DATA CAPTURE FORM

This form is dated September 2021.

This form is not to be submitted as a replacement of a new application. Please read the below important information.

Life Insured full name

Adviser name

Reference number (if applicable)

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.

OnePath

Data Capture Form

This form is dated September 2021

Privacy

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 OnePath). 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 OnePath. This information may include your personal and sensitive information. OnePath 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 OnePath's Privacy Policy please visit our website at onepathinsurance.com.au or contact the OnePath Privacy Officer on 133 667 or email us at insurancefeedback@onepath.com.au

1. Life Insured details

A Life insured

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname First name

Maiden name (if applicable) Date of birth (dd/mm/yyyy) / /

B Residence and travel details

1. Are you an Australian or New Zealand citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No

2. How long have you lived in Australia? Years ☐☐ Months ☐☐

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

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

Date of departure (dd/mm/yyyy) / / Duration of stay

Destination(s)

Purpose of stay ☐ Holiday ☐ Business ☐ Residing ☐ Other Please specify if **other**

C Insurance details

1a. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance, business expenses, living expenses, accidental death, terminal illness, needle stick, extended needle stick or cover for pregnancy and/or infancy, with any company, including OnePath Life (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

1b. Apart from this application do you have, or will you be replacing cover with either, OnePath Life Limited or any other life insurance company (this includes insurance through your superannuation fund and employer)? ☐ Yes ☐ No

1c. If you have answered **yes** to either question 1a or 1b, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below.

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)
		$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /
		$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, or accepted with a higher than normal premium, or with restrictions or exclusions? ☐ Yes ☐ No

If **yes**, please provide name of company, alteration, type of cover, date and reason (if known).

Please note that questions continue on the next page.

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

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

D Occupation details

1a. Occupation

b. How many hours per week do you work in total in your principal occupation (include any hours worked at home)?

c. In which industry do you work?

d. Years in this industry

2. Which of the following best describes your employment situation?

☐ Employed by family company/trust ☐ Employed by my own company ☐ Partnership ☐ Casual
☐ Sole trader ☐ Employed by an independent employer ☐ Employed under terms of a contract

3. When did your present job/employment situation start? (dd/mm/yyyy) / /

If less than 3 years ago, for each job you have had within the last 3 years, provide details of the name of the employer or business, your duties, the industry worked in, and the dates of employment?

4. What is your current annual income earned through personal exertion, before tax, but after deduction of business expenses?

Annual income (excluding superannuation guarantee (SG) contributions) $ ☐☐☐,☐☐☐,☐☐☐

Superannuation guarantee (SG) contributions $ ☐☐☐,☐☐☐,☐☐☐

5. Has the coronavirus (COVID-19) had any impact on your employment or on the way your business operates? (Possible impact may include reduced working hours or duties, stood down, reduced income or revenue, changes to core business operations, working from home or reduced staffing) ☐ Yes ☐ No

If **yes**, please provide details including the date of the impact.

6. Are any of your duties hazardous (e.g. working from heights, working underground, handling dangerous substances/explosives/chemicals, handling needles, sharps or biohazardous materials)? ☐ Yes ☐ No

If **yes**, please provide details.

Hazardous activity	Maximum height/depth (metres)	Average height/depth (metres)	Average hours per week
Heights			
Underground			

Other hazardous duties/hazardous chemical use

7. Are you familiar with all applicable safe-work procedures relating to your occupation? ☐ Yes ☐ No

If **no**, please indicate the reason you gave this response.

If **yes**, do you practice these at all times when performing your work? ☐ Yes ☐ No

If **no**, please provide details of when safe-work procedures are not practiced in your occupation.

8. Do you hold all appropriate work-safety certification, where required? ☐ Yes ☐ No ☐ Not required

If **no**, please provide details of certification not currently held and of future plans to obtain this.

9. Are you considering a change in your current occupation(s), duties, working hours, employment situation(s) or financial situation (including income)? ☐ Yes ☐ No

If **yes**, please provide details (e.g. 'concluding contract in three weeks', 'moving to new permanent job in 25 days', 'retiring permanently from the workforce in 12 months').

Please complete the following section if your application relates to TPD, Income Secure, Business Expense or Living Expense Cover.

Otherwise, please **Go to G**.

10. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases).

Type of work	% of time	Please describe your specific duties and where they are performed.
Sedentary/Administration (e.g. filing, computer work, answering telephone, reception duties)		
Manual work – supervising (specify where, e.g. factory, building construction site)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5kg)		
Manual work – heavy (e.g. bricklaying, lifting, painting, carpentry, mechanic, driving heavy plant/machinery)		
Site visits/inspections (e.g. real estate sales, building industry inspector, contractor, underground)		
Other (please specify)		
Total	100%	

11. Do you possess any trade or tertiary qualifications relevant to your occupation? ☐ Yes ☐ No

If **yes**, please provide details.

Qualifications, degree, licence number, etc.

When and where was the qualification received?

12a. Do you have a second occupation? ☐ Yes ☐ No

If **yes**, please specify occupation.

b. Please provide details of duties and earnings of second occupation.

Duties

c. Current annual income earned through personal exertion, before tax, but after deduction of business expenses from second occupation?

Annual income (excluding superannuation guarantee (SG) contributions) $ ☐☐☐,☐☐☐,☐☐☐

Superannuation guarantee (SG) contributions $ ☐☐☐,☐☐☐,☐☐☐

d. Hours worked per week in second occupation ☐☐

E Further occupation details – Income Secure Cover/Business Expense Cover only

If your application does not relate to Income Secure Cover or Business Expense Cover **Go to G**.

1. Employer's name or name of business or practice

Business address no. and street

Suburb/Town State Postcode

2. Are any of your occupational duties performed at home? ☐ Yes ☐ No

If **yes**, advise how many hours you work at home and describe duties performed at home.

3. Please give details of your previous employment situation.

Previous employment situation

Industry Number of years in industry ☐☐

4. If your present employment situation started within the last 12 months, please describe the circumstances under which you changed to your current occupation e.g. promotion, commenced/ceased self-employment, started/purchased a business/practice.

5. What was your annual income earned through personal exertion from your principal occupation, before tax, but after deduction of business expenses for the two previous financial years?

Period	30/6/_____	30/6/_____
Annual Income (excluding superannuation guarantee (SG) contributions)	$	$
Superannuation guarantee (SG) contributions	$	$

If the variance between the two years is greater than 20% please advise reason(s).

6. Is any of your income likely to continue if you become disabled, e.g. sick pay, investment income, company profit share, income generated by your business while you are unable to work? ☐ Yes ☐ No

If **yes**, what is the source of this income?

How long will the income continue if you become totally disabled?

How much income will be received (annual figure) $ ☐☐☐,☐☐☐,☐☐☐

7. Have you or any entities owned or controlled by you ever been declared bankrupt or insolvent, or are you or any entities owned or controlled by you currently being declared bankrupt or insolvent? ☐ Yes ☐ No

If **yes**, please provide date, date of discharge and circumstances (if applicable).....Date declared bankrupt (dd/mm/yyyy) / /

Date discharged (dd/mm/yyyy) / /

Circumstances of bankruptcy

Please complete the following for all employment situations other than 'Employed by an Independent Employer' (i.e. complete if you are a sole trader, work for your own/family company or are in a partnership)

8. Please provide the following with respect to your business:

a. Including yourself, how many people have an ownership stake in your business?

b. What percentage of the business do you own?

c. What percentage of the business does your spouse own?

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

9. Excluding yourself, your spouse and any other partners, how many people do you/does your business employ?

Full-time ..... Part-time/Casual .....

10. In the event of your total disability, would you expect the business to continue to generate income for at least 3 months afterward? ☐ Yes ☐ No

If yes:

a. Approximately what percentage of your pre-disability income would you reasonably expect to continue to receive from the business (through salary, net profit share, etc.)

1% to 75% of pre-disability income ..... %

76% to 100% of pre-disability income ..... %

b. For approximately how long would you expect this income to continue?

11. Is your business currently trading profitably? ☐ Yes ☐ No

If no, please give full details:

Please complete if your application relates to Priority Income Option including Mortgage Maintenance and/or Superannuation Maintenance.

12. If your application relates to Mortgage Maintenance, what was the average of your share of the minimum monthly mortgage repayments made over the previous 12 months? $ ☐☐,☐☐☐ per month

13. If your application relates to Superannuation Maintenance, what were the average monthly superannuation contributions made by you or your employer over the previous 12 months? $ ☐☐,☐☐☐ per month

Please note that questions continue on the next page.

F Business Expense Cover Only

If your application does not relate to Business Expense Cover **Go to G** **.**

1. What percentage of:

a. business income is derived from your personal exertion? ..... %

b. total business expenses are you responsible for? ..... %

c. business income can be attributed to other income-producing employees? ..... %

2. Please state the number of employees and briefly describe their duties.

3. If working in a partnership, please specify how many partners you have: .....

4. Eligible expenses – please provide details in the table below of any average monthly expenses for which you are responsible and which will continue during your absence.

	Annual amount
If income splitting exists, please indicate the annual amount paid to your spouse (please do not include this amount in the expenses below)	$

Details of expenses (excluding recoverable GST)	Monthly amount
Accounting and audit fees	$
Bank fees and charges	$
Office cleaning costs	$
Electricity, gas, water and property rates	$
Equipment hire and motor vehicle leases	$
Business related insurance premiums (not including premiums for this Business Expense Cover)	$
Minimum monthly loan repayments, as per the relevant loan agreement, on:	
• business loans (short-term and long-term bank debt that relates to the operations and capitalisation of the business) including mortgage repayments on the business premises	$
• finance lease payments relating to plant and equipment loans	$
Office rent or leasing fees	$
Salaries and superannuation contributions for employees not directly involved in the generation of revenue	$
Payroll tax for the above salaries	$
Regular advertising costs	$
Telephone costs	$
Subscriptions/fees/dues to professional associations	$
Net cost of a locum (a person from outside your business who is a direct replacement for you in your business), less any business earnings generated by the locum	$
Other expenses*	$
Total	$

* Other expenses cannot include personal remuneration, salary, fees or drawings, payments to related entities or businesses also owned or controlled by you or an immediate family member, cost of goods or merchandise, cost of implements to the life insured's profession, salaries and superannuation contributions for employees directly involved in the generation of income, depreciation and the purchase cost of any assets, tools or other capital items.

Please fully describe other expenses.

Please note that questions continue on the next page.

G Pastimes

1. Have you any intention of engaging in:

a. motorcycle riding other than as a means of transportation to and from work (e.g. offroad, racing)? ☐ Yes ☐ No

b. any hazardous activities, sports or pastimes e.g. motor or water sports (such as canoeing), football, parachuting, gliding, recreations involving heights, underwater sports, caving, body contact sports, hang gliding? ☐ Yes ☐ No

c. aviation, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered yes to any of questions 1a, b or c above, please complete the relevant questionnaire(s) on page 40.

H Personal health statement

1. What is your current height and weight? Height (cm) ☐ Weight (kg) ☐

2. Has your weight varied by more than 10kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance, or used any form of electronic cigarette? ☐ Yes ☐ No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Chantix, etc.)? ☐ Yes ☐ No

If **yes**, please state **type(s)** used and **length of time** you have been using this.

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No

If **yes**, please state **type**, **quantity** per day and **date** ceased.

6. Do you consume alcohol? ☐ Yes ☐ No

If **yes**, please state how many standard drinks you consume **per** day (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop or reduce your alcohol intake or stop smoking due to a medical condition? ☐ Yes ☐ No

If **yes**, please provide full details.

8. Have you within the past five years suffered a needle stick injury? ☐ Yes ☐ No

If **yes**, please provide date of incident, dates and results of all follow up blood tests.

9. Have you had or are you awaiting a test for coronavirus (COVID-19)? ☐ Yes ☐ No

If **yes**, please provide details, including the date of the test and the outcome if known.

10. Are you currently in quarantine or enforced self-isolation for coronavirus (COVID-19) due to possible infection? ☐ Yes ☐ No

If **yes**, please provide details, including when this commenced and when it is scheduled to finish.

Please note that questions continue on the next page.

I Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)? ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).

J Medical history

To the best of your knowledge, have you ever had any of the following (please tick the appropriate box and circle the specific conditions that are applicable):

1. Asthma? ☐ Yes ☐ No
2. High blood pressure? ☐ Yes ☐ No
3. High cholesterol? ☐ Yes ☐ No
4. Diabetes? ☐ Yes ☐ No
5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No
6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No
7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No
8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 31 to 39.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart trouble or murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits, hydrocephalus, dizziness, fainting of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No
18. Cancer (including carcinoma in situ of any organ), tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No
19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No
20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? ☐ Yes ☐ No
22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No
23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No
24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No
25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No

Please note that questions continue on the next page.

26. Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)? ☐ Yes ☐ No

27. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No

28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation, or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc.) ☐ Yes ☐ No

29. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No

30. Have you ever used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? ☐ Yes ☐ No

31. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No

32. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition? ☐ Yes ☐ No

33. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted infection including but not limited to HIV (AIDS), gonorrhoea or syphilis? ☐ Yes ☐ No

34a. Is the combined total of your existing insurance(s) detailed in section C2 question 1c, and any new insurance you are applying for with OnePath Life, more than any one of the following; $500,000 Life; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? ☐ Yes ☐ No

If you answered **yes** to question 34a, please proceed to 34b, otherwise continue to question 35.

34b. Have you ever had, or have you scheduled an appointment to have, a genetic test where you received (or are currently awaiting) an individual result? (please do not include any test conducted solely for the purpose of a medical research study where the result of the test has not been or will not be, provided to you) ☐ Yes ☐ No

35. Females only

a. Have you ever had any complications with pregnancy or childbirth (e.g. gestational diabetes)? Please do not include an elective caesarean section or miscarriage within the first 15 weeks of pregnancy as complications ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date (dd/mm/yyyy) / / ☐ Yes ☐ No

c. Are you currently on maternity leave or intending to take maternity leave? If **yes**, please advise date due to return to work. (dd/mm/yyyy) / / ☐ Yes ☐ No

d. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

e. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered **yes** to any questions from 9 to 35, please complete the following table.

Question number	
Disability, illness, injury or condition	
Investigation type(s) and result(s)	
Date of first symptoms (dd/mm/yyyy) / /	Frequency of symptoms
Type of treatment	
Date treatment provided and ceased (dd/mm/yyyy): From / / to / /	
Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No	
Time off work	
Have you completely recovered? ☐ Yes ☐ No	Date of last symptoms (dd/mm/yyyy) / /
Name and address of medical facility and attending doctor	

Please note that questions continue on the next page.

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Please note that questions continue on the next page.

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? ☐ Yes ☐ No

Time off work

Have you completely recovered? ☐ Yes ☐ No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

K Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone Fax

No. and street

Suburb/Town State Postcode

2. How many years have you been attending this doctor/medical centre?.....Years ☐☐ Months ☐☐

3. Please advise the approximate date of your last consultation with your usual doctor.

4. Please advise the reason for your last consultation with your usual doctor.

*Note: If **"check up"** please advise the outcome below

5. Please indicate the outcome of the consultation, including the results of any tests, any treatment or medication prescribed and the nature of any planned investigations or recommended referrals.

Outcome	Degree of recovery

6. Have you had any consultations with your doctor or any other medical professional regarding any illness, injury, prescription medication or any other medical issue within the last five years that you have not already indicated in sections above in J or K.

☐ Yes ☐ No

If **yes,** please provide details below

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		

Please note that questions continue on the next page.

L TPD Cover (non-working) or Living Expense Cover

If your application does not relate to TPD Cover (non-working) or Living Expense Cover **Go to M** **.**

1. What is your annual household income?

$0 to $30,000 ☐
$30,001 to $50,000 ☐
$50,001 to $65,000 ☐
$65,001 to $80,000 ☐
$80,001 and over ☐

Please continue to complete this section only if you are age 65 or over.

2. Do you have children? ..... ☐ Yes ☐ No

If **yes**, how many?

3. Are you involved in social activities (e.g. bowls, golf, trips, volunteer work)? ..... ☐ Yes ☐ No

If **yes**, describe what type.

4. Do you have family that lives close by, with whom you have regular contact? ..... ☐ Yes ☐ No

5. Are there any duties you are unable to perform as part of your normal daily activities due to physical, mental, emotional or memory problems?

Bathing and showering ..... ☐ Yes ☐ No
Using the toilet, including getting up and down ..... ☐ Yes ☐ No
Dressing and undressing, including putting on shoes and socks ..... ☐ Yes ☐ No
Doing work around the house or garden ..... ☐ Yes ☐ No
Eating and drinking, including cutting up food ..... ☐ Yes ☐ No
Managing money such as paying bills and keeping track of expenses ..... ☐ Yes ☐ No
Shopping for groceries ..... ☐ Yes ☐ No
Making telephone calls ..... ☐ Yes ☐ No
Taking medications ..... ☐ Yes ☐ No
Walking across a room ..... ☐ Yes ☐ No
Getting in and out of bed ..... ☐ Yes ☐ No

If you answered **yes** to any part of question 5, please give details.

6. Do you need assistance with walking? ..... ☐ Yes ☐ No

If **yes**, please give details (e.g. walking stick, zimmer frame, wheelchair).

7. If you have answered **yes** to questions 5 or 6 above, does anyone help you with these activities? ..... ☐ Yes ☐ No

If **yes**, what relationship does the person providing assistance have to you (e.g. husband, daughter, friend, health worker, etc.)?

Please note that questions continue on the next page.

M Child Cover only

If your application does not relate to Child Cover **Go to 2. Questionnaires** **.**

1. Do any of the children have any Life, TPD or Trauma Cover with OnePath Life or any other company? ☐ Yes ☐ No

If **yes**, please provide details.

Name of child	Gender	Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?
1.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No
2.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No
3.				$ ☐,☐☐☐,☐☐☐	/ /	☐ Yes ☐ No

	Child 1		Child 2		Child 3	
2. Has this child ever had:						
• high blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• rheumatic fever or any heart complaint?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• asthma, tuberculosis or any other lung disease?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• cancer, cyst, lesion or tumour of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• diabetes?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• indigestion, or gastric or duodenal ulcer?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• epilepsy, fainting attacks or fits of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• a physical or neurological defect, impaired sight or hearing?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• anaemia, leukaemia, haemophilia or any other blood disorder?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• kidney, liver or gall bladder problems, including hepatitis of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• or been diagnosed with, investigated for or displayed symptoms of any form of mental underdevelopment, incapacity or retardation?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
3. Has this child ever:						
• been advised to have an operation or surgery in the future?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• been infected with the virus which causes AIDS (the Human Immunodeficiency Virus) or are they carrying antibodies to that virus?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• been injected with or used any drug not prescribed by a medical practitioner?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• received a blood transfusion or treatment with human blood products?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
4. Has the child's mother, father, brother or sister:						
• suffered from diabetes, heart disease, cancer, stroke, mental disorder or breakdown, kidney disorder, Huntington's disease, multiple sclerosis, muscular dystrophy, motor neurone disease or any hereditary disease?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

For any **yes** answer for questions 2, 3, or 4, please advise the name of condition, dates of treatment, name and address of doctors or hospitals consulted and the relationship of the person who had the condition to the child.

Child 1

Child 2

Child 3

2. Questionnaires

A Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in J.

1. When did you have your first episode of asthma? ..... (dd/mm/yyyy) / /

2. When was your most recent episode of asthma? ..... (dd/mm/yyyy) / /

3. Approximately how many episodes have occurred in the last 12 months?

4. Have you ever suffered from nocturnal asthma attacks? ..... ☐ Yes ☐ No

If **yes**, please provide the frequency of these attacks and approximate date of last attack.

(dd/mm/yyyy) / /

5. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ..... ☐ Yes ☐ No

If **yes**, please provide details.

7. Have you sought medical treatment or advice for asthma? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

8. How has your doctor described your asthma? ..... ☐ Mild ☐ Moderate ☐ Severe

9. Have you ever used any medication, including steroids? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

10. Have you ever been hospitalised due to asthma? ..... ☐ Yes ☐ No

If **yes**, please provide details ..... From (dd/mm/yyyy) / / to (dd/mm/yyyy) / /

Name and address of hospital

11. Have you ever had lung function tests performed? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

B Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in J.

1. When was your high blood pressure first diagnosed? ..... (dd/mm/yyyy) / /

2. What was your blood pressure reading at that time? ..... Systolic ____ Diastolic ____

3. Have you ever been treated by medication? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Name ____

Address ____

Suburb/Town ____ State ____ Postcode ____

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last blood pressure check? ..... (dd/mm/yyyy) / /

7. What was your blood pressure reading at that time? ..... Systolic ____ Diastolic ____

8. How has your doctor described your blood pressure control? ..... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

____

____

____

9. What is the date of your next blood pressure check-up? ..... (dd/mm/yyyy) / /

C Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in J.

1. When was your high cholesterol first diagnosed? ..... (dd/mm/yyyy) / /

2. What were your cholesterol readings at that time? Cholesterol ____ Triglycerides ____ HDL Cholesterol ____ LDL Cholesterol ____

3. Did you undergo any tests or investigations? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

4a. Have you ever used any medication? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ..... ☐ Yes ☐ No

If **yes,** please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

6. What was the date of your last cholesterol check? ..... (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol ____ Triglycerides ____ HDL Cholesterol ____ LDL Cholesterol ____

8. How has your doctor described your cholesterol control? ..... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? ..... (dd/mm/yyyy) / /

D Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in J.

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed? (dd/mm/yyyy) / /

3. How is your diabetes controlled?

☐ Insulin – go to question 4

☐ Diet only – go to question 5

☐ Oral – list medications below and then go to question 5

4. How many times a day do you administer insulin?

☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

5. How often do you monitor your sugar levels?

☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details.

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details.

Condition	Date (dd/mm/yyyy)	Treatment
	/ /	
	/ /	

7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details.

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

8. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

E Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in J.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa or bulimia
- ☐ Depression including major depression or dysthymia
- ☐ Manic depressive illness or bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness
- ☐ Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable)
		/ /	
		/ /	
		/ /	
		/ /	

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

Date (dd/mm/yyyy)	Details
/ /	
/ /	

4. Are you currently symptom free? ☐ Yes ☐ No

5. Date of last symptoms (dd/mm/yyyy) / /

6. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

7. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details.

8. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

Please note that questions continue on the next page.

9. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details.

Treatment (e.g. tranquilisers, sedatives, ECT, counselling)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details.

11. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details.

Date of last consultation (dd/mm/yyyy) / /

Name of consultant

Address

Suburb/Town State Postcode

12. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details.

Date last admitted (dd/mm/yyyy) / /

Name of institution

Address

Suburb/Town State Postcode

Doctor(s) consulted

13. Does your usual doctor, as advised in section K, have details of this condition(s)? ☐ Yes ☐ No

Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

F Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in J.

1. When did your back/neck condition first occur? (dd/mm/yyyy) / /

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash).

5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No

If **yes**, please provide details.

Tests	Results	Date of tests (dd/mm/yyyy)
		/ /
		/ /

6. Have you had recurrent or multiple episodes of the back/neck condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? (dd/mm/yyyy) / /

G Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in J.

1. Which joint is/was affected (please tick relevant box(es))? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other	☐	☐
Knee	☐	☐	If **other**, state which joint		

2. When did this condition first occur? ..... (dd/mm/yyyy) / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? ..... ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? ..... ☐ Yes ☐ No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition? ..... ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? ..... ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your condition is: ..... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? ..... (dd/mm/yyyy) / /

H Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in J.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each.

Date of removal (dd/mm/yyyy) / /

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

I Pastime questionnaire

Only complete this questionnaire if you answered **yes** to question 1a, b or c in J.

Motorcycle/Motor racing

Vehicle type including the class or formula and engine capacity (cc)

Races p.a. Max. speed (km/h)

Do you have a Motorcycling Australia (MA), FIM international or similar licence? ☐ Yes ☐ No

If **yes**, please advise which licence you hold and when you obtained.

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Scuba/Skin diving

Average depth (m) Maximum depth (m) Dives p.a

Do you use explosives? ☐ Yes ☐ No

Do you dive in wrecks, caves or potholes? ☐ Yes ☐ No

If **yes**, to either of the above please give details.

Football/Soccer/Australian Rules, etc.

Code played and grade Games p.a.

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income for participating in Football/Soccer/Australian Rules etc.? ☐ Yes ☐ No

If **yes**, please provide amount and details.

Aviation/Flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes,** state type and period held.

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

Please complete the table below.

No. of hours flown	**Past 12 months**		**Future annual average**	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

Other sports or pastimes

Do you participate in any other hazardous activities or sports (e.g. competitive riding, mountain climbing, body contact sports)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Adviser notes

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