Income Protection, Life and Total and Permanent Disablement Insurance for Avant doctors Application Form

Avant
Avant Mutual Group Limited
ABN 58 123 154 898

This is an application form for income protection, life and total and permanent disablement (TPD) insurance. This is a legal document, which will form the basis of the contract of insurance.

Avant Insurance Limited ABN 82 003 707 471 and AFS Licence 238765 has entered into an arrangement with Hannover Life Re of Australasia Ltd ABN 37 062 395 484 to provide eligible members of Avant Mutual Group Limited ABN 58 123 154 898 (Avant) with insurance cover for income protection, life and TPD.

When reading this application form:

- a reference to 'the insurer' means Hannover Life Re of Australasia Ltd ABN 37 062 395 484;
- a reference to 'we', 'our' and 'us' means Avant Insurance Limited ABN 82 003 707 471 and AFS Licence 238765; and
- a reference to 'you' or 'your' means the insured person.

We only provide general financial product advice. This advice does not take into account your objectives, financial situation or needs. You should read and consider the product disclosure statement (PDS) and consider the appropriateness of the advice before deciding to purchase this product through us. The PDS is available at www.avant.org.au or by contacting us on 1800 128 268.

This application only applies if you meet the following eligibility criteria

You are:

1. a registered medical practitioner employed as a medical practitioner in Australia;
2. at the 'entry age' (between the ages of 20 and 45 years old) at the time the policy starts; and
3. a member of Avant.

How to apply

1. You need to meet the eligibility criteria outlined above.
2. Read the duty of disclosure and ensure that you disclose the matters you are required to in order to comply with that duty.
3. Carefully read the combined Financial Services Guide (FSG) and Product Disclosure Statement (PDS) which contains the terms and conditions of the insurance.
4. Complete every section of the form.
5. You must read and confirm that you agree to the declarations.

If you are unsure about the information to be supplied please contact Member Services on 1800 128 268.

Duty of disclosure

Under the *Insurance Contracts Act 1984* (Cth), before you enter into a contract of insurance you have a duty to disclose every matter that you know, or could reasonably be expected to know, which is relevant to the insurer 's decision to accept the risk of the insurance and, if so, on what terms. Any disclosure made to us in relation to this insurance application or insurance cover will be considered to have been made to the insurer.

You have the same duty to disclose those matters before this policy is extended or varied.

You do not have to tell us about:

a) a matter that diminishes the risk undertaken by the insurer; or

b) a matter that is considered to be common knowledge; or

c) facts that the insurer knows or should know in the ordinary course of business; or

d) matters that we tell you we or the insurer do not need to know.

If in doubt you should disclose a matter to us.

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 had the matter you failed to disclose been known then the insurer may avoid the contract within 3 years from the date you entered into the contract. If your non-disclosure is fraudulent the insurer can avoid the contract at any time.

If you have failed to comply with your duty of disclosure and the insurer is entitled to avoid the contract but the insurer elects not to avoid the contract, they may, within 3 years from the date the contract was entered into, reduce the insured amount in accordance with a formula which takes into account the premium the insurer would have charged had you not failed to comply with your duty of disclosure.

1. Insured details

Member id:	Title:	Given name:
Middle name:	Surname:	
Gender: ☐ Male ☐ Female		Date of birth:
Residential address:		
Telephone:		Mobile:
Email:		

Would you like to receive your annual certificate of insurance documentation electronically? ☐ Yes ☐ No

2. Other insurance details

Do you currently have any income protection insurance in force that you intend to retain if your application is approved? ☐ Yes ☐ No

If **YES** please provide details

Insurer	Type of insurance	Amount covered

3. Hazardous or sporting activities

Do you engage in any of the following? ☐ Yes ☐ No

Hazardous or sporting activities including underground activities, activities involving heights, motor sports (land or water),rock or mountain climbing, scuba diving below 40 meters and/or dives in caves or wrecks, aviation activities (other than as a fare paying passenger) or other *(please specify)*

If **YES** please provide details

Type of activity

4. Medical/ health details and history

4.1	What is your weight?	kg
4.2	What is your height?	cm

4.3 Do you smoke or have you smoked in the last 12 months? ☐ Yes ☐ No

If **YES** please provide details

How many per day? _____ How many years? _____

4.4 Do you consume alcohol? ☐ Yes ☐ No

If **YES** please provide details

Standard drinks: Weekly quantity _____

How many would you typically consumer per sitting? _____

4.5 Have you ever used by mouth, inhalation or injection, any drug not prescribed by a doctor (including self-prescription), other than medicines ordinarily purchased at a chemist or supermarket? ☐ Yes ☐ No

If **YES** please provide details

4.6 To the best of your knowledge have your parents or siblings (alive or dead) ever suffered from diabetes, heart disorders, respiratory disorders, high cholesterol, mental disorder, cancer, kidney disease, cystic fibrosis, muscular dystrophy, Huntington's disease or any other hereditary disease? ☐ Yes ☐ No

If **YES** please provide details

Condition	Relationship	Age of diagnosis

4.7 To the best of your knowledge have you ever had any symptoms or suffered from diabetes, heart disorders, respiratory disorders, high cholesterol, mental disorder, kidney disease, cystic fibrosis, muscular dystrophy, ulcers, epilepsy, back, neck or muscle pain, arthritis, sexually transmitted disease, blood disorders, hearing or sight disorders, bowel or stomach disorders, high blood pressure or circulatory disorders, cancer or tumour, skin disorders, hepatitis or any other medical condition or illness (aside from colds, flu, or birth control, pap smears for females)? ☐ Yes ☐ No

If **YES** please provide details

Condition	Treatment	Date of last symptoms	Name and address of Dr consulted

5. Release of medical information

Dear Doctor,

I hereby authorise you to release details of my medical history to Avant Insurance Limited and Hannover Life Re of Australasia Ltd or any company appointed by these entities to obtain my medical history. A photocopy, facsimile or scanned copy of this authority shall be considered as valid as if it were the original.

Signature of the person to be insured:	Date:

6. Nominated beneficiaries – life insurance

As the insured person, you have the option to nominate a beneficiary or beneficiaries to receive your insurance benefit payable on your death. If you do not nominate a beneficiary or beneficiaries your life insurance benefit will be paid to your estate.

If you wish to make a nomination that will be followed at the time of your death you must comply with the following conditions:

- complete the table below with your nominated beneficiary or beneficiaries' details (all details must be included before this application may be processed);
- You acknowledge that:
  - this nomination will remain valid until you revoke or replace this nomination in writing to us and it has been received by us;
  - payment of the life insurance benefit will be made to the latest nominated beneficiary or beneficiaries whose details have been received by the insurer ; and
  - a nominated beneficiary or beneficiaries have no rights under the policy other than to receive the life insurance amount in the event of your death.

Full name of beneficiary	Date of birth	Address of beneficiary	Portion of benefit %	Relationship to the life insured

total= 100%

7. Insurance cover options

This insurance is offered as a package with all three types of cover – Income Protection, Life and Total and Permanent Disablement (TPD) cover.

I wish to apply for the following cover:

7.1.1 **Life and TPD Cover** (select 1 option)

☐ I **do not** require life & TPD cover; or

☐ $100,000 ☐ $200,000 ☐ $300,000 ☐ $400,000 ☐ $500,000

7.1.2 **Income protection cover**- select the applicable annual benefit.

Select	Benefit Level	If your annual income earned as a medical practitioner employed in Australia
☐	$40,000	is up to $65,000 then you can apply for an annual benefit of $40,000
☐	$50,000	is $65,000 or more and less than $80,000 then you can apply for an annual benefit of $50,000
☐	$60,000	is $80,000 or more and less than $95,000 then you can apply for an annual benefit of $60,000
☐	$70,000	is $95,000 or more and less than $105,000 then you can apply for an annual benefit of $70,000
☐	$80,000	is $105,000 or more and less than $115,000 then you can apply for an annual benefit of $80,000
☐	$90,000	is $115,000 or more and less than $130,000 then you can apply for an annual benefit of $90,000
☐	$100,000	is $130,000 or more and less than $145,000 then you can apply for an annual benefit of $100,000
☐	$110,000	is $145,000 or more and less than $160,000 then you can apply for an annual benefit of $110,000
☐	$120,000	is $160,000 or more then you can apply for an annual benefit of $120,000

Note: The definition of annual income is: gross income from your employment as a medical practitioner in Australia earned before tax from personal exertion, less business expenses incurred in earning that income.

7.1.3 I wish to apply for the following waiting period in respect of income protection cover (this is the time before the monthly benefits will begin):

☐ 30 days ☐ 90 days

7.1.4 I wish to apply for the following benefit period in respect of income protection cover:

☐ 2 years ….Please complete section 9 'Declaration and signature'

☐ to age 65…. Please complete section 8 'Personal statement for income protection benefit period to age 65.'

8. Personal statement for income protection benefit period to age 65

Insurance history

8.1 Have you ever had Life, Disability, Accident and Sickness or Superannuation cover declined, deferred to withdrawn from any Insurance Company or accepted with a loading, exclusion or other than as applied? ☐ Yes ☐ No

If **YES** please provide details (including dates, name of company and reason):

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

If **YES** please provide details (including dates, cause of claim, type of benefit and amount paid, claim number and insurance company)

Residence

8.3 Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's visa? ☐ Yes ☐ No

If **NO** provide full details:

8.4 Do you intend travelling overseas in the immediate future (i.e. next 2 years)? ☐ Yes ☐ No

If **YES** please provide details (where, when, duration and reason):

Occupation details

8.5 Name and address of employer:

telephone number:

8.6 How long have you been in your current occupation?_____years _____months

What is your employment status? (permanent/ part time/ contractor/ casual)

How many hours do you work per week? _____

8.7 Has your main occupation, employer or employment status changed in the last 3 years? ☐ Yes ☐ No

If **YES** please provide details

Previous occupation	Employer	Employment status	Date from	Date to

8.8 Do you have another occupation? ☐ Yes ☐ No

If **YES** please provide details

Other occupation	Employer	Hours per week	How long have you been doing this occupation	Monthly income

Financial details

8.9 If disabled, would all or part of your income continue? (e.g. sick leave, other disability income policies, pension, investment, rental, company profit share, etc.) ☐ Yes ☐ No

If **YES** please provide details

8.10 In respect of your principal occupation, what has been the total remuneration paid by your employer in each of the last two tax years?

This should be determined by calculating the total you receive as a base salary/wage as one amount and the total you receive from commission, bonus or overtime as a separate amount (before income tax is deducted).

Current financial year base salary/wage	Current financial year overtime/bonus/ commission	Last financial year base salary/wage	Last financial year over-time/bonus/ commission
$	$	$	$

Medical details

8.11 Name and Address of your Doctor:

telephone number:

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

Date	Healthcare professional	Address	Reason	Outcome

8.13 Within the LAST THREE YEARS have you, other than advised above 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? ☐ Yes ☐ No

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

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

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

Please provide full details for all **YES** answers to questions 8.13 to 8.16. If more space is required, please attach.

Date from and to	Name and address of doctor, hospital, clinic etc.	Conditions, medication, treatments, time off work	Recovery %

8.17 Within the LAST THREE YEARS have you, other than advised above, either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection? ☐ Yes ☐ No

If **YES** please provide details

8.18 Have you EVER received any advice or treatment for:

(a) High blood pressure, raised cholesterol, stroke or circulatory disorder ? ☐ Yes ☐ No

(b) Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever? ☐ Yes ☐ No

(c) Asthma, bronchitis or other lung complaint? ☐ Yes ☐ No

(d) Diabetes? ☐ Yes ☐ No

(e) Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder? ☐ Yes ☐ No

(f) Hepatitis or other liver or gall bladder disease? ☐ Yes ☐ No

(g) Back, neck or knee complaint or any disorder of the joints, bones or muscles (e.g. gout, arthritis)? ☐ Yes ☐ No

(h) Kidney or bladder disease, renal colic, stones or blood in the urine? ☐ Yes ☐ No

(i) Depression, anxiety, stress, mental or nervous condition, or chronic fatigue? ☐ Yes ☐ No

(j) Cancer, tumour, melanoma, sunspots or growth of any kind? ☐ Yes ☐ No

(k) Eczema, dermatitis, psoriasis or any other skin condition? ☐ Yes ☐ No

(l) Tinnitus, hearing loss or any defect in hearing, sight or speech? ☐ Yes ☐ No

(m) Anaemia, leukaemia, haemophilia or other blood disorder? ☐ Yes ☐ No

(n) Thyroid or prostate disorder, any disorder of the reproductive organs, or sexually transmitted disease? ☐ Yes ☐ No

(o) Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats? ☐ Yes ☐ No

(p) Multiple sclerosis, epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks? ☐ Yes ☐ No

(q) Any other physical impairment, congenital abnormality, deformity or symptoms of ill health, illness or injury? ☐ Yes ☐ No

Females only

(r) Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)? ☐ Yes ☐ No

(s) Have you ever had any complications of pregnancy or childbirth? ☐ Yes ☐ No

(t) Are you currently pregnant?
What is the expected delivery date?_____/_____/_____ ☐ Yes ☐ No

u) Have you ever had a breast lump (even if you have not seen a doctor about it)? ☐ Yes ☐ No

Please provide full details for all **YES** answers to question 8.18. If more space is required, please attach.

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

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

8.20 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? ☐ Yes ☐ No

8.21 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? ☐ Yes ☐ No

9. Declaration and signature

As the insured I hereby apply for Avant's income protection, life and total and permanent disablement cover offered through Avant and as selected above at Section 7.

I declare that:

(a) the information I have given in this application form and in any accompanying documents is true and correct, and I understand that this information will be relied upon in deciding whether to provide me with an insurance contract and on what terms and conditions, and that this application forms the basis of my contract;

(b) I understand my duty of disclosure exists until the contract of insurance is entered into, extended or varied and that I have an obligation to inform Avant Insurance of any material alteration of the risk;

(c) I have read and understood the PDS which contains the terms and conditions of the insurance cover;

(d) I authorise Avant Insurance to collect my health and other personal information for the purposes of assessing my application for this insurance cover and for the provision of ongoing services by Avant or Avant Insurance and to disclose this information to Hannover Life Re of Australasia Ltd ABN 37 062 395 484 or related entities in connection with this application for insurance and any subsequent claims made under the insurance cover;

(e) I confirm that as at the date of this application I am not absent from work from any reason due to illness or injury; and

(f) I understand this application is subject to approval and that cover will not commence unless and until my application has been approved.

Signature of applicant:	Date:

Payment Options

1. **Choose your payment frequency**

☐ Annual payment ☐ Monthly instalments

2. **Choose your payment method (subject to your application being accepted)**

Please note when you choose either the direct debit or credit card option, we will deduct the initial payment on the date your application is accepted.

☐ Cheque	***Payment in full only.*** Please do not include with this payment any other Avant Insurance product or membership subscription. Please make the cheque payable to **"Avant Insurance Limited - Trust Account No: 550025"**			
☐ Credit card	☐ Amex	☐ Diners	☐ MasterCard	☐ Visa
	Name on card:			
	Card number:			
	Expiry date:			
	Signature:			Date:
☐ Direct Debit Request	I/we authorise Avant Insurance Limited (under User ID 407295) to arrange for payments to be debited from my/our nominated account through the Bulk Electronic Clearing System (BECS) in accordance with terms described in the Avant Insurance Direct Debit Service Agreement.			
	Financial institution:		Address of Financial Institution:	
	Branch:		BSB Number:	
	Account name:		Account number:	
	Signature 1:			Date:
	Signature 2:			Date:
	If debiting from a joint bank account, both signatures are required. By submitting this Direct Debit Request (DDR) you are providing us with a valid instruction in respect to your DDR, and confirming that you have read, understood and agreed to the terms and conditions governing the debit arrangements between you and Avant Insurance as set out in this DDR and in our Direct Debit Service Agreement. Subject to the terms of Direct Debit Service Agreement, 14 days notice is required if the terms of the above DDR are to be changed.			

Direct Debit Request Service Agreement

This document outlines our service commitment to you, in respect of the Direct Debit Request (DDR) arrangements made between Avant Insurance Limited (Avant Insurance) ABN 82 003 707 471 (under User ID 407295 or User ID 010731, as identified in the DDR) and you. Avant Insurance is a subsidiary of Avant Mutual Group Limited ABN 58 123 154 898 (Avant). Avant Insurance collects payments and debits member nominated accounts for insurance premiums and Avant membership subscriptions.

In this document a reference to 'our', 'we' or 'us' means Avant Insurance and Avant. It sets out your rights, our commitment to you and your responsibilities to us, together with where you should go for assistance.

Debiting your account

- By submitting your DDR, you are confirming that you have provided us with a valid instruction and you have authorised us to arrange for funds to be debited from your account. You should refer to the DDR and this agreement for the terms of the arrangement between us and you.
- We will only arrange for funds to be debited from your account as authorised in the DDR.
- If there are insufficient clear funds in your account to meet a debit payment:
  - (a) you may be charged a fee and/or interest by your financial institution;
  - (b) you may also incur fees or charges imposed or incurred by us; and
  - (c) you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be in your account by an agreed time so that we can process the debit payment.
- If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you are unsure about which day your account has or will be debited you should ask your financial institution.

Our commitment to you

- We undertake to debit your nominated account for Avant Insurance premium and related monies as determined by the DDR made between us and accepted by you
- we will give not less than 14 days written notice should we make any change to the DDR including the amount, except where an amount has dishonoured
- we will keep any information (including your account details) in your DDR confidential
- we will only disclose information that we have about you to the extent specifically required by law or for the purposes of this agreement (including disclosing information in connection with any query).

Your commitment to us

It is your responsibility to ensure that:

- your nominated account can accept direct debits as the Bulk Electronic Clearing System (BECS) may not be available on all accounts (your financial institution can confirm this);
- you validate your account details against a recent bank statement;
- you check with your financial institution if you are unsure how to complete the DDR;
- there are sufficient clear funds in your account to allow a debit payment to be made;
- you advise us if the nominated account is transferred or closed;
- you pay your Avant Insurance premiums by an alternate method if the direct debit arrangements are cancelled either by you or by us;
- your payments are up to date, whether advice is received from us or not;
- you will check your account statement to verify that the amounts debited from your account are correct;
- if your drawing is returned or dishonoured by your financial institution you may be charged fees or charges by the financial institution and you may also incur a fee or charges by imposed or incurred by us for the failed transaction.

Your rights

Members may:

- request we alter the DDR (e.g. frequency and amount) at any time by notifying us in writing not less than 14 days before the next lodgement;
- dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than 14 days before the next lodgement.

Enquiries

For all general enquiries please contact Member Services on 1800 128 268.

All disputes, requests for payment changes to the initial term of the arrangement and/or to defer, cancel or stop a debit should be directed in writing to us rather than to your financial institution. All communications addressed to us should include your Avant member ID.

Sydney Office – Registered Office
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PO Box 746 Queen Victoria Building NSW 1230

Telephone 02 9260 9000 Facsimile 02 9261 2921

Freecall 1800 128 268

www.avant.org.au