FINANCIAL ADVICE FOR PROFESSIONALS

MAP Superannuation Plan Application Form

18 May 2018

MAP Superannuation Plan ABN 71 603 157 863, SFN 2967 359 49, SPIN MAP0005AU, APRA Registrable Superannuation Entity No R1001587 is issued by Diversa Trustees Limited ABN 49 006 421 638, AFSL No 235153 RSE Licence No L0000635 (referred to as Diversa, we, our, us, the Trustee).

IMPORTANT INFORMATION. Before completing this form you must read the MAP Superannuation Plan Product Disclosure Statement (PDS) dated 18 May 2018.

Please complete this form in BLOCK LETTERS. Questions? Call us on 1800 640 055 or email enquiries@mapfunds.com.au.

Are you an existing / previous MAP Member?

☐ No

☐ Yes Please enter your existing / previous member number

Personal Details

Title Surname

Given Name(s)

Date of Birth

Gender ☐ Male ☐ Female ☐ Indeterminate/Unspecified /Intersex

Tax File Number (It is not compulsory to quote your TFN)

☐ My Tax File Number is:

I understand that this information will be used strictly for the purpose of compliance with Australian Federal taxation laws and will, if appropriate, be forwarded to the Australian Taxation Office (ATO).

☐ I do not wish to provide my Tax File Number. I understand the consequences of not providing my TFN.

Address Details

Residential Address

State Postcode

Postal Address (if same as Residential Address write "as above")

State Postcode

Contact Details

Phone (home) Phone (work) Phone (fax)

Phone (mobile) Email

Employment Details

Employment Status

☐ Full-Time ☐ Part-Time ☐ Permanent Part-Time ☐ Casual ☐ Employee Of Your Own Company

☐ Not Employed (go to Your Investment Choice) ☐ Self-Employed /Substantially Self-Employed

Occupation

Business / Company Name

Employer Postal Address

State Postcode

Employer Phone

Employer Fax

Date You Joined Your Employer

D D / M M / Y Y Y Y

Are You Currently In Active Employment*?

☐ Yes ☐ No

*Active Employment means you are gainfully employed (including being on Employer approved leave except leave caused by illness or injury) and attending work and performing your normal duties and hours without restriction due to illness or injury.

Your Investment Choice

MAP Super offers eight (8) investment options. Please nominate the investment option/s you wish to invest in. You can select one option, or a combination of options, however your total nomination must equal to 100%.

Australian Equities	International Equities	Diversified Property	Cash	Capital Stable	Balanced Moderate	Balanced	Growth	Total
%	%	%	%	%	%	%	%	100%

Death Benefit Nomination

In the event of my death, I request the Trustee of the MAP Superannuation Plan to distribute my benefit as set out below.

Please select one of the below options:

☐ Non-Binding Nomination: I understand that my nomination is not binding on the Trustee of the MAP Superannuation Plan

	Beneficiary Name	Relationship	Proportion
1			%
2			%
3			%
4			%
		Total Proportion	100%

☐ Binding Nomination: Please complete a Binding Death Benefit Nomination Form (available at www.mapfunds.com.au)

☐ I do not wish to make a Death Benefit Nomination

Insurance Cover

MAP Super offers two types of insurance cover – personal and employee. The type of insurance cover available to you is determined by your employment status;

Your employment status:	You are eligible to apply for:
You are self-employed	Personal Cover
You are an employee of your own company or of a Participating Employer [1]	Either Personal Cover or Employee Cover
You are neither of the above	Personal Cover

[1]Participating Employer means an employer who makes or agrees to make contribution payments to the MAP Superannuation Plan.

Please indicate which insurance cover type you are eligible to apply for:

☐ Personal Cover ☐ Employee Cover

Provided you meet eligibility conditions, when you sign up to MAP Super you receive Default Death and TPD Cover. The level and cost of insurance cover will depend on whether you are eligible for Personal or Employee Cover.

NOTE: You do not need to complete any additional paperwork to receive Default Cover.

Other Insurance Options

☐ I wish to apply for Death Only or Death and TPD insurance in excess of, the Default Cover. (Please complete the Insurance Application Form on pages 5 to 17 of this document.)

☐ I wish to apply for Income Protection Insurance. (Please complete the Insurance Application Form on pages 5 to 17 of this document.)

☐ I wish to decrease my Default Cover or downgrade my Default Cover to Death Only Cover (Please submit this request in writing to us.)

☐ I wish to opt-out of Default Cover. (You do not need to complete any additional paperwork.)

Privacy

We are committed to protecting the privacy of information you have provided to us in relation to your investments. The information provided is only used to administer your investment, to communicate with you about your investment and to ensure that you receive the benefits relating to your investment.

We do not normally disclose member information to outside parties, except those contracted to provide services to the MAP Superannuation Plan. These include the Fund's Auditors, Lawyers, Custodian and Insurer. If you, or anyone else on your behalf, makes a claim for a benefit, the Insurer may give or receive information about you to or from medical practitioners, legal practitioners, health service providers, past or present employers, other consultants, experts and companies in order to assess and process the claim.

With your written consent, we will disclose information about your MAP Superannuation Plan investment to your accountant, financial consultant or others you have nominated. Personal information may also be disclosed to the Australian Taxation Office or other government authorities or agencies as required by law.

Promotional Mail

☐ Please tick here if you do not wish to receive promotional material.

Declaration

- I have received and read the Product Disclosure Statement dated 18 May 2018 and any supplementary information to this document,
- I apply to become a participant in the MAP Superannuation Plan,
- I declare that all of the details on the application are correct,
- I understand the conditions I must meet to be eligible for Default Personal Cover or Default Employee Cover (see pages 6 and 7 of the PDS),
- I understand that insurance cover requiring underwriting as outlined on pages 6 to 8 of this PDS requires me to complete the Insurance Application Form at the back of this document,
- I consent to the collection and disclosure of information about me for the purposes outlined above,
- I give the MAP permission to contact my employer if required to confirm my employment, and
- Upon acceptance of my application, I agree to be bound by the provisions of the Trust Deed dated 28 Jul 1994 as amended from time to time which relates to the MAP Superannuation Plan.

Signature

Date

D D / M M / Y Y Y Y

Privacy Policy - The information you are providing in this form is subject to the Privacy Amendment (Private Sector) Act 2000. The Act sets out principles for dealing with personal information which includes standards for collection, storage, accuracy and use of information and for disclosure required by the Australian Taxation Office as well as your right to access your personal information which we hold. MAP has developed policies for complying with this legislation which you may view on request.

MAP Superannuation Plan Insurance Application Form

18 May 2018

MAP Superannuation Plan ABN 71 603 157 863, SFN 2967 359 49, SPIN MAP0005AU, APRA Registrable Superannuation Entity No R1001587 is issued by Diversa Trustees Limited ABN 49 006 421 638, AFSL No 235153 RSE Licence No L0000635 (referred to as Diversa, we, our, us, the Trustee).

COMPLETE THIS FORM ONLY IF YOU WANT COVER IN EXCESS OF OR INSTEAD OF DEFAULT COVER OR IF YOU WANT INCOME PROTECTION COVER.

IMPORTANT INFORMATION. Before completing this form you must read the MAP Superannuation Product Disclosure Statement (PDS) dated 18 May 2018.

1 Member details

MAP Account Number

Date of Birth

Title

Given Name(s)

Surname

Postal Address

Residential Address (if same as Postal Address write "as above")

Phone (home)

Phone (work)

Phone (mobile)

Email

2 Employment Details

Employment Status

☐ Full-Time ☐ Part-Time ☐ Permanent Part-Time ☐ Casual ☐ Employee Of Your Own Company

☐ Not Employed (go to Death Only and Death and TPD Insurance) ☐ Self-Employed /Substantially Self-Employed

Occupation

Business / Company Name

Employer Postal Address

Employer Phone

Employer Fax

If you are self-employed or an employee of your own company: How long have you been self employed? ☐ years ☐ months

☐ % of business you own ☐ No. of employees (excluding yourself)

3 Death only and Death and Total and Permanent Disablement (TPD) Insurance

Do you wish to apply for Death Only or Death & TPD Insurance in excess of or instead of Default Cover?

☐ No (Go to Income Protection Insurance) OR ☐ Yes (complete this section for EITHER personal cover or employee cover)

PERSONAL COVER ONLY

☐ I already have MAP Group Life cover (including Default Cover) which I would like to increase as shown (do not complete if you wish to increase cover due to a Lifetime Event – see below):

	Death Only ($)	Death & TPD ($)
Amount of MAP cover I currently have (including default cover)		
ADD: I would like to increase my current cover by the amount shown:		
EQUALS: Total cover required:		

	Death Only ($)	Death & TPD ($)
☐ I don't currently have MAP Group Life cover. I would like to apply for:		
	No Maximum	Maximum $3m total cover, all sources

☐ Due to a Lifetime Event* I wish to increase my cover by ☐ Must be the lesser of 25% of agreed benefit, $200,000 or amount of / increase in mortgage

* Includes the purchase of a home, marriage, birth or adoption of a child. See the MAP Superannuation Plan Additional Information Guide for details.

☐ I wish to upgrade my Personal Default Cover to Full cover (equal to Default Cover amount with 36 Limited Cover condition removed).

ADDITIONAL INFORMATION YOU NEED TO PROVIDE TO APPLY FOR DEATH ONLY OR DEATH & TPD COVER

- For cover less than $1 million total cover, complete a Short Form Personal Statement (Section 5).
- For cover greater than $1 million total cover, complete a Personal Statement & Declaration of Health (Section 6).
- For Increase in cover due to a Lifetime Event attach a certified copy of your marriage certificate, your child's birth certificate or loan agreement and go straight to Privacy, Duty of Disclosure and Declaration (Section 7).
- To decrease your default cover or to change your default cover to Death Only, request this in writing to MAP.

EMPLOYEE COVER ONLY

☐ I already have MAP Group Life cover (including Default Cover) which I would like to increase as shown (do not complete if you wish to increase cover due to a Lifetime Event – see below):

	Death Only (units)	Death & TPD (units)
Amount of MAP cover I currently have (including default cover)		
ADD: I would like to increase my current cover by the amount shown:		
EQUALS: Total cover required:		

	Death Only (units)	Death & TPD (units)
☐ I don't currently have MAP Group Life cover. I would like to apply for:		
	No Maximum	Maximum $3m total cover, all sources

☐ Due to a Lifetime Event* I wish to increase my cover by one (1) unit.

* Includes the purchase of a home, marriage, birth or adoption of a child. See the MAP Superannuation Plan Additional Information Guide for details.

ADDITIONAL INFORMATION YOU NEED TO PROVIDE TO APPLY FOR DEATH ONLY OR DEATH & TPD COVER

- For cover less than $1 million total cover, complete a Short Form Personal Statement (Section 5).
- For cover greater than $1 million total cover, complete a Personal Statement & Declaration of Health (Section 6).
- For Increase in cover due to a Lifetime Event attach a certified copy of your marriage certificate, your child's birth certificate or loan agreement and go straight to Privacy, Duty of Disclosure and Declaration. (Section 7)
- To decrease your default cover or to change your default cover to Death Only, request this in writing to MAP.

4 Income Protection Insurance

Do you wish to apply for Income Protection Insurance?

☐ No (go to section 5) ☐ Yes If yes, are you applying for: ☐ New insurance? OR ☐ An increase in existing insurance?

Benefit Period

☐ 2 years

OR

☐ To age 65

Waiting Period

☐ 30 days

OR

☐ 90 days

Benefit Amount

What is your Annual Salary* (excluding superannuation)? $

The benefit you require (as a % of your annual salary): %

Max. 75% but not greater than $25,000/month

Do you require optional Employer Superannuation Contribution Cover? (not available for self-employed)

☐ Yes % OR ☐ No

Max 10% but not greater than actual contribution amount
(this is included in your max $25,000 per month benefit)

ADDITIONAL INFORMATION YOU NEED TO PROVIDE TO APPLY FOR INCOME PROTECTION COVER

- Complete a Personal Statement & Declaration of Health (Section 6).

* Definition of Salary: Where the member does not directly or indirectly own part of their employer, salary is pre-tax salary from the employer but not including any director's fees, commissions, overtime payments, bonuses, penalty or shift allowances, investment income, income received from deferred compensation plans, disability income policies or retirement plans, income not derived from vocational activities, unless the Insurer has expressly agreed otherwise. Where the person directly or indirectly owns part or all of a business or practice which is their employer, salary is the annual share of the income of that business or practice generated by their personal exertion in the previous 12 months after the deduction of their share of expenses in generating that income, or any other income the Insurer has expressly approved.

5 Short form personal statement

IF YOU ARE REQUIRED TO COMPLETE A PERSONAL STATEMENT AND DECLARATION OF HEALTH, DO NOT COMPLETE A SHORT FORM PERSONAL STATEMENT, GO STRAIGHT TO PERSONAL STATEMENT AND DECLARATION OF HEALTH (SECTION 6).

Personal Details

Occupation

Height Weight

cm kg

Health Questionnaire

(Before you begin, please read the Duty of Disclosure warning at the back of this form). Tick either"No" or"Yes" for each question:

(1)	Have you had any medical advice, investigation or treatment for any of the following:		
(a)	Chest pain, indigestion or ulcer?	No	Yes
(b)	High blood pressure, rheumatic fever, or any heart disorder or complaint?	No	Yes
(c)	Cancer or tumour of any type?	No	Yes
(d)	Mental illness, depression, nervous conditions, stress or fatigue?	No	Yes
(e)	Diabetes, any ailment or condition relating to the thyroid, bowel, liver, gall bladder, kidney or bladder (including thyroidism, renal colic, nephritis, pyelitis, cystitis or irritable bowel syndrome)?	No	Yes
(f)	Any disease or injury to the head, neck or spine including back strain, disc disorder, lumbago, fibrositis, sciatica or neuritis?	No	Yes
(g)	Tendonitis, tenosynovitis, RSI or Regional Pain Syndrome, arthritis, gout or any other injury, deformity or disease involving any joint or limb?	No	Yes
(h)	Fainting attacks, fits of any kind, epilepsy, paralysis or stroke?	No	Yes
(i)	Anaemia, Leukaemia, Haemophillia or any other blood disorder?	No	Yes
(j)	Any sexually transmitted disease?	No	Yes
(k)	Coughing of blood or passage of blood from the bowel or in the urine?	No	Yes
(l)	Any skin disorders or conditions; any congenial abnormality?	No	Yes
(2)	Any impairment of sight, hearing or speech?	No	Yes
(3)	Have you required surgical treatment, medical examinations, investigations, X-rays or blood tests?	No	Yes
(4)	During the last 5 years, have you taken, or been prescribed any medication or drug, such as stimulants, sedatives or tranquillisers? If yes, list name of drug and dosage below:	No	Yes
(5)	Has any insurance company ever refused, set special conditions, or charged a higher than normal premium for life or disability insurance cover on your life?	No	Yes
(6)	Have you ever made a claim for or received benefits under disablement insurance, Workers compensation, Motor Vehicle Accident Insurance, Social Security sickness or invalid benefits or Veterans Affairs sickness or invalid benefits?	No	Yes
(7)	Have any of your Parents, Brothers or Sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer or other hereditary disorder? If yes, provide details below:	No	Yes
(8)	Do you engage in any hazardous pastimes or pursuits including motor sports, private flying, scuba diving, abseiling, parachuting, competitive football, etc? If yes, please provide details below:	No	Yes

If you answered"yes" to any question above, please provide full details below, or alternatively attach more information or paper where required.

5 DOCTOR DETAILS

My regular doctor's name and address:

Name

Address

State Postcode

Date of last consultation

D D / M M / Y Y Y Y

How long has this doctor known you?

Reason for and result of last consultation

Aids Statement

Please tick No or Yes to each of the following:

Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus)?	☐ No	☐ Yes
Have you EVER sought or are expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV?	☐ No	☐ Yes
Have you EVER injected yourself with any drug not prescribed by a medical practitioner, engaged in male to male anal sexual activity or worked as or engaged in sexual activity with a prostitute or someone you know or suspect to be HIV positive?	☐ No	☐ Yes

If you answered"Yes" to any question above, please provide full details below, or alternatively attach more information or paper where required:

6 Personal Statement and Declaration of Health

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR DEATH ONLY OR DEATH & TPD COVER GREATER THAN $1 MILLION TOTAL COVER OR IF YOU ARE APPLYING FOR INCOME PROTECTION COVER.

Insurance History

Has Life, Disability, Accident and Sickness or Superannuation cover on your life ever been declined, deferred or withdrawn from any Insurance Company or accepted with a loading, exclusion or other than as applied? ☐ No ☐ Yes

If you answered"yes", please provide full details (including dates, name of company and reason):

Have you ever made a claim for disability benefits under an Insurance, Superannuation or Worker's Compensation policy, Veterans Affairs or under Social Security or Centrelink (including CTP and public liability)? ☐ No ☐ Yes

Please provide full details (including dates, cause of claim, type of benefit and amount paid, claim number and insurance company):

Other than this application, do you have or are you applying for Life, TPD, Trauma, Disability Income or Income Protection with any other company?

If yes, please provide full details:

Company	Type of Policy	Benefit Amount	Owner	To be replaced
				☐ No ☐ Yes
				☐ No ☐ Yes

Habits, Activities and Residence

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

Do you drink alcohol?
☐ No ☐ Yes Please state type and weekly quantity:

Have you smoked in the last 12 months?
☐ No ☐ Yes Please state form and daily quantity:

Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a recognised airline), motor racing of any kind, diving, football, parachuting, hang gliding, etc?
☐ No ☐ Yes Please provide full details:

Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's visa?
☐ No ☐ Yes Please provide full details

Do you intend travelling overseas in the immediate future (i.e. next 2 years)?
☐ No ☐ Yes Please give full details (where, when, duration and reason):

Occupation Details

Occupation

How long have you been in your current occupation?

Years months

How many hours do you work per week?

What are your principal duties and where do you perform these duties?

Duties (eg sales, office work)	% of time	Location (eg office, driving (local, interstate))	% of time

Do you hold any professional / trade qualifications? No Yes (please provide details)

Qualification obtained	Name of institution where obtained

Has your main occupation, employer or employment status changed in the last three (3) years? No Yes (please provide details)

Previous Occupation	Employer	Employment Status*	Date from	Date to

*Employment Status (eg unemployed, employed, employed by own company, self employed, partnership)

Do you have any other occupation? No Yes (please provide details)

Occupation

Name of Employer

How long have you been in this other occupation?

years months

How many hours do you work per week in this other occupation?

What is your monthly income from this other occupation?

$

Financial Details

COMPLETE THE FINANCIAL DETAILS SECTION ONLY IF YOU ARE APPLYING FOR INCOME PROTECTION INSURANCE, OTHERWISE GO TO MEDICAL STATEMENT. PLEASE NOTE THAT BASED ON THE FINANCIAL INFORMATION BELOW, ADDITIONAL FINANCIAL INFORMATION MAY BE REQUIRED.

If disabled, would all or part of your income continue?
(eg sick leave, other disability income policies, pension, investment, rental, company profit share, etc)

No Yes (please provide details)

Financial Details continued..

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

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

Last tax year Y Y Y Y

Remuneration $ How much of this was commission / bonus / overtime? $

Previous tax year Y Y Y Y

Remuneration $ How much of this was commission / bonus / overtime? $

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

Last tax year Y Y Y Y Previous tax year Y Y Y Y

	Business $	Your share $	Business $	Your Share $
Gross Income				
LESS Business Expenses				
Net Income (Loss)				
PLUS the following paid to you				
Wages / salary / drawings / Director's fees				
Superannuation costs				
Total				

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

Medical Statement

Name and address of your Doctor:

Name

Address

State Postcode

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

Date	Health Professional	Address	Reason	Outcome / Result

Your height cm

Your weight kg

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

Within the LAST THREE YEARS have you, other than advised above:

(a) Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation? ☐ No ☐ Yes

(b) Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection? ☐ No ☐ Yes

Have you EVER had an ECG, x-ray, transfusion, mammogram, surgery or any other investigation? ☐ No ☐ Yes

Have you EVER had any blood tests which revealed an abnormality, eg raised blood sugar, liver function or renal function results, or anaemia, etc? ☐ No ☐ Yes

Do you contemplate seeking any medical examination, advice, treatment or surgery in the future? ☐ No ☐ Yes

Please provide full details for all YES answers to the questions above. If more space is required, please go to Additional Information.

Date	Health Professional	Address	Reason	Outcome / Result

Have you EVER received any advice or treatment for:

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

Females only

(r)	Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc)?	☐ No	☐ Yes
(s)	Have you ever had any complications of pregnancy or childbirth?	☐ No	☐ Yes
(t)	Are you currently pregnant?	☐ No	☐ Yes
	If yes, what is the expected date of delivery?	D D / M M / Y Y Y Y	
(u)	Have you ever had a breast lump (even if you have not seen a doctor about it)?	☐ No	☐ Yes

Please provide full details for all YES answers to the above questions on the following page.

Please provide full details for all YES answers to the questions on the previous page. If more space is required, please attach a separate sheet addressing the questions below.

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

Family History

Please tick No or Yes:

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

☐ No ☐ Yes (please provide full details Including age at diagnosis and age at death, if applicable)

Questions in Relation to AIDS

Please tick No or Yes to each of the following:

Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus)? ☐ No ☐ Yes

Have you EVER sought or are expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV? ☐ No ☐ Yes

Have you EVER injected yourself with any drug not prescribed by a medical practitioner, engaged in male to male anal sexual activity or worked as or engaged in sexual activity with a prostitute or someone you know or suspect to be HIV positive? ☐ No ☐ Yes

If you answered"yes" to any question above, please provide full details below, or alternatively attach more information or paper where required:

Additional Information (to assist with clarification of any issue)

Please use this section to assist with clarification of any issue.

Please attach additional pages if there is insufficient room. Are you attaching additional pages? ☐ No ☐ Yes

7 Privacy, and Duty of Disclosure

PRIVACY

We are committed to protecting the privacy of information you have provided to us in relation to your investments. The information provided is only used to administer your investment, to communicate with you about your investment and to ensure that you receive the benefits relating to your investment. We do not normally disclose member information to outside parties, except those contracted to provide services to the MAP Superannuation Plan. These include the Fund's Auditors, Lawyers, Custodian and Insurer. If you, or anyone else on your behalf, makes a claim for a benefit, the Insurer may give or receive information about you to or from medical practitioners, legal practitioners, health service providers, past or present employers, other consultants, experts and companies in order to assess and process the claim. With your written consent, we will disclose information about your MAP Superannuation Plan investment to your accountant, financial consultant or others you have nominated. Personal information may also be disclosed to the Australian Taxation Office or other government authorities or agencies as required by law.

IMPORTANT INFORMATION FROM THE INSURANCE PROVIDER REGARDING PRIVACY

Note: References to 'we', 'us', or 'our in the following two paragraphs refer to the Insurance Provider, Hannover Life Re of Australasia Ltd (HLRA), Level 7, 70 Phillip Street, Sydney NSW 2000, Tel: 02 9251 6911, Fax: 02 9251 6862.

Privacy Act 1988 - Our Obligations under the Act

The Privacy Act 1988 (the Act) sets out a number of principles that we must comply with in the collection, security, storage, use and disclosure of personal information. These principles are known as the National Privacy Principles. The following information is provided to you in accordance with these principles. The organisation collecting information about you is HLRA. We can be contacted at the address shown above, either in writing, by telephone or by fax. If you ask us, we must provide you with access to the personal information we hold about you. We may be entitled to refuse access to some information as set out in the Act. Your right to access this information is set out in our Privacy Policy Document, which is available on request. The information we collect will be used to assess and process your application for life insurance. We may also use the information if a claim is submitted by you, or by someone acting on your behalf. The information we collect may be disclosed to other organisations, including but not limited to, medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, the trustees of a superannuation fund you belong to, an organisation that is duly appointed to manage the administration of such fund and interpreters. If you fail to provide us with all or part of the information we require, we will be unable to assess and process your application.

Consent

I understand that in order to assess and process my application, HLRA may need health and employment information about me. I consent to HLRA obtaining information about me from any medical practitioner or health professional that I have or may consult in the future, or that HLRA appoints to examine me, and from my employers. I further understand that if I apply for increased or different insurance cover, HLRA may require further information about me. I now consent to HLRA obtaining such further information as and when required, from any medical practitioner or health professional that I have consulted or may consult in the future, or that HLRA appoints to examine me, and from my employers. I understand that if I or anyone else on my behalf, makes a claim for a benefit, HLRA will need information about me in order to assess and process the claim. I hereby consent to HLRA obtaining information about me from any of the following: medical practitioners that I have consulted at any time and any that HLRA wishes to appoint to examine me, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers and interpreters. For the purpose of this application and any future application and any claim for a benefit, I also consent to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for HLRA to perform its functions.

DUTY OF DISCLOSURE

Duty of Disclosure

Before you enter into a contract of life insurance with an Insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the Insurer every matter that you know, or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of insurance and if so, on what terms. You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate a contract of life insurance. Your duty, however, does not require disclosure of a matter that diminishes the risk to be undertaken by the Insurer; that is of common knowledge; that your Insurer knows, or, in the ordinary course of its business, ought to know; as to which compliance with your duty is waived by the Insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the Insurer would not have entered into the contract on any terms if the failure had not occurred, the Insurer may avoid the contract within three (3) years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract at any time. An Insurer who is entitled to avoid a contract of life insurance may, within three (3) years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer. Your Duty of Disclosure continues until the contract of life insurance has been accepted by the Insurer and confirmation is issued in writing. Please ensure all applicable questions are fully answered.

Declaration

- I have received and read the Product Disclosure Statement dated 18 May 2018;
- I consent to the collection and disclosure of information about me for the purposes outlined in the Privacy section above;
- I have read and understand the Duty of Disclosure section above;
- I understand that I may be sent additional documentation which I need to submit before my application for insurance is complete;
- I understand that insurance cover will commence from the date I am advised in writing; and
- I declare that all of the details I have provided on the insurance application are correct.

Signature

Date

D D / M M / Y Y Y Y

Privacy Policy – The information you are providing in this form is subject to the Privacy Amendment (Private Sector) Act 2000. The Act sets out principles for dealing with personal information which includes standards for collection, storage, accuracy and use of information and for disclosure required by the Australian Tax Office as well as your right to access your personal information which we hold. MAP has developed polices for complying with this legislation which you may view on request.

Please send the completed form to: MAP, PO Box 1282, Albury NSW 2640