offers you insurance and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dash is not acceptable. Please use Section I, or attach additional pages, if there is insufficient room to provide full information for any question.

### IMPORTANT NOTICES – PLEASE READ

#### Duty of Disclosure

Before you enter into a life insurance contract with us, whether on your own behalf or on behalf of another person, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure and the terms of that insurance.

This duty of disclosure continues after you have completed this statement until the cover has been issued by us.

The same duty applies before you extend, vary or reinstate the contract.

You do not need to tell us anything that:

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

If the insurance is for the life of another person and that person does not tell us everything he or she should have, this may be treated as a failure by you to disclose.

#### If you or the person who becomes the life insured under the policy do not tell us 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 you or the life insured does not tell us something that you or they are required to tell us, and we would not have insured you on the same terms if we had been told, we may avoid your cover within 3 years of issuing it.

If we choose not to avoid your cover, we may, at any time, reduce the amount for which you or the life insured have been insured. This would be worked out using a formula that takes into account the premium that would have been payable if you and the life insured had told us everything you should have. However, for death cover, we may only exercise this right within 3 years of issuing the cover.

If we choose not to avoid the cover or reduce the amount for which you or the life insured have been insured, we may, at any time vary the cover 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 to death cover.

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

#### Privacy Collection Notice

This Privacy Collection Notice outlines how **Hannover Life Re of Australasia Ltd** ("Hannover", "we", "us" or "our") collects and handles your personal information in compliance with the *Privacy Act 1988 (Cth)*.

##### Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may on occasions collect it from a third party such as our related bodies corporate, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

##### Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance / reinsurance companies, legal practitioners, medical practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

##### Overseas disclosure

We may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

##### Access

Our Privacy Policy which is available at [https://www.hannover-re.com/1094181/australia\\_lh\\_privacy](https://www.hannover-re.com/1094181/australia_lh_privacy) (or, by contacting us using the details set out in the 'Contact Us' section below) outlines our personal information handling practices, including details on how you can seek access or correction of the personal information that we hold about you, how to complain if you believe we have breached the Australian privacy laws and our complaint handling processes.

##### Contact

You may contact Hannover as follows:

The Privacy Officer. Hannover Life Re of Australasia Ltd Tower 1, Level 33, 100 Barangaroo Avenue SYDNEY NSW 2000  
Telephone: (02) 9251 6911 Facsimile: (02) 9251 6862 Email: [privacyofficer@hlra.com.au](mailto:privacyofficer@hlra.com.au)

## Section A. Fund / Plan name & type of cover

Name of  
Fund / Plan

AvSuper

Type of Cover: (please tick appropriate box)		Amount of Benefit / Cover:
Death (Life) Only	<input type="checkbox"/>	\$
Death (Life) and Total and Permanent Disablement (TPD)	<input type="checkbox"/>	\$
Group Income Protection (GIP)	<input type="checkbox"/>	\$ (monthly benefit)

## Section B. Member Details and Insurance History

### 1. Member Details:

Surname  Given Name(s)

Sex: Male ☐ Female ☐ Date of Birth

Home Address   
 State  Postcode

2. Occupation


3. Annual Salary \$


4. Email


Telephone  Mobile

Please tick your preferred contact method and most convenient time to contact you: Telephone ☐ Mobile ☐ Email ☐ am ☐ / pm ☐

### Please tick No or Yes to each of the following:

5. Has Death (Life), TPD, GIP, Disability, Accident and Sickness or Superannuation cover on your life ever been declined, deferred or withdrawn from any insurance Company or accepted with a loading, exclusion or other than as applied? No ☐ Yes ☐ 
- Please provide full details including dates, name of company and reason:*

6. Have you ever made a claim for disability benefits under an Insurance, Superannuation or Worker's Compensation policy, Veteran's Affairs or under Social Security (including CTP and public liability)? No ☐ Yes ☐ 
- Please provide full details including dates, cause of claim, type of benefit and amount paid, claim number and insurance company:*

7. Other than this application, do you have or are you applying for any Death (Life), TPD, Disability Income or GIP with any other company? No ☐ Yes ☐ 
- Please provide full details:*

Company	Type of Policy	Benefit Amount	Owner	To be Replaced
				No <input type="checkbox"/> Yes <input type="checkbox"/>
				No <input type="checkbox"/> Yes <input type="checkbox"/>
				No <input type="checkbox"/> Yes <input type="checkbox"/>

## Section C. Habits, Activities and Residence

Please tick No or Yes to each of the following:

1. Do you drink alcohol? No ☐ Yes ☐ *If 'Yes' please state type and weekly quantity:*
2. Have you smoked in the past 12 months? No ☐ Yes ☐ *If 'Yes' please state form and daily quantity:*
3. 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 recognised airline), motor racing of any kind, diving, football, parachuting, hang gliding, etc? No ☐ Yes ☐ *If 'Yes' please give full details:*
4. Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's Visa? No ☐ Yes ☐ *If 'No' please give full details*
5. Do you intend travelling overseas in the immediate future (i.e. next 2 years)? No ☐ Yes ☐ *If 'Yes' please give full details (where, when, duration and reason):*

## Section D. Occupation Details


1. Employer's Name  Telephone   
Employer's Address  State  Postcode
2. How long have you been in your current occupation?  years /  months  
Are you a Permanent ☐ or Casual ☐ employee? How many hours do you work per week?
3. Are you self-employed (this means shareholder or employee of own company, sole trader or partner)? No ☐ Yes ☐ *If 'Yes', please provide details*   
How long?  years /  months % of business you own?  %  
Business/ Company Name   
Business/ Company Address  State  Postcode   
How many employees do you have? (excluding yourself)
4. What industry do you work in?

## Section D. Occupation Details (cont.)

5. What are the main duties of your occupation?

Duties (e.g., office work, sales, supervision, manual)	% of Time	Location (eg., office, on-site, travel, at home)	% of Time


6. Do you hold any professional/trade qualifications?

No ☐ Yes ☐ 

If 'Yes', please provide details:

Type	Name of Institution where Obtained

7. Has your main occupation, employer or employment status changed in the last 3 years?


No ☐ Yes ☐ 

If 'Yes', please provide details:

Previous Occupation	Employer	Employment Status*	Date from	Date to
			/ /	/ /
			/ /	/ /
			/ /	/ /

\* Employment Status (e.g. unemployed, employed, employed by own company, self employed, partnership)

8. Do you have any other occupation?

No ☐ Yes ☐  If 'Yes', please complete the following:

Type of occupation:	<input type="text"/>		
Name of your employer:	<input type="text"/>	How many hours per week do you work in this other occupation?	<input type="text"/>
How long have you been doing this other occupation?	<input type="text"/> years / <input type="text"/> months	What is your monthly income from this other occupation?	\$ <input type="text"/>

## Section E. Financial Details\*

**\* Only complete this section if applying for Group Income Protection – otherwise go to Section F.**

Please note that based on the financial information provided below, additional financial information may be required.

1. If disabled, would all or part of your income continue?

(e.g., sick leave, other disability income policies, pension, investment, rental, company profit share, etc.)

No ☐ Yes ☐ 

If 'Yes' please provide full details:

2. **Employees only** (i.e., no ownership in employer's business)

In respect of your principal occupation, what has been the total value of remuneration paid by your employer of the last two years? This should be determined by calculating the amount you could be expected to receive if your total remuneration was received as a salary or wage (before income tax is deducted).

Current Tax Year is	Commission/Bonus/Overtime component this amount is	Last Tax Year was	Commission/Bonus/Overtime component this amount is
	\$ <input type="text"/>		\$ <input type="text"/>

## Section E. Financial Details\*

2. **Self-Employed only** (i.e., sole trader, employed by/director of own company or trust, partnership)

Last Tax Year:			Previous Tax Year:		
	Business \$	Your Share \$		Business \$	Your Share \$
Gross Income	\$	\$	Gross Income	\$	\$
LESS Business Expenses	\$	\$	LESS Business Expenses	\$	\$
<b>Net Income (Loss)</b>	<b>\$</b>	<b>\$</b>	<b>Net Income (Loss)</b>	<b>\$</b>	<b>\$</b>
PLUS the following paid to you:			PLUS the following paid to you:		
Wages/Salary/Drawings/Director's Fees	\$		Wages/Salary/Drawings/Director's Fees	\$	
Superannuation Costs	\$		Superannuation Costs	\$	
<b>Total</b>	<b>\$</b>		<b>Total</b>	<b>\$</b>	

**NB:** any amounts received as wages/salary/drawings/director's fees must not be paid from past profits, capital or loans.

## Section F. Medical Statement

1. Name and Address of your Doctor

Doctor's Name	<input type="text"/>	Telephone	<input type="text"/>
Doctor's Address	<input type="text"/>		

2. Details of last medical consultation, including doctors, physiotherapists, chiropractors or ANY other health professional.

Date	Health Professional	Address	Reason	Outcome/Result

3. Please state your **Height**  cm **Weight**  kg

Please tick **No** or **Yes** to each of the following:

4. Within the **LAST THREE YEARS** have you, other than advised above:
- a. Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or other health care professional (naturopath, etc.) or been in a hospital or been advised to have an operation? No ☐ Yes ☐
- b. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection? No ☐ Yes ☐
5. Have you **EVER** had an ECG, x-ray, transfusion, mammogram, surgery or any other investigation? No ☐ Yes ☐
6. Have you **EVER** had any blood tests which revealed an abnormality, eg raised blood sugar, liver function or renal function results, or anaemia, etc? No ☐ Yes ☐
7. Do you contemplate seeking any medical examination, advice, treatment or surgery in the future? No ☐ Yes ☐

Please provide full details for all **YES** answers above (if more space is required, please go to Section JJ).

Dates from – to	Name and address of Doctor or Hospital, Clinic, etc.	Conditions, Medications Treatment and Time off Work	Recovery %
/ / to / /			
/ / to / /			
/ / to / /			

## Section F. Medical Statement (cont.)

Please tick **No** or **Yes** to each of the following:

8. Have you **EVER** received any advice or treatment for:

a. High blood pressure, raised cholesterol, stroke or circulatory disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>
b. Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?	No <input type="checkbox"/> Yes <input type="checkbox"/>
c. Asthma, bronchitis or other lung complaint?	No <input type="checkbox"/> Yes <input type="checkbox"/>
d. Diabetes?	No <input type="checkbox"/> Yes <input type="checkbox"/>
e. Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>
f. Hepatitis or other liver or gall bladder disease?	No <input type="checkbox"/> Yes <input type="checkbox"/>
g. Back, neck or knee complaint or any disorder of the joints, bones or muscles (e.g. gout, arthritis)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
h. Kidney or bladder disease, renal colic, stones or blood in the urine?	No <input type="checkbox"/> Yes <input type="checkbox"/>
i. Depression, anxiety, stress, mental or nervous condition, or chronic fatigue?	No <input type="checkbox"/> Yes <input type="checkbox"/>
j. Cancer, tumour, melanoma, sunspots or growth of any kind?	No <input type="checkbox"/> Yes <input type="checkbox"/>
k. Eczema, dermatitis, psoriasis or any other skin condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>
l. Tinnitus, hearing loss or any defect in hearing, sight or speech?	No <input type="checkbox"/> Yes <input type="checkbox"/>
m. Anaemia, leukaemia, haemophilia or other blood disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>
n. Thyroid or prostate disorder, any disorder of the reproductive organs, or sexually transmitted disease?	No <input type="checkbox"/> Yes <input type="checkbox"/>
o. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	No <input type="checkbox"/> Yes <input type="checkbox"/>
p. Multiple sclerosis, epilepsy, fits of any kind, recurrent headaches, dizziness, fainting or any other neurological disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>
q. An autoimmune disease, immunodeficiency, immunosuppression from medical therapies or any other disorder of the immune system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
r. Any other physical impairment, congenital abnormality, deformity or symptoms of ill health, illness or injury?	No <input type="checkbox"/> Yes <input type="checkbox"/>

**Females only:**

s. Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
t. Have you ever had any complications of pregnancy or childbirth?	No <input type="checkbox"/> Yes <input type="checkbox"/>
u. Are you currently pregnant?	No <input type="checkbox"/> Yes <input type="checkbox"/> if 'Yes', what is the expected delivery date? <div style="border: 1px solid black; width: 100px; height: 20px; text-align: center; margin: 0 auto;">/ /</div>
v. Have you ever had a breast lump (even if you have not seen a doctor about it)?	No <input type="checkbox"/> Yes <input type="checkbox"/>

Please provide full details for all YES answers above (if more space is required, please go to Section J).

Specific Condition	Question No. _____	Question No. _____	Question No. _____
1. Date symptoms first started and description of symptoms?			
2. What was the condition and which part of the body was affected?			
3. What was the medical diagnosis including results of x-rays and investigations?			
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?			
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
6. How long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide date and duration of your stay.			
8. What advice/treatment did you receive?			
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
10. When did you last suffer from any symptoms			
11. Degree of recovery (%)			
12. Please supply name and address of all doctors or hospitals or other consultants			

## Section G. Family History

Please tick **No** or **Yes**:

1. Have any of your parents, brothers or sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer, Huntington's Disease or any other hereditary disease?

No ☐ Yes ☐

*If 'Yes' please provide full details (including age at diagnosis and age at death (if applicable)):*

## Section H. Questions in relation to Aids

Please tick **No** or **Yes** to each of the following:

- a. Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus)? No ☐ Yes ☐
- b. Have you EVER sought or are you expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV? No ☐ Yes ☐
- c. Have you EVER:
- i. Injected yourself with any drug not prescribed by a medical practitioner? No ☐ Yes ☐
- ii. Worked as or engaged in sexual activity with a sex worker? No ☐ Yes ☐
- iii. Engaged in sexual activity someone you know or suspect to be HIV positive? No ☐ Yes ☐
- d. Have you engaged in male to male anal sexual intercourse (except in a relationship between you and only one other person where neither of you had sex with anyone else in the past 5 years)? No ☐ Yes ☐

*Please note: if any of these questions are answered "Yes", we will send you a separate questionnaire.*

## Section I. Questions in relation to COVID-19

Please tick **No** or **Yes** to each of the following:

- a. Have you returned from overseas in the last 2 weeks? No ☐ Yes ☐
- b. Have you had close contact with a person confirmed or suspected to have COVID-19 in the last 14 days? No ☐ Yes ☐
- c. Have you been diagnosed with COVID-19 or is it likely that you have this disease? No ☐ Yes ☐
- d. Have you suffered from one of the following symptoms in the last 14 days: sore throat, runny nose, fever of 38°Celsius or above, cough, shortness of breath, difficulty breathing, chest pain or unexplained fatigue, aches and pains? No ☐ Yes ☐
- e. Have you been advised to undergo a test for COVID-19 or do you currently await the result from a test for COVID-19? No ☐ Yes ☐

*If 'Yes' to any of the above, please provide further details:*

## Section J. Additional Information (to assist with clarification of any issue)

***Please ensure you have read and signed the last page.***



## Section K. Consent for Accessing Health Information

### Notes on releasing information about your health:

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **Hannover Life Re of Australasia Ltd**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the *Insurance Contracts Act 1984 (Cth)*.

***Please read each Authority carefully and the explanatory notes below.***

**Authority 1 explanatory notes** – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

**Authority 2 explanatory notes** – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

*If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.*

### Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **Hannover Life Re of Australasia Ltd (“HLRA”)**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **HLRA** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **HLRA** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **HLRA** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Applicant's Name

Applicant's Signature

Date  /  /

### Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **Hannover Life Re of Australasia Ltd (“HLRA”)**, or to third parties they engage, only if **HLRA** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **HLRA** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **HLRA** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Applicant's Name

Applicant's Signature

Date  /  /

## Section L. Consent, Declaration & Authority to Provide Information

By continuing with your application (and, any variation, extension or reinstatement of your application) or application for different insurance cover you agree that:

- You have read, understand and agree to the terms of our Duty of Disclosure and all your answers are correct. In particular, you give us a general authority to obtain information we reasonably believe is relevant to your application unless you tell us otherwise (e.g. where you request we only obtain particular information from particular sources or you have not consented for your health provider to release your health information to us) which may delay or invalidate your application and, if you fail to comply with your duty of disclosure, we may avoid your cover or reduce the amount of cover if it is within a 3 year period.
- You have read, understand and agree to the terms of our Privacy Collection Notice. In particular, you consent to us collecting and where required disclosing certain personal information and sensitive information (including medical and health information) from or to third parties (the details of which can be found in our Privacy Collection Notice [https://www.hannover-re.com/1094181/australia\\_lh\\_privacy](https://www.hannover-re.com/1094181/australia_lh_privacy)) who may contact you and provide information to you about our or their services.
- As at the date of this application you are not absent from work for reason of illness or injury and you are performing all duties you would ordinarily perform in your occupation.

Applicant's Name

Applicant's Date of Birth  /  /

Applicant's Signature

Date  /  /