This form is dated September 2021

Data Capture Form

This form is not to be submitted as a replacement of a new application.

Life Insured full name

Adviser name

Reference number (if applicable)

Please read the below important information.

THE DUTY TO TAKE REASONABLE CARE

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into. To meet this duty, each person whose life is to be insured must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance of each life to be insured. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, the fund trustee passes on your personal information to us. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

Guidance for answering our questions

You are responsible for the information provided to us. Each person answering our questions should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume we will ask others such as your doctor
- review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we'll let you know whether it has any impact on the cover.

Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

If you need help

It's important that you and every person answering our questions understands this information and the questions we ask. Ask us or your adviser for help if you have difficulty answering our questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If a person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including all of the following:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was
- what we would have done if the duty had been met – for example, whether we would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

ZURICH

Data Capture Form

This form is to collect certain information about you to be given to your financial adviser to input into your application (it is not provided to Zurich). Your adviser will be in contact with you again and provide you with a copy of the proposed application for you to check and agree to before submitting.

Your adviser may pass the information on this form to Zurich. This information may include your personal and sensitive information. Zurich is bound by the *Privacy Act 1988* (Cth). Please refer to the Privacy section contained in the current Product Disclosure Statement (PDS) for the product you will be applying for. For a more detailed explanation of Zurich's Privacy Policy please visit our website at zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au

1. Life insured

Title | Surname | First name | Middle name

◯ Male ◯ Female | Date of birth / /

2. Residence and travel

Cover is only available to Australian residents.

2.01. Are you currently living in Australia, either

- **as an Australian or New Zealand citizen, or**
- **as a permanent resident of Australia?**

◯ No → please clarify your current citizenship and residency details, including Visa type, expiry date, and application date for permanent residency

◯ Yes → go to 2.02

Citizenship and residency details

Visa type | Expiry date / /

Application date / /

2.02. Do you have definite plans to travel or live outside of Australia within the next two years?

◯ No → go to 2.03

◯ Yes → provide details

Country | City/Area/Region

Date you are travelling / / | How long you are travelling for

Reason for travel: ◯ Holiday ◯ Business ◯ Study ◯ Visit family/friends ◯ Other → provide details

2.03. Within the last 8 weeks, have you been to any country outside of Australia?

◯ No → go to 2.04

◯ Yes → provide details (If you've been in more than one country, please list them all)

Country/ies | City/ies

Region(s)

Date you returned to Australia / /

2.04. Within the last 8 weeks, have you been in contact with any person you know or suspect to be infected by the coronavirus (COVID-19)?

◯ No → go to 3

◯ Yes → provide details, including the date of your exposure, whether you have experienced any symptoms of fever, cough, fatigue, sore throat, and/or shortness of breath, and whether you have had or are awaiting any medical testing for the coronavirus

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3. Insurance history

3.01. Other than this application, is there any other insurance on your life currently in place or being applied for (including cover provided by your employer or attached to your super)?

- Death
- Trauma
- Total & Permanent Disablement (TPD)
- Health Events (Zurich Active)
- Income Protection
- Business Expenses cover

◯ No → go to 4

◯ Yes → provide details of all existing policies in the table below

Policy No. (if known)	Company	Benefit Type	Amount	Waiting Period	Benefit Period	Risk Comm Date	Replacing
			$				
			$				
			$				
			$				

If you need more space to provide your answers, attach a separate sheet signed and dated by you. Note: If this Application for insurance is intended to replace any existing policy/ies you must cancel said policy/ies as soon as we notify you that we have accepted your Application for insurance. If you do not cancel the existing policy/ies the insurance applied for and accepted by Zurich will be ineffective and any claim made to Zurich, by you or any other applicable person, will be rejected.

4. Cover details

4.01. Are you applying for

- Life cover in excess of $3,000,000 (or $1,500,000 for domestic duties)
- TPD cover in excess of $3,000,000 (or $1,500,000 for domestic duties)
- Trauma cover in excess of $1,500,000 or
- Active Health Events cover in excess of $3,000,000 (or $1,500,000 for domestic duties)?

◯ No → go to 4.02

◯ Yes → complete the Financial questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application or tick the following box if you wish to provide a copy of the Statement of Advice (SOA) instead (make sure the SOA answers all the questions in the Financial questionnaire)

◯ SOA will be provided

4.02. Are you applying for

- Income protection cover in excess of $30,000 per month or
- Business expenses cover in excess of $30,000 per month?

◯ No → go to 5

◯ Yes → do you receive or expect to receive net income from other sources (such as rental income, dividends etc.) in excess of $250,000 per annum?

◯ No → go to 5

◯ Yes → complete the Financial questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application or tick the following box if you wish to provide a copy of the SOA instead (make sure the SOA answers all the questions in the Financial questionnaire)

◯ SOA will be provided

5. Occupation

5.01. Are you non-working (e.g. home duties/student/retiree)?

◯ No → go to 5.02

◯ Yes → go to 7

5.02. What is your job and industry?

Occupation

Business/Employer name and physical address

Website Email

Industry

5.03. Are you a member of the armed forces, either full-time or part-time?

◯ No → go to 5.04

◯ Yes → Is your involvement limited to army reserve only, AND can you confirm that you have no current deployment orders or have any reason to suspect that a deployment would take place within the next 12 months?

- ◯ No → provide full clarification as to your involvement with the armed forces, and details of any current or previous deployments
- ◯ Yes → go to 5.04

5.04. Does your job require you to perform any of the following hazardous duties:

- using or handling explosives, chemicals, dangerous substances or asbestos
- working underground, offshore, underwater or at heights over 10m
- agricultural flying (e.g. mustering) or
- any other hazardous duties not listed above?

◯ No → go to 5.05

◯ Yes → provide details of the duties, including the amount of time spent undertaking each duty

5.05. Are you applying for?

- TPD cover
- Active Health Events cover
- Income protection cover or
- Business expenses cover?

◯ No → go to 6

◯ Yes → complete questions below

5.06. Do you have a degree, trade or other professional qualification?

◯ No → go to 5.07

◯ Yes → provide details

Continue filling out this form on the following page →

5.07. What duties do you perform?

Complete the table below

Duty	% of time
Administrative/sedentary	
Supervision of manual labour	
Manual duties usual to qualification/trade	
Other manual duties (specify)	
Travel or working in the field	
Other duties (specify)	
	100 %

5.08. How long have you worked in your current role? years months

If less than 3 years, advise your work history for the last 3 years

5.09. How many hours per week are you currently working in your main job?

(If your typical working hours vary each week, please average your weekly working hours over a three month period) hours per week

5.10. Do you have a second job?

◯ No → go to 5.11

◯ Yes → provide details

Occupation/Industry

Duties

Hours per week Income per annum $

Do not include this income amount in your current annual income in question 6.01

5.11. Do you have definite plans to change your current job, employment arrangement, usual duties, or working hours?

◯ No → go to 5.12

◯ Yes → provide details

5.12. Do you have definite plans to take leave for more than three months?

◯ No → go to 6

◯ Yes → provide details

6. Income

6.01. What is your current annual income from your principal job?

Employee: total remuneration paid by employer, including superannuation and other benefits

Self-employed: gross income of the business, less any business expenses incurred to earn this income

Annual income (excluding superannuation guarantee (SG) contributions)	
Superannuation guarantee (SG) contributions	

6.02. Have you:

- ever been declared bankrupt, or
- had any entity associated with you placed into receivership, liquidation or administration in the last 5 years?

◯ No → go to 6.03

◯ Yes → are you currently bankrupt, or have you had a bankruptcy discharged within the last 3 years?

◯ Yes → complete the Bankruptcy questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ No → provide full details including date of discharge

6.03. Are you an employee only with no ownership (directly or otherwise) in the business you work in?

◯ No → go to 6.09

◯ Yes → go to 6.04

Employee only

6.04. On what basis are you employed?

◯ Permanent (full- or part-time) ◯ Casual contractor* ◯ Fixed term contractor*

* If casual or fixed term contractor is selected, provide full details, including the date you commenced your current contract, the contract term/expiration date and your plans following the contract expiry.

6.05. When did you start working for your current employer? Date / /

6.06. Are you applying for Income protection cover?

◯ No → go to 7

◯ Yes → complete questions below

6.07. Provide your annual income details for the last 2 years below

	Year ending 30/06/	Year ending 30/06/
Wages/salary		
Superannuation contributions		
Bonus		
Commission		
Other benefits (specify)		
TOTAL	$ 0.00	$ 0.00

If you make a claim, the income figures provided may need to be substantiated with the appropriate financial evidence.

6.08. Do you have any sick leave entitlements?

◯ No

◯ Yes → How many accrued sick leave days do you have?

Now go to 7

Self-employed only

6.09. Are you applying for Income Protection cover or Business expenses cover?

- ◯ No → go to 7
- ◯ Yes → complete questions below

6.10. How long have you been self-employed or owned your own business? years months

If less than 3 years, advise your work history for the last 3 years

6.11. Do you own 100% of the business personally (if only sharing ownership with your spouse for income splitting purposes, select 'Yes')?

- ◯ No → provide details of your ownership in the business, the names and ownership percentages of your business partners as well as a description of their role in the business
- ◯ Yes → go to 6.12

6.12. Has your ownership interest for your business changed during the last 3 years?

- ◯ No → go to 6.13
- ◯ Yes → outline the changes

6.13. How many registered business entities (including trusts) does your business structure include?

6.14. What proportion of total business earnings are from your personal exertion? %

6.15. Do you have any employees?

- ◯ No → go to 6.16
- ◯ Yes → complete the table below

	Total	Number of income producing
Full-time		
Part-time		
Casual		

6.16. If you were unable to work, would any part of the business revenue continue, such as:

- **ongoing sales, or**
- **trail commissions**

- ◯ No → go to 6.16
- ◯ Yes → provide details including percentage and duration of ongoing business earnings, and the amount of net income you would expect to receive

6.17. If you were unable to work, would your business hire a replacement person to complete your role?

- ◯ No → go to 6.17
- ◯ Yes → estimated replacement cost (at market rates) $ per month

Continue filling out this form on the following page →

6.18. Advise the following income details as per your Profit and Loss account for the last 2 years

Your income is the gross income earned before tax, from personal exertion, less any business expenses incurred to earn that income.

	Year ending 30/06/	Year ending 30/06/
Your share of gross business income		
Your share of net business profit		
Your personal salary or directors fee		
Salary paid to a non-working spouse or other family members not working in this business		
Superannuation payments to yourself, a non-working spouse or family members not working in this business		
Other add backs (e.g. depreciation, donations or personal use of motor vehicles)		
Total	$ 0.00	$ 0.00

If you make a claim, the income figures provided may need to be substantiated with the appropriate financial evidence.

If you need more space to provide your answers, attach a separate page, signed and dated by you.

6.19. Are you applying for Business expenses cover (Fixed or Key Person Replacement)?

◯ No → go to 7

◯ Yes → complete the Business expenses questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

7. Hazardous activities/sports

Do you take part in, or have definite plans to take part in any sports, recreations or pastimes?

Examples include but are not limited to aviation (other than as a fare-paying passenger), diving, hang gliding, skydiving, motor sports, rock or mountain climbing, football, boxing, martial arts and bungy jumping.

◯ No → go to 8

◯ Yes → provide details where indicated below

If you are applying for TPD, Active Health Events, Income Protection cover or Business expenses cover and you engage in this activity at a professional level, you must have disclosed this job/duties and income in section 6 of this Application.

Select ALL activities which you participate in below:

◯ Aviation (other than as a fare-paying passenger) → complete the Aviation questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Diving → complete the Diving questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Motor sports (car/cycle) → complete the Motor sports questionnaire contained in the 'Underwriting questionnaires' booklet attached to this Application

◯ Football

◯ Amateur/Recreational ◯ Competitive Code:

◯ Boxing

◯ Amateur/Recreational ◯ Competitive ◯ Group boxing/Fitness class only

◯ Martial arts

◯ Non-contact ◯ Contact

◯ Cycling, including mountain biking, BMX, road, and track/velodrome

◯ Amateur/recreational ◯ Competitive Type (i.e. BMX/road etc):

If you participate in any other hazardous activities, complete the questions below. If you participate in multiple activities, you must provide details for each one.

An additional Other activity questionnaire can be found in the 'Underwriting questionnaires' booklet attached to this Application.
If you need more space to provide your answers, attach a separate sheet signed and dated by you.

◯ BASE jumping ◯ Caving/potholing ◯ Equestrian sports ◯ Hang-gliding

◯ Mountain climbing ◯ Rock climbing ◯ Sailing/yachting ◯ Skydiving

◯ Snow skiing/boarding ◯ Water skiing/boarding ◯ Other, specify

Continue filling out this form on the following page →

7.01. On what basis do you participate in this activity? ◯ Amateur/Recreational ◯ Competitive ◯ Professional

7.02. How often do you participate in this activity? Events/Hours per year

7.03. Provide details of the level at which you participate in this activity, e.g. maximum depths, heights, speeds or grades

7.04. Provide details of any injuries you have sustained from this activity

8. Personal details

8.01. How much do you weigh? Weight kg **or** lb

8.02. How tall are you? Height cm **or** feet/inches

8.03. Has your weight changed by more than 10 kgs (or 22 lbs) during the last 12 months?

◯ No → go to 8.04

◯ Yes → provide details (loss/gain, amount, reason and time period)

Lifestyle

8.04 Have you smoked tobacco, e-cigarettes (vaping) or any other substance, or used a nicotine product within the last 12 months?

◯ No → go to 8.05

◯ Yes → provide details of what you have smoked/used within the last 12 months, how often you smoke and how many per day on average

8.05. In a typical week, on how many days would you drink alcohol?

_____ days per week → go to 8.06

◯ I drink less than once a week → go to 8.07

◯ I have never drunk alcohol → go to 8.08

8.06. On days you do drink, how many standard drinks would you typically have?

One standard drink is equal to 285ml of full strength beer, 100ml of wine, or 30ml of spirits.

8.07. Have you ever received advice, treatment or counselling due to excessive alcohol consumption?

◯ No → go to 8.08

◯ Yes → please provide details, including type of advice, treatment and dates

8.08. According to the Australian Government, 42% of Australians have taken recreational drugs at some time in their life. Within the last 10 years, have you taken recreational drugs?

◯ No → go to 8.09

◯ Yes → provide details

8.09. Have you ever injected recreational drugs?

◯ No → go to 8.10

◯ Yes → provide details

8.10. Within the last 10 years, have you misused or been addicted to any pharmaceutical drug(s) (such as pain killers or sedatives), even if they were prescribed for you?

◯ No → go to 8.11

◯ Yes → provide details

8.11. Have you ever received advice, treatment or counselling due to drug taking?

◯ No → go to 9

◯ Yes → please provide details, including type of advice, treatment and dates

9. Family medical history

9.01. Have your biological (i.e. blood related) parents, brothers or sisters had any of the following conditions before the age of 65?

- Heart disease, Heart attack, angina or stroke
- Diabetes (provide details if type 1 or 2)
- Cancer (provide details of type and site)
- Muscular dystrophy, Huntington's disease or Motor neurone disease
- Polycystic kidney disease
- Cardiomyopathy
- Multiple sclerosis, Parkinson's disease or Alzheimer's disease
- A mental health condition
- Any other hereditary condition, which runs in your family

◯ No → go to 9.02

◯ Yes → provide details

1. Relative:	Condition:	Age diagnosed:
2. Relative:	Condition:	Age diagnosed:
3. Relative:	Condition:	Age diagnosed:
4. Relative:	Condition:	Age diagnosed:

9.02 Combined with this application, does the total amount of any existing insurance(s) on your life (with Zurich or any other insurer, including cover provided by your employer or attached to your super) exceed the following:

- $500,000 Life, or
- $500,000 TPD, or
- $200,000 Trauma and Health events, or
- $4,000 per month Income protection and Business Expenses?

◯ No → go to 10

◯ Yes → 9.03

9.03 Have you ever had or are you considering having a genetic test?

◯ No → go to 10

◯ Yes → provide details

Note: You do not need to disclose to us any genetic test that was conducted for the purpose of a medical research study conducted by an accredited university or medical research institution where;

- the test results are not known by you and will not be provided to you, or
- you have specifically requested not to receive the test results

You also do not need to disclose to us any genetic test that was conducted for fertility or paternity testing, for fitness, for nutrition or to trace ancestry.

Continue filling out this form on the following page →

10. Your medical history

10.01. Have you ever had, been treated for or had symptoms from:

		No	Yes
1	Asthma?	○	○
2	Skin cancer, cyst, mole or lesion?	○	○
3	Raised blood pressure or cholesterol managed through medication, diet or lifestyle?	○	○
4	Any form of diabetes, raised blood sugar or impaired glucose tolerance managed through medication, diet or lifestyle?	○	○
5	Sleep apnoea or sleep disorder?	○	○
6	Anxiety or depression, or have you received any mental health treatment or counselling with any healthcare professional?	○	○
7	Any other mental health condition or disorder? (including post traumatic stress disorder, bipolar disorder, schizophrenia, personality disorder, eating disorder or attention deficit disorder (ADD/ADHD))	○	○

Are you applying for Trauma, TPD, Income protection, Business expenses or Health events?

○ No → go to 10

○ Yes → go to 8

8	Back or neck pain or a condition affecting your back, neck or spine? (including sciatica, whiplash, trapped nerves or back or neck muscular aches or pains)	○	○
9	Joint or muscle pain, any condition affecting your bones, joints, muscles or limbs, or have you received treatment from a physio or chiro? (including gout, ligament, tendon or repetitive strain injuries, carpal tunnel syndrome, fractures, a head injury or muscle aches or pains)	○	○

If you have answered 'Yes' to any question in 1– 9, you will need to complete the relevant questionnaire/s contained in the 'Underwriting questionnaires' booklet attached to this Application.

If you answer 'Yes' to any of the questions 10–35, you will need to provide details in 10.02 on page 14.

10	Chronic fatigue or fibromyalgia?	○	○
11	Dermatitis, psoriasis, eczema or any other skin condition?	○	○
12	Bronchitis, or any other condition affecting your lungs or breathing? (including chronic obstructive pulmonary disease (COPD) or emphysema)	○	○
13	Cancer, pre-cancerous condition, or any kind of tumour or growth? (including melanoma or other skin cancers, Hodgkin's or non-Hodgkin's lymphoma, leukaemia, Barrett's oesophagus or bowel polyps)	○	○
14	A heart or artery condition or surgery on your heart or arteries? (including angina or heart attack, angioplasty, stent or bypass, irregular heart beat, heart valve or heart structure abnormalities, or any scan or test of your heart which required follow up or a change in your treatment)	○	○
15	A stroke, brain haemorrhage or damage or surgery to your brain? (including mini stroke, transient ischaemic attack (TIA) or brain aneurysm)	○	○
16	Any thyroid condition? (including over active or under active thyroid, Graves' or Hashimoto's disease)	○	○
17	Any condition affecting your kidneys or bladder? (including blood or protein in your urine, kidney or bladder stones)	○	○
18	Any condition affecting your bowel or digestive system? (Crohn's disease, colitis, irritable bowel syndrome, gastric banding or sleeve, hernias or ulcers)	○	○
19	Any condition affecting your liver or pancreas? (fatty liver, hepatitis or an abnormal blood test or scan of your liver)	○	○
20	Any condition affecting your nerves or nervous system? (including epilepsy, confirmed or possible multiple sclerosis, Parkinson's disease, muscular dystrophy or motor neurone disease)	○	○
21	Recurrent or persistent numbness, pins and needles, muscle weakness, or difficulty with coordination?	○	○
22	Anaemia, an autoimmune disease, or any blood condition or abnormality which required follow up with a doctor? (including DVT or pulmonary embolism, Lupus or Sjogren's syndrome, haemochromatosis or haemophilia)	○	○
23	Any condition you have had since birth? (including a heart or kidney condition you were born with, cerebral palsy or spina bifida)	○	○
24	Have you ever tested positive for HIV or hepatitis B or C, or are you awaiting the results of such a test (other than as part of this application)?	○	○

		No	Yes
25	Any condition affecting your ears or hearing? (including total or partial hearing loss, tinnitus or Meniere's disease, or vertigo)	◯	◯
26	Recurrent migraines, or persistent fatigue or tiredness?	◯	◯
27	Any condition affecting your eyes or vision other than long or short-sightedness which is fully corrected with glasses, lenses or laser surgery? (including total or partial loss of vision, or optic neuritis)	◯	◯
28	Any sexually transmitted disease including but not limited to gonorrhoea, syphilis or chlamydia?	◯	◯

FEMALE ONLY (Questions 29-31)

29	Are you currently pregnant? ◯ No → go to 30 ◯ Yes → go to 29.01 29.01. Are you currently in good health with no complications associated with the pregnancy and no medical investigations planned other than routine pre-natal screening? ◯ No → please provide details ◯ Yes → go to 29.02 29.02. Are you applying for TPD, income protection, business expenses or Active Health Events cover? ◯ No → go to 30 ◯ Yes → do you intend to return to work for at least your current working hours within 12 months following the birth of your baby? ◯ No → provide details of your plans of when you return to work, and how many hours per week you plan to work on return ◯ Yes → go to 30		
30	Have you ever had any abnormal cervical screening test? (including abnormal PAP smear, abnormal HPV test result)	◯	◯
31	Have you ever had any breast lump, cyst or breast abnormality? (including an abnormal mammogram, ultrasound or MRI)	◯	◯

MALE ONLY (Question 32)

32	Have you ever had a prostate condition?	◯	◯

ALL TO ANSWER

In the last 5 years (and apart from anything you have already told us):

33	Have you experienced or been advised of any symptom or health concern for which you have: • seen or intend to see a healthcare professional, • been admitted to hospital, or • been unable to work?	◯	◯
34	Have you been prescribed any medication?	◯	◯
35	Have you been referred for, or are you currently awaiting the results of any medical investigation, procedure, follow up or any other medical or blood test?	◯	◯

Continue filling out this form on the following page →

10.02. Did you answer 'Yes' to any of the questions 10–35 in question 10.01?

◯ No → go to 10.03

◯ Yes → provide full details for each 'Yes' response in the table below (more space is available on the next page if required)

	Question no:		**Question no:**	
What is the condition/diagnosis?				
Date of diagnosis	/ /		/ /	
What symptoms have you experienced?				
Date of first/last symptoms	First / /	Last / /	First / /	Last / /
Frequency of symptoms				
What treatment have you received?				
Date of first/last treatment	First / /	Last / /	First / /	Last / /
Frequency of treatment				
Degree of recovery	%		%	
Have you undergone any specific testing or investigations (such as scans or X-rays) for this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Have you taken time off work or are your work duties or lifestyle affected or restricted due to this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Is your usual doctor noted in question 11 of this Application the treating doctor for this condition?	◯ Yes ◯ No → provide details		◯ Yes ◯ No → provide details	
Doctor's/Clinic's name				
Doctor's/Clinic's address, state and postcode				
Doctor's/Clinic's phone number	( )		( )	

	Question no:		Question no:	
What is the condition/diagnosis?				
Date of diagnosis	/ /		/ /	
What symptoms have you experienced?				
Date of first/last symptoms	First / /	Last / /	First / /	Last / /
Frequency of symptoms				
What treatment have you received?				
Date of first/last treatment	First / /	Last / /	First / /	Last / /
Frequency of treatment				
Degree of recovery	%		%	
Have you undergone any specific testing or investigations (such as scans or X-rays) for this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Have you taken time off work or are your work duties or lifestyle affected or restricted due to this condition?	◯ No ◯ Yes → provide details		◯ No ◯ Yes → provide details	
Is your usual doctor noted in question 11 of this Application the treating doctor for this condition?	◯ Yes ◯ No → provide details		◯ Yes ◯ No → provide details	
Doctor's/Clinic's name				
Doctor's/Clinic's address, state and postcode				
Doctor's/Clinic's phone number	( )		( )	

10.03. As the result of illness or injury, have you ever or are you expecting to claim under any:

- Trauma, Total & Permanent Disability (TPD), Income protection or Salary Continuance policy
- Workers compensation
- Any other benefits paid due to sickness, disability or injury (other than Health insurance)

◯ No → go to 11

◯ Yes → provide details

Company/Source

Date / / Period of disability

Cause of claim

11. Doctor's details

11.01 Do you have a doctor/medical centre that you usually attend?

◯ No → provide details of the most recent doctor/medical centre

◯ Yes → provide details

Doctor's /Clinic's name Name of medical centre

Address of doctor or medical centre

State Postcode Phone number ( )

11.02 When was the last time you saw this doctor and/or clinic? Date / /

11.03 Will this doctor have information about all of your disclosed medical history?

◯ No → go to 11.04

◯ Yes → go to 11.06

11.04 Which of your conditions will this doctor have information about?

11.05 Are you able to provide details of another doctor who may have details of your disclosed medical history?

◯ No → go to 11.06

◯ Yes → provide details

Doctor's /Clinic's name Name of medical centre

Address of doctor or medical centre

State Postcode

Phone number ( )

11.06 Is there any additional information you would like to provide to assist Zurich in assessing your application?

◯ No

◯ Yes → provide details

ZURICH

Underwriting questionnaires

Select and complete the relevant questionnaire as prompted by your previous answers

- ◯ **Asthma questionnaire**
- ◯ **Sleep disorder questionnaire**
- ◯ **Raised cholesterol questionnaire**
- ◯ **High blood pressure questionnaire**
- ◯ **Diabetes questionnaire**
- ◯ **Cyst/Mole/Skin lesion questionnaire**
- ◯ **Mental health questionnaire**
- ◯ **Back/Neck pain questionnaire**
- ◯ **Joint/Musculoskeletal questionnaire**
- ◯ **Activity questionnaires**
  - Diving questionnaire
  - Motor sports questionnaire
  - Aviation questionnaire
  - Other activity questionnaire
- ◯ **Financial questionnaire**
- ◯ **Business Expenses questionnaire**
- ◯ **Bankruptcy questionnaire**

ASTHMA QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When did you have your first symptoms/episode of asthma?

2. When were your most recent symptoms/episodes of asthma?

3. Approximately how many episodes of asthma do you have per year?

4. In the past two years, have you had time off work as a result of asthma?

◯ No

◯ Yes → provide details How much? When?

5. Within the last two years, has your asthma required any of the following:

- More than three scripts of oral steroids
- A hospital stay longer than one night
- More than five continuous days off
- Any heart or lung test that required a specialist or hospital referral

◯ No

◯ Yes → provide details

Name	Dosage	Frequency

6. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's name

Address State Postcode

Phone number ( )

SLEEP DISORDER QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What is the condition/diagnosis? Date diagnosed / /

2. Have you been using a CPAP machine every night for 3 months or more?

- ◯ No
- ◯ Yes

3. Have you been using a mouthguard or mandibular splint nightly for the last 3 months?

- ◯ No
- ◯ Yes

4. Is your condition fully controlled? (this means that your symptoms have not got worse or more frequent, and your treatment hasn't changed, for at least 6 months)

- ◯ No
- ◯ Yes

5. Do you suffer from excessive daytime tiredness? (this means you are likely to fall asleep or feel the urge to sleep when sitting inactive in a public place (e.g. in a theatre or a meeting), watching TV, as a passenger in a car or sitting talking to someone)

- ◯ No
- ◯ Yes

6. Does this condition limit your ability to work or carry out the normal duties of your normal daily activities?

- ◯ No
- ◯ Yes

7. Unless already provided, please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered

Date when first suffered the symptoms / /

Symptoms

Tests/investigations

Treatment

Time off work Date last had symptoms / /

8. Is your usual doctor the treating doctor for this condition?

- ◯ No → provide details of your treating doctor for this condition
- ◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

RAISED CHOLESTEROL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When were you first diagnosed with this condition? Date / /

2. What was your most recent cholesterol result, and when was this taken?

Result Date / /

3. Have you ever taken medication for this condition?

◯ No → go to 8

◯ Yes → provide details

Treatment/dosage Date commenced treatment / /

Date ceased treatment / /

4. Has your treating doctor advised you that your cholesterol is controlled and within normal limits?

◯ No → provide details

◯ Yes

5. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

HIGH BLOOD PRESSURE QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. When were you first diagnosed with this condition? Date / /

2. What was your most recent blood pressure result, and when was this taken?

Result Date / /

3. Is this result consistent with previous blood pressure checks?

◯ No → provide details including your typical blood pressure reading and reason for variance

◯ Yes

4. Have you ever taken medication for this condition?

◯ No → go to 5

◯ Yes → provide details

Treatment/dosage Date commenced treatment / /

Date ceased treatment / /

5. Has your treating doctor advised you that your blood pressure is controlled and within normal limits?

◯ No → provide details

◯ Yes

6. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

DIABETES QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. State the diagnosis relevant to you, e.g. Type I or Type II Diabetes Mellitus, Gestational Diabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose etc.

2. When were you diagnosed with this condition? Date / /

3. How often do you consult with your usual doctor/clinic for monitoring?

4. What was the date of your most recent consult with this doctor/clinic? Date / /

5. Are you currently undertaking treatment for this condition?

- ◯ No → go to 6
- ◯ Yes → what type of treatment are you undertaking?
  - ◯ Diet
  - ◯ Insulin – number of daily units:
  - ◯ Oral Drug treatment – medication name and dosage:
  - ◯ Other – specify:

6. Has your doctor changed your treatment within the last 2 years?

- ◯ No
- ◯ Yes → provide details of previous treatment including type, dosage and frequency (if applicable)

7. Have you ever suffered from the following complications of diabetes:

- problems with your eyes
- high blood pressure or other heart/circulatory problems
- kidney problems, including albumin or protein in the urine or
- numbness or tingling in your feet or legs?

◯ No

◯ Yes → provide details including complication/s, severity, treatment and date

8. Do you know your most recent Blood Glucose result?

◯ No

◯ Yes → Blood Glucose result: Date of reading / /

Continue filling out this questionnaire on the following page →

9. Do you know your most recent HbA1C (glycosylated haemoglobin) result?

◯ No

◯ Yes → HbA1C result: Date of reading / /

10. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

11. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

CYST/MOLE/SKIN LESION QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What type of cyst/mole/skin lesion do you, or did you have?

2. What is, or was, the location of the cyst/mole/skin lesion?

3. When was the date of diagnosis? / /

4. Was the cyst/mole/skin lesion removed?

◯ No

◯ Yes → provide date and method of removal

5. Were any special tests, investigations or treatment required?

◯ No

◯ Yes → provide details

6. Do you have pathology results, if required?

◯ Yes

◯ No

7. Was the cyst/mole/skin lesion malignant or benign?

◯ Benign ◯ Malignant ◯ Unknown

8. Have you, or do you require any further treatment or follow-up since the original removal?

◯ No

◯ Yes → provide details

9. Is your usual doctor the treating doctor for this condition?

◯ Yes

◯ No → provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

MENTAL HEALTH QUESTIONNAIRE

1. Were you advised by your treating practitioner of a diagnosis or name for your condition?

◯ No → go to 3

◯ Yes → please check the following condition(s) you experienced and confirm age or date of diagnosis: (if more than one condition, please check all that apply)

- ◯ Grief reaction, stressful life events or difficulties — Age — OR Date / /
- ◯ Post natal depression — Age — OR Date / /
- ◯ Depression (including major depression or dysthymia) — Age — OR Date / /
- ◯ Anxiety (including panic disorder or generalised anxiety disorder) — Age — OR Date / /
- ◯ Bipolar disorder — Age — OR Date / /
- ◯ Obsessive compulsive disorder (OCD) — Age — OR Date / /
- ◯ Post traumatic stress disorder (PTSD) — Age — OR Date / /
- ◯ Schizophrenia or other psychotic disorder — Age — OR Date / /
- ◯ Dissociative disorder (Including dissociative identity disorder) — Age — OR Date / /
- ◯ Eating disorder (including anorexia or bulimia) — Age — OR Date / /
- ◯ Attention deficit or hyperactivity disorder (ADD/ADHD) — Age — OR Date / /
- ◯ Personality disorder (including Borderline personality disorder) — Age — OR Date / /
- ◯ Any other mental health condition not already mentioned.
  What name was given to your condition — Age — OR Date / /

2. Have you experienced any of these conditions more than once?

◯ No

◯ Yes → which condition did you experience more than once, and when did this happen?

3. When did you first experience symptoms relating to your mental health? Age OR Date / /

4. How have you been affected by your mental health?

Please select each which apply

◯ Have taken time off work under the care of a doctor

When was the last time you were unable to work due to your mental health? Age OR Date / /

What is the longest number of consecutive days you have been off work due to your mental health?

◯ Have taken time off work under personal or employer sponsored leave

When was the last time you were unable to work due to your mental health? Age OR Date / /

What is the longest number of consecutive days you have been off work due to your mental health?

◯ My work or social relationships have been negatively impacted

When was the last time you were impacted in this way? Age OR Date / /

◯ My ability to engage in my usual work and social activities have been negatively impacted

When was the last time you were impacted in this way? Age OR Date / /

◯ My ability to function has been impacted by my mental health in other ways

Please describe how you have been impacted by your condition:

When was the last time you were impacted in this way? Age OR Date / /

◯ My mental health has never impacted my ability to function or my relationships

When was the last time you were impacted in this way? Age OR Date / /

5. Have you ever taken or been prescribed any medication for your mental health condition?

◯ No → go to 6

◯ Yes → please complete below (please check all that apply)

Medication type	Date first prescribed	Are you still taking this?	Has this been prescribed more than once?
◯ Antidepressants (e.g. Zoloft, Cipramil, Effexor, Lovan, Aropax)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Mood stabilisers (e.g. Lithium)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Antipsychotics (e.g. Clozaril, Seroquel, Zyrprexa, Risperdal)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Anticonvulsants (e.g. Epilim, Tegretol, Lamictal)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Sedatives / Hypnotics (e.g. Normison, Diazepam)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Stimulants (e.g. Ritalin, Concerta, Provigil)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Substance abuse related medications (e.g. Campral, Naloxone, Suboxone, Methadone)	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name:	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes
◯ Other or unknown form of medication: Drug name:	/ /	◯ No ◯ Yes Ceased / /	◯ No ◯ Yes

6. Have you ever received or been recommended any talk-based therapy such as counselling, CBT, other forms of mental health treatment or been referred to a psychiatrist?

◯ No → go to 7

◯ Yes → please complete below (please check all that apply)

Treatment type	Date commenced/ recommenced	Are you still attending?	Date ceased (if applicable)
◯ General counselling	/ /	◯ No ◯ Yes	/ /
◯ Cognitive behaviour therapy (CBT) or Dialectical behaviour therapy (DBT))	/ /	◯ No ◯ Yes	/ /
◯ Other forms of talk-therapy Please specify:	/ /	◯ No ◯ Yes	/ /
◯ Consultation with a psychiatrist	/ /	◯ No ◯ Yes	/ /

7. Have you ever been treated in hospital for your mental health condition?

◯ No → go to 8

◯ Yes → when did this happen, what is the name of the hospital where you stayed, and how long was your admission

Continue filling out this questionnaire on the following page →

8. Have you ever thought of hurting yourself?

◯ No → go to 9
◯ Yes → when did you last have these thoughts? Age OR Date / /

Had you experienced these feelings previously?

◯ No
◯ Yes → please describe how often you had experienced these feelings previously, and when you first had these thoughts

Have you ever acted on those thoughts?

◯ No
◯ Yes → please provide details including when this has happened

9. Provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / Most recent / /

10. Have you consulted any other health professionals for the condition/s?

◯ No
◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

BACK/NECK PAIN QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Which part of your back/neck is, or was affected? Select all that apply

◯ Neck (Cervical spine) ◯ Upper/Middle (Thoracic spine) ◯ Lower (Lumbar-sacral spine)

2. When did you first experience back/neck symptoms?

3. Have you ever experienced any symptoms of sciatica, numbness or pins and needles?

◯ No

◯ Yes → provide details including dates

4. Do you continue to experience symptoms?

◯ No → when did you last experience any symptoms of this condition? / /

→ how many episodes of back/neck symptoms have you experienced, and how long did the symptoms last for?

◯ Yes → what was the date of your most recent symptoms? / /

→ how many episodes of back/neck symptoms do you experience per year?

→ how long do the symptoms normally last for?

5. Have you made a complete recovery?

◯ No

◯ Yes → how long have you been free of all symptoms?

6. Are you currently undertaking treatment/therapy for this condition?

◯ No → Have you ever undertaken treatment/therapy for this condition?

◯ No

◯ Yes → provide details

◯ Yes → provide details of treatment/therapy below

Type of treatment		**Date commenced**	**Date ceased (if applicable)**
◯ Medication			
Name	Dosage	/ /	/ /
Name	Dosage	/ /	/ /
◯ Physiotherapy		/ /	/ /
◯ Chiropractor/Osteopath		/ /	/ /
◯ Surgery		/ /	/ /
Details			
◯ Other – advise		/ /	/ /

Continue filling out this questionnaire on the following page →

7. Does this condition interfere with or restrict your lifestyle activities or normal occupational duties?

◯ No

◯ Yes → provide details

8. Have you ever taken time off work as a result of your back/neck condition?

◯ No

◯ Yes → advise when and for how long

9. Is your usual doctor the treating doctor for this condition?

◯ No → provide details of your treating doctor for this condition

◯ Yes

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

10. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

If you need more space to provide your answers, attach a separate sheet signed and dated by you.

JOINT/MUSCULOSKELETAL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Which joint/s or area/s of the body is/are affected?

2. When did you first experience symptoms?

3. What is, or was the cause of your symptoms/condition?

4. Have you made a complete recovery?

◯ No

◯ Yes → for how long have you been free of all symptoms?

5. Are you currently undertaking treatment/therapy for this condition?

◯ No → have you ever undertaken treatment/therapy for this condition?

- ◯ No
- ◯ Yes → provide details below

◯ Yes → provide details of treatment/therapy below

Type of treatment		Date commenced	Date ceased (if applicable)
◯ Medication			
Name	Dosage	/ /	/ /
Name	Dosage	/ /	/ /
◯ Physiotherapy		/ /	/ /
◯ Chiropractor/Osteopath		/ /	/ /
◯ Surgery		/ /	/ /
Details			
◯ Other – advise		/ /	/ /

6. Does this condition interfere with or restrict your lifestyle activities or normal occupational duties?

◯ No

◯ Yes → provide details

7. Have you ever taken time off work as a result of this condition?

◯ No

◯ Yes → advise when and for how long

Continue filling out this questionnaire on the following page →

8. Is your usual doctor the treating doctor for this condition?

◯ Yes

◯ No → provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

9. Have you consulted any other health professionals for the condition/s?

◯ No

◯ Yes → provide details of other doctors

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

Doctor's/Clinic's name

Address State Postcode

Phone number ( )

Dates consulted: From / / To / /

ACTIVITY QUESTIONNAIRES

DIVING QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Are you amateur, professional and/or an instructor? ◯ Amateur ◯ Professional/Instructor

2. Do you have a current diving qualification?

◯ No

◯ Yes → provide details

3. What type of diving do you do? Tick all that apply

◯ Scuba ◯ Snorkelling ◯ Skin diving ◯ Free diving ◯ Wreck diving ◯ Cave/Pothole diving

4. What depths do you dive, and how often (per annum)?

	Average	Maximum
Depth	m	m
Number of dives at this depth	p.a.	p.a.

5. Have you ever been injured, or had an accident while diving?

◯ No

◯ Yes → provide details

Continue filling out this questionnaire on the following page →

MOTOR SPORTS (CAR/CYCLE) QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Are you amateur or professional or competitive? ◯ Amateur ◯ Professional ◯ Competitive

2. What types of events do you participate in, and how often per year, e.g. drag racing, speedway, rally driving?

Type and location of event	Number of events per annum

3. What type of vehicles do you drive/ride?

Vehicle type	Engine type/size	Max. racing speed

4. Have you ever been injured, or had an accident while participating?

◯ No

◯ Yes → provide details

Continue filling out this questionnaire on the following page →

AVIATION QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. Do you hold a Civil Aviation Authority licence?

◯ No

◯ Yes → state the type and period held

2. Do you intend to change the scope of this licence, including engaging in any other form of aviation?

◯ No

◯ Yes → provide details

3. Have you ever had an accident or been charged with violating Civil Aviation Authority regulations?

◯ No

◯ Yes → provide details

4. Complete the following schedule

Category	Flight hours in past 12 months	Flight hours future annual average
Commercial airline		
Charter		
Private		
Aero club/Flying school		
Agriculture		
Helicopter		
Ultralight/Microlight		

OTHER ACTIVITY QUESTIONNAIRE

1. What is the activity?

2. On what basis do you participate in this activity? ◯ Amateur/Recreational ◯ Competitive ◯ Professional

3. How often do you participate in this activity? Events / Hours per year

4. Provide details of the level at which you participate in this activity. e.g. maximum depths, heights, speeds, or grades?

5. Provide details of any injuries you have sustained from this activity

FINANCIAL QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

SECTION 1 – PERSONAL FINANCIAL POSITION

1.1. Provide details of your assets and liabilities.
This includes any asset or liability that you directly or indirectly have ownership interest in and/or control over, including those which are not held in your personal name (e.g. those held in your spouse's name).

Assets		**Liabilities**	
Primary residence/farm property	$	Primary residence loan balance	$
Motor vehicle/boat etc.	$	Car loan balance	$
Investment property	$	Credit card balance	$
Investment – shares etc.	$	Personal loan balance	$
Business/es	$	Investment property debt/s	$
Other assets (specify):		Other Investment debt/s	$
	$	Business/es debt/s	$
	$	Other liabilities (specify):	
	$		$
	$		$
	$		$
Total assets	**$** 0.00	**Total liabilities**	**$** 0.00

1.2. Do you have any financial dependants?

◯ No

◯ Yes → provide clarification including the age of each dependant, their relationship to yourself (the life insured), and the length of time they will be dependent on you

1.3. Do you receive or expect to receive net income from other sources such as rental income, dividends etc.?

◯ No

◯ Yes → provide clarification, including details of the source of the income, the amount of annual net income from this source, and how long this would continue

1.4. Are you applying for (if more than one applies, tick and complete all sections)

◯ Business loan cover → complete section 2

◯ Business key person cover → complete section 3

◯ Business buy/sell cover → complete section 4

◯ Personal cover → provide a summary of how the sum insured has been calculated for any personal life, trauma, TPD or Active Health Events cover including details of any formulas/methodologies used or other factors relevant to your situation considered

(If only personal cover is ticked, end here)

Continue filling out this questionnaire on the following page →

SECTION 2 – BUSINESS LOAN COVER

2.1. Provide details of the loan/s this cover relates to in the table below

	Lender	Amount	Term	Interest rate	Drawdown date	Repayment method
1		$		%	/ /	
2		$		%	/ /	
3		$		%	/ /	
4		$		%	/ /	

2.2. What is the purpose of the loan/s and what is your share?

2.3. Are there joint and several guarantees?

◯ No

◯ Yes → outline who the other person/s are

2.4. Is insurance a requirement of the lender in providing the loan/s?

◯ No

◯ Yes

SECTION 3 – BUSINESS KEYPERSON COVER

3.1. What is your position in the business?

3.2. What are the duties, special skills, knowledge, expertise, qualifications, contacts or other factors that contribute to make you a key person?

3.3. What proportion of business net profit can be directly attributed to you (the life insured)? %

Clarify how this percentage has been determined

3.4. Outline the calculation methodology showing how the level of key person cover was determined

3.5. What are the roles and duties of other shareholders/trustees and key personnel in the business, and how much do they contribute to income generation in the business?

	Role/Duties	Contribution	Position	Value policies in force
1		%		$
2		%		$
3		%		$
4		%		$

3.6. Is cover in force or being effected on the lives of any other persons in the business?

◯ No

◯ Yes → provide details of on whom, their role/duties and how much

Continue filling out this questionnaire on the following page →

SECTION 4 – BUSINESS BUY/SELL COVER

4.1. Has an independent valuation been completed?

◯ No

◯ Yes → are you able to provide a copy of the valuation?

- ◯ No
- ◯ Yes

4.2. Provide a detailed outline of the calculation methodology showing how the cover was calculated

4.3. Has a Partnership, Share Purchase and/or Buy/Sell Agreement been put in place?

◯ No

◯ Yes → are you able to provide a copy of the Partnership, Share Purchase and/or Buy/Sell Agreement?

- ◯ No
- ◯ Yes

4.4. Is cover in force or being effected on the lives of all business partners or shareholders?

◯ No → provide details as to why not

◯ Yes → are the business partners/shareholders also applying for cover with Zurich?

- ◯ No → what levels of cover are being applied for, and with which insurer?
- ◯ Yes → confirm the names of the other business partners/shareholders applying for cover with Zurich

BUSINESS EXPENSES QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

SECTION 1 – BUSINESS DETAILS

1.1. When did your business commence? / /

1.2. What are the principal business activities?

1.3. Describe what you would expect to happen to your business in the event of your disability and over what timeframe.
Include details of any contingencies (including use of a locum) that may be in place

1.4. What proportion of total business expenses are you responsible for? %

1.5. Provide the following details for all income generating employees and business owners/partners

Name of employee or business owner/partner	% of income generated	Role/duties	Annual salary	% interest in the business (if any)
	%		$	%
	%		$	%
	%		$	%
	%		$	%

1.6. Are you applying for:

◯ Keyperson replacement cover → complete section 2

◯ Ongoing fixed expenses cover → complete section 3

SECTION 2 – KEYPERSON REPLACEMENT COVER

2.1. What is your position in the business?

2.2. What are the duties, special skills, knowledge, expertise, qualifications, contacts or other factors that contribute to make you a key person that would require the business to get a replacement in the event of your disability?

2.3. What proportion of the business net profit can be directly attributed to you (the life insured)? %

2.4. What would a replacement cost at market rates? $ per month

2.5. Outline the basis on which the replacement cost was determined?

2.6. Clarify how long it would most likely take to source a replacement

Continue filling out this questionnaire on the following page →

SECTION 3 – ONGOING FIXED EXPENSES COVER

Enter your share of average monthly business expenses (that you are responsible for). Some expenses are not eligible for this insurance, e.g. partner share of expenses and salaries. Refer to the relevant PDS for a list of business expenses that we will cover.

Accounting and auditing fees (regular only)	$
Bank fees and charges	$
Cleaning costs (regular only)	$
Electricity, gas and water	$
Fees for professional associations	$
Insurance premiums (excluding this policy and income protection policies)	$
Interest payments on business loans	$
Leasing/Hire purchase of office equipment, machinery or motor vehicles	$
Minimum loan repayments of business capital/principal loan	$
Locum cover (less earnings generated by locum)	$
Motor vehicle fixed business related costs (registration etc.)	$
Payroll tax for employees not directly involved in revenue generation	$
Printing postage and stationery	$
Property rates/taxes	$
Rent/Leasing fees (business premises)	$
Repairs and maintenance	$
Salaries of employees not directly involved in revenue generation (excluding income splitting)	$
Security costs	$
Subscriptions/fees for business related associated memberships	$
Superannuation contribution for employees not directly involved in revenue generation (excluding income splitting)	$
Telephone	$
Other expenses (specify the nature of the expense) Expense:	$
Expense:	$
Expense:	$
Total	**$** 0.00

BANKRUPTCY QUESTIONNAIRE

Life insured full name:

Life insured date of birth / /

1. What date were you declared bankrupt? / /

2. Has your bankruptcy been discharged?

◯ No
◯ Yes → when was it discharged? / /

3. Was this bankruptcy:

◯ Voluntary?
◯ Forced?

4. Provide a detailed description of the reason for and the circumstances under which you were declared bankrupt on the above occasion

5. At the time of your bankruptcy, were you an employee only with no ownership (directly or otherwise) in the business you were working in?

◯ No → detail how the bankruptcy affected your business structure, trading operation and/or management of the business at the time

◯ Yes → detail how the bankruptcy affected your employment situation

6. Apart from any original creditor's petition, were any legal proceedings instigated against you arising from this bankruptcy?

◯ No
◯ Yes → provide details, including whether any proceedings are still in place

7. Have you ever been declared bankrupt prior to this bankruptcy?

◯ No
◯ Yes → provide full details, including date of discharge

8. Has any entity you have been associated with been placed into receivership, liquidation or administration?

◯ No
◯ Yes → provide details

9. Do you still have financial commitments to any other parties involved?

◯ No
◯ Yes → provide details

10. Did you suffer from any health problems at the time of bankruptcy, e.g. stress, anxiety or high blood pressure?

◯ No
◯ Yes → provide details

ADVISER NOTES

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AROD-017587-2021 544199_ZUR8817/0821

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