Application for insurance Rest Corporate

Use this form to:

- apply for insurance cover
- increase your existing insurance cover
- lengthen your Benefit Period

Do not use this form if you wish to take up the 'Special offer for new members' (refer to Special offer for new members in the Rest Corporate insurance guide), reduce or cancel your insurance cover, lengthen your IP Waiting Period or shorten your IP Benefit Period. Instead call Rest Customer Service on 1300 300 778.

Please write in **BLOCK LETTERS** and use a **BLACK** or **BLUE** pen. Print **'X'** to mark boxes where applicable.

Please ensure you have completed all relevant sections and provided additional evidence (if required).
Please note: If there is not enough room on this form, please provide information on a separate sheet of paper and attach it.

You have a duty to disclose information in an honest and accurate manner. Please read your Duty of Disclosure on page 16.

The information you provide in this application form will be used by the Insurer to determine the type and level of insurance cover offered to you. If you provide misleading or inaccurate information you may experience delays upon lodging a claim or be determined ineligible to claim benefits. In some cases your insurance cover may be avoided or cancelled.

If you need clarification about any issue or the nature of the questions asked in this application form, please seek independent assistance before completing and submitting this application.

Once you have completed and signed this form, please mail to: **PO Box 350, Parramatta NSW 2124.**

Section 1: Personal details

Member number (if applicable)

Date of birth (dd/mm/yyyy)

Gender ◯ (M/F)

Mr/Mrs/Ms/Miss/Dr

Surname

Given name(s)

Unit number

Street number

Street name

Suburb/Town

State

Postcode

Mailing Address (if different from above)

Unit number

Street number

Street name

Suburb/Town

State

Postcode

Telephone (business hours)

Mobile

Email address (Use a personal email address as we may send sensitive information)

Country of Birth

Are you an Australian citizen, a New Zealand citizen residing in Australia, a holder of an Australian permanent visa or a person who resides in Australia on an approved working visa? Yes ◯ No ◯

If 'No', please advise what type of visa you hold.

Office Use

Section 1: Personal details Continued

Your approximate gross annual salary from all sources, excluding investment income

$

Employer name

Type of industry

Occupation/Job title

Detailed description of duties performed

Do you work in a:

shop office warehouse factory other, please specify

Are you a senior manager in a company with at least ten employees? Yes No

Qualifications/membership of professional associations

To ensure you receive the appropriate insurance cover, please let Rest know if you change your occupation. Please be aware that any future changes to your occupation may result in amendments to the cost of your cover.

Section 2: Type and amount of cover

Please refer to 'Calculate your insurance cover' in the Rest Corporate Insurance Guide to determine the level of insurance you may need, or try our Rest insurance needs calculator at **rest.com.au/calculators**. If you wish to apply for additional cover, please advise the total amount of cover you require below. If you have Default cover, Rest will determine the amount of cover that will be provided as voluntary cover. Where you have Default cover, the difference between the amount of Default cover and the total amount of cover approved by the insurer will be provided as fixed sum insured Voluntary cover. If you are applying for cover above your employer plan's Automatic Acceptance Limit (AAL) the increase in cover related to this will remain as Default Cover.

Voluntary cover

Types of cover required	Total amount of cover required including any existing Default cover
Death (no maximum benefit limit applies)	$
Total & Permanent Disability (TPD) (maximum insurance cover is $5,000,000)	$
Income Protection (IP) (monthly benefit) (maximum insurance cover is $30,000 or 87% of salary, whichever is the lesser per month)	$ per month

IP waiting period of:

30 days 60 days 90 days

Benefit period required

IP benefit period of:

age 65 5 years 2 years

Cover formula required

Select one of the following if you'd like to increase your employer selected cover. This is only available for members with default cover based on an equivalent design:

Percentage of Salary

10% 15% 20% 25%

or

Multiple of Salary

3 x salary 4 x salary 5 x salary

Office Use

Section 3: Your regular doctor/medical centre

Name of regular doctor/medical centre

Phone number

Unit number

Street number

Street name

Suburb/Town

State

Postcode

How long have you been attending this surgery or practice?

What was the date of your last consultation? (dd/mm/yyyy)

What was the reason for this consultation and what was the result?

Section 4: Personal History (Please complete this section in full)

1. a) Do you have or are you applying for any other Life, Total and Permanent Disability, Income Protection or Salary Continuance insurance? (Please include cover held and/or applied for through TAL or under superannuation). If yes, please complete details below. Yes ◯ No ◯

Policy Number	Commencing Date	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/Benefit Period	To Be Replaced 'Y' or 'N'

b) Has an application for life, disability, trauma, accident or illness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? Yes ◯ No ◯

c) Are you claiming or have you ever claimed a benefit from any source e.g. Total and Permanent Disability benefit from any superannuation fund, workers' compensation, disability pension, Veterans' Affairs or any other insurance policy providing accident or illness benefits? If 'Yes' please give the name of the company, date, amount and reason for each claim below. Yes ◯ No ◯

If you answered 'Yes' to 1(b) or 1(c) please provide details.

Office Use

Section 4: Personal History Continued (Please complete this section in full)

2. a) Have you smoked tobacco or any other substance during the last twelve months? Yes ◯ No ◯
If 'Yes', please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

b) How many standard drinks do you consume per week on average?
One standard drink = one nip (30 ml) spirits, 100ml wine, 10 oz/285ml beer.

c) In the last 5 years have you smoked any substance other than tobacco? Yes ◯ No ◯
If yes, please advise substances smoked, frequency of use, date first smoked and date last smoked.

3. a) What is your height? cm b) What is your weight? kg

4. Do you intend to travel or reside overseas in the next 12 months? If 'Yes', please state: Yes ◯ No ◯

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure
				/ /
				/ /
				/ /

5. 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 commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing? Yes ◯ No ◯
If 'Yes', please complete relevant questionnaire in **Section 8**.

Family History

6. Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 60? Heart disease (e.g. angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, Huntington's disease and/or any other inherited blood or neurological disorder? You are only required to disclose family history information pertaining to first degree blood related family members. If 'Yes', please provide details in the table below. Yes ◯ No ◯

	Condition/Illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

Office Use

Section 5: Medical and Health History (Please complete this section in full and complete relevant questionnaire)

1. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?

   a) Chest pain, high blood pressure, raised cholesterol or any heart / circulatory disorder? (If 'Yes', please complete **Section 11**.) Yes ◯ No ◯

   b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? (If 'Yes', please complete **Section 13**.) Yes ◯ No ◯

   c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder? (If 'Yes', please complete **Section 13**.) Yes ◯ No ◯

   d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? (If 'Yes', please complete **Section 9**.) Yes ◯ No ◯

   e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? (If 'Yes', please complete **Section 10**.) Yes ◯ No ◯

   f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? (If 'Yes', please complete **Section 12**.) Yes ◯ No ◯

   g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind? (If 'Yes', please complete **Section 13**.) Yes ◯ No ◯

   h) Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse? Yes ◯ No ◯

   i) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)? Yes ◯ No ◯

   j) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? Yes ◯ No ◯

2. Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? Yes ◯ No ◯

3. In the last 2 years have you engaged in any activity reasonably expected to having an increased risk of exposure to the HIV/AIDS virus? (This includes unprotected anal sex, sex with a sex worker or sex with someone you know, or suspect to be HIV positive). Yes ◯ No ◯

4. Apart from treating any condition already disclosed, have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives and *treatment for hay fever, hair loss and acne*)? Yes ◯ No ◯

5. Apart from any condition already disclosed, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms? Yes ◯ No ◯

6. Apart from any condition you have already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis? Yes ◯ No ◯

7. Apart from any condition you have already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years? Yes ◯ No ◯

Office Use

Section 5: Medical and Health History Continued (Please complete this section in full)

For each 'Yes' answer in questions 1h–1j, 2 to 7 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

Section 6: Authority to Release Medical Information

I,

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to TAL Life Limited, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of applicant

(dd/mm/yyyy)

Office Use

Section 7: Privacy

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which TAL collects, uses, secures and discloses your personal and sensitive information is set out in the TAL Privacy Policy available at https://www.tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1300 209 088.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following.

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

Office Use

Questionnaires (Please complete – may be photocopied for additional activities/pursuits)

Section 8: Aviation Questionnaire

1. Please state the number of hours flown where applicable:

a)	**Private flying**	**Previous 12 months**		**Next 12 months**	
	Type of Aircraft	Pilot	Passenger	Pilot	Passenger
	Fixed Wing				
	Rotary				
	Other (eg. Ultralight, Microlight)				
b)	**Commercial flying** (excluding large mainstream carriers, eg. Qantas)	**Previous 12 months**		**Next 12 months**	
	Type of Aircraft	Pilot	Passenger	Pilot	Passenger
	Fixed Wing				
	Rotary				
	Other (eg. Ultralight, Microlight)				
c)	**Agricultural flying**	**Previous 12 months**		**Next 12 months**	
	Type of Aircraft	Pilot	Passenger	Pilot	Passenger
	Fixed Wing				
	Rotary				
	Other (eg. Ultralight, Microlight)				

2. Are your flying activities:

   ◯ Recreational, or ◯ Required for your occupation?

   Please provide details.

3. (a) Name of aircrafts flown.

   (b) Make and model of the aircrafts.

   (c) **If pilot only.**

   (i) Age of the aircrafts flown.

   (ii) Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced? Yes ◯ No ◯

4. Do you fly or intend to fly outside Australia?
   If 'Yes', please provide details. Yes ◯ No ◯

5. Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? If 'Yes', please provide details. Yes ◯ No ◯

6. Have you ever been involved in any aviation accidents? If 'Yes', please provide details. Yes ◯ No ◯

Office Use

Questionnaires (Please complete – may be photocopied for additional activities/pursuits)

Section 8: Activities/Pursuits Questionnaire

1. Please describe the activity or pursuit.

2. Please advise the number of times you engage in the activity per year.

3. How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4. What qualifications, certificates, licences, associations and club memberships do you hold?

5. How long have you been involved in this activity?

6. Where do you engage in this activity and in what locations?

7. Do you ever engage in this activity alone, or are you always with a group?

8. Do you compete in this activity?
   If 'Yes', please advise the level of competition and names of events. Yes ◯ No ◯

9. Do you receive any payments for your involvement in this activity?
   If 'Yes', please advise details. Yes ◯ No ◯

10. Please advise the maximum heights, speeds, depths the activity includes.

11. Are any of the above likely to change over the next 2 years?
    If 'Yes', please advise details. Yes ◯ No ◯

12. Are you involved in any record attempts?
    If 'Yes', please advise details. Yes ◯ No ◯

13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details.

14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15. Have you ever been involved in any accident mishap whilst participating in this activity?
    If 'Yes', please advise details. Yes ◯ No ◯

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 9: Asthma Questionnaire

1. Date asthma first diagnosed. / /
2. How often do you experience symptoms? eg. wheezing, breathlessness, chest tightness:
   ◯ Daily ◯ Weekly ◯ Monthly ◯ Other
3. When was your most recent episode of asthma? / /
4. Are you aware of any causes that trigger your symptoms? eg. allergy, exercise.
5. Have you ever been off work due to asthma? Yes ◯ No ◯
   If 'Yes', please advise when and for how long.
6. Name of medications
   (a) Dosage (b) Frequency
   (c) When was the last time you received medication?
   (d) What additional treatment do you use to control an attack?
7. Have you ever required steroid therapy (by tablet or syrup)? Yes ◯ No ◯
   If 'Yes', please provide details.
8. Have you ever been in hospital or received emergency treatment for asthma? Yes ◯ No ◯
   If 'Yes', please state when, for how long and where?
9. Have you ever undergone a lung function test? Yes ◯ No ◯
   If 'Yes', please advise dates and highest and lowest readings, if known.
10. Have you ever consulted a specialist for this condition? Yes ◯ No ◯
    If 'Yes', please advise name and address of doctor of last consultation.
11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 10: Spinal/Joints Disorder Questionnaire

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. left knee, right hip, shoulders, elbows etc)

2. Please state the precise diagnosis.

3. When did symptoms first occur?

4. (a) What was the cause?

   (b) Please describe your symptoms.

   (c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? Yes ◯ No ◯

   (d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms? Yes ◯ No ◯

   (a) If 'No', date of last experienced symptoms. / /

   (b) If 'Yes', how frequently have symptoms occurred since commencing treatment?

   ◯ Daily ◯ Weekly ◯ Monthly ◯ Other

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

   (b) Are you still receiving treatment? Yes ◯ No ◯

   (i) If 'No', when did you cease treatment? / /

   (ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

   (c) Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition? If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor. Yes ◯ No ◯

8. Have you had an operation for this condition or is an operation being considered? If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor. Yes ◯ No ◯

9. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long? Yes ◯ No ◯

   (b) Are your occupation duties restricted in any way? If 'Yes', please provide details. Yes ◯ No ◯

   (c) Is it necessary to avoid lifting or to restrict your daily activities in any way? If 'Yes', please provide details. Yes ◯ No ◯

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 11: High Blood Pressure/High Cholesterol Questionnaire

1. When was high blood pressure/high cholesterol first diagnosed? / /
2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

Readings	Results	Date diagnosed
Blood Pressure		/ /
Total Cholesterol		/ /
HDL		/ /
LDL		/ /
Triglycerides		/ /

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage
/ /		
/ /		

4. Are you still on treatment? If 'No', when was treatment discontinued and why? Yes ◯ No ◯

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Results
/ /		
/ /		

6. Regarding the monitoring of your condition:

(a) Name of medical attendant:

(b) How often do you attend for follow-up?

(c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.

(d) Have you suffered from any of the following conditions:

(i) Eye disorder (other than short/long sightedness) Yes ◯ No ◯

(ii) Symptoms or disorder relating to heart or circulatory system Yes ◯ No ◯

(iii) Kidney disorder or protein in urine Yes ◯ No ◯

(iv) Dizziness, fainting episodes or stroke Yes ◯ No ◯

If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigations	Results
/ /			
/ /			

(e) How long has your blood pressure/cholesterol been well controlled?

◯ 6 months ◯ 6 months to 12 months ◯ > 12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application:

8. Please attach copies of any reports or results (eg. xray, pathology, ultrasound, etc) you may have.

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 12: Mental Health Questionnaire

1. Please indicate the condition(s) you have had or received treatment for.

- ◯ Anxiety including generalised anxiety, panic or phobic disorder
- ◯ Eating disorder including anorexia nervosa, bulimia
- ◯ Depression including major depression or mild depression
- ◯ Manic depressive illness, bi-polar disorder
- ◯ Alcohol or other substance abuse or addiction
- ◯ Post traumatic stress
- ◯ Schizophrenic or any other psychotic disorder
- ◯ Stress, sleeplessness, chronic fatigue
- ◯ Other (please specify) _____

2. Describe your symptoms including the date started and how long they lasted.

Symtoms	Date from	Date to
	/ /	/ /
	/ /	/ /
	/ /	/ /

3. (a) Has any reason for your condition been identified or are there any factors which trigger your condition?

(b) Have you ever had suicidal thoughts or attempted suicide? If 'Yes', please provide details. Yes ◯ No ◯

4. (a) Date symptoms commenced. / /

(b) Date of last symptoms. / /

(c) Have you had any recurrences of this condition? Yes ◯ No ◯

If 'Yes', how many times? _____ When? / /

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased
	/ /	/ /
	/ /	/ /
	/ /	/ /

(b) Are you currently receiving treatment? If 'Yes', please provide details. Yes ◯ No ◯

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 12: Mental Health Questionnaire Continued

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted
	/ /	/ /
	/ /	/ /
	/ /	/ /

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition? If 'Yes', when and how long? Yes ◯ No ◯

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? If 'Yes', please provide details. Yes ◯ No ◯

Office Use

Questionnaires (Please complete – may be photocopied for additional conditions)

Section 13: Multi-Purpose Questionnaire

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?

   (b) Please state which side. ◯ Left ◯ Right ◯ Not applicable
3. The cause.
4. (a) Date symptoms commenced / /

   (b) How long have you been free of symptoms?

   (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? If 'Yes', please state when, duration and reason/restriction. Yes ◯ No ◯
6. Have you any residual, on-going effects or restriction in your daily activities? If 'Yes', please give details. Yes ◯ No ◯
7. Have you taken regular or occasional medication for this condition? If 'Yes', advise names of medication(s), dosage(s) and frequency. Yes ◯ No ◯

   Are you still taking this medication? Yes ◯ No ◯
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? Yes ◯ No ◯
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? Yes ◯ No ◯
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? Yes ◯ No ◯
11. Have you seen a doctor or other therapist for anything related to this condition. If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and speciality of the doctor/therapist. Yes ◯ No ◯

If you answered 'Yes' to questions 8–11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? If 'Yes', please provide details. Yes ◯ No ◯
13. Does your usual doctor have details of this condition?
    If 'No', provide name and address of doctor who has full details. Yes ◯ No ◯

Office Use

Section 14: Declaration

Your duty of disclosure

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know, may affect their decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell the insurer anything that:

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

If you do not tell us something

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, they may apply the following rights separately to each type of cover.

If you do not tell the insurer anything you are required to, and they would not have insured you if you had told them, they may avoid the contract within 3 years of entering into it.

If the insurer chooses not to avoid the contract, they may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told them everything you should have. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell the insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

I declare that I:

- agree to be bound by the terms of cover set out in this application form and I have read and understood the Rest Corporate Insurance Guide
- have carefully considered all the questions and all answers provided are true and correct
- have read and understand the duty of disclosure above and I have not withheld any information that may affect the Insurer's decision as to whether to accept my application
- have read and understand TAL's Privacy Policy available at https://www.tal.com.au/Privacy-Policy and Rest's Privacy Policy available at rest.com.au and agree that the Trustee and/or the Insurer may use my personal information for the purposes described
- understand that my request for cover or request to vary my cover (whichever is applicable) will not commence until the Insurer accepts it and Rest advises me in writing
- understand that the cost of my insurance is in part affected by my occupation, and that any change to my occupation in the future will be reflected in the cost of my cover

Signature of applicant

(dd/mm/yyyy)

If you are happy for the Insurer to contact you directly over the phone to clarify any issues (rather than sending you questions via mail), please tick this box:

Office use only

Occupation code

A	B	C	D	E	

Approved ☐ Declined ☐

Office Use