



ABN 82 890 650 204  
Fund Registration Number R1073560

# PERSONAL UNDERWRITING STATEMENT

**Mail to:**

DIY Master Admin  
P O Box 7540  
GCMC QLD 9726  
Phone 07 5555 5656  
Fax 07 5574 1311

The Trust Company (Superannuation) Limited (AFSL 235153) (RSE Licence No L0000635) (ABN 49 006 421 638)  
The Product Disclosure Statement for the Powerwrap Superannuation and Pension Account dated 24 September 2010

## Part 1. Member Details

Date of birth   Male  Female

Surname

Give name/s

Title Mr  Mrs  Miss  Ms  Other

Employer/Fund name\*

Occupation  Required Field

Paid hours per week  Tertiary Qualifications  Yes  No

Annual salary \$

Daily duties (including % time spent performing each duty)

- Are you an Australian or New Zealand citizen or do you have an Australian Permanent Resident's visa?  
 No  Yes ▶ how long have you lived in Australia?   
 Country of birth   
 Visa type (if applicable)
- Height  cm Weight  kg  
 Have you lost more than 5kilos in the last 12 months?  No  Yes ▶ how much  kg
- Have you smoked tobacco or any other substance in the last 12 months?  
 No  Yes ▶ form  daily quantity
- Do you have **definite** plans to live or travel overseas in the future?  
 No  Yes ▶ please advise Date leaving  Date returning   
 Countries to be visited   
 Reason for trip
- Have you ever:
  - suffered from AIDS or been infected with the HIV virus; or  Yes  No
  - engaged in male-to-male anal sexual activity?  Yes  No





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**b) Have you ever had a breast lump or breast cyst (even if you have not consulted a doctor)?**

Yes ► Please complete below:

No ► Go to Question c

**i. Was the breast lump or breast cyst fully investigated by the following?**

Ultrasound only  Mammogram only  Not investigated

Ultrasound/Mammogram & Fine needle aspiration

Other (please specify):

**ii. What was the result/outcome of your test?**

Test conducted – results pending  Test conducted – results all clear and normal

Ongoing treatment/investigations

**c) Are you currently pregnant?**  No  Yes ► Please complete below:

**i. Date Due**

**ii. Do you or have you ever had any complications with pregnancy or childbirth,**

e.g. diabetes, ectopic pregnancy?  No  Yes ► Please complete below:

Gestational Diabetes  Pre-clampsia (high blood pressure)  Ectopic pregnancy

Post-natal depression  Other (please specify):

## Part 3. Family History

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 complete table:

Relation	Condition/illness	Age at onset (approx)	Age at Death (if applicable)

## Part 4. Other Details

**1) Do you drink alcohol?**

No

Yes ► Please state type and weekly standard drinks

**2) Have you EVER used or injected any drugs not prescribed by a medical attendant?**

No  Yes ► form  daily/weekly quantity

Date  to

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3) Have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity e.g. underwater diving, motor sport of any kind, parachuting, hang gliding, boxing, wrestling, football of any kind, caving, mountaineering, bungee jumping, rock climbing, paragliding, ocean racing, rodeo, martial arts or aviation other than as a fare paying passenger on a commercial airline?

- No  
 Yes ▶ Type of activity

Please complete Activities questionnaire on page 12

4) Do you have existing life, disability or crisis recovery on your life (including any current applications held with any insurer)?

- No  
 Yes ▶ Please complete table below

Commencement date	Insurer	Type of Cover	Amount of Cover	To be replaced	
				Yes	No
D, D, M, M, Y, Y				<input type="checkbox"/>	<input type="checkbox"/>
D, D, M, M, Y, Y				<input type="checkbox"/>	<input type="checkbox"/>
D, D, M, M, Y, Y				<input type="checkbox"/>	<input type="checkbox"/>

5) Has any insurance held or applied for by you, ever been declined, withdrawn, loaded, exclusion applied or altered in any way?

- No  
 Yes ▶ Please give details

## Part 5. Doctor's Details

Name

Date of last consultation  How long have you been a patient?  Years

Reason for last consultation

What was the result?

Address

Suburb  State  Postcode

Phone  Facsimile

Email

### Medical Authority

I,  authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter) to disclose to NobleOak 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 person to be insured

Date

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## Part 6. Occupation Details

- 1) Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administrator  
 No  Yes ► Please give details
- 2) Name and address of present employer or business if self-employed (self-employed includes partnerships or employee of own company)  
 Name   
 Street Address
- 3) How long have you been in your current occupation?  years  months  
 What is your employment status? (Permanent/part time/contractor/casual)
- 4) Do you work from home?  
 No  Yes ► provide details: percentage of time working from home  %
- 5) Do you perform manual work in your occupation?  
 No  Yes ► provide details:  
 Describe activities  % of time spent
- 6) Please give details of your current and previous occupations over the last three years.  
 Current Occ  to   Employed  Self Employed  
 Occupation  Industry   
 Previous Occ  to   Employed  Self Employed  
 Occupation  Industry   
 Previous Occ  to   Employed  Self Employed  
 Occupation  Industry
- 7) Do you have a second occupation?  
 No  Yes ► Occupation  Hours per week?   
 Duties  Annual income \$
- 8) Do you intend to change your occupation in the next 12 months?  
 No  Yes ► Details of change  Date of change

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## Part 7. IP ONLY: Income / Occupation Details

1) Are you self-employed? (This means employee of own company, sole trader or partner)?

No ► go to question 3

Yes ► Please provide full details:

a) Date your business started

b) What percentage of the business do you own?  %

c) How long have you been self employed?  years  months

d) What percentage of work is: (i) Freelance?  % (ii) Contract?  %

e) How many people do you employ?

f) Did your business make a loss in the last financial year? \$

2) What was your annual earned income generated through personal exertion, from your main occupation, less all business expenses, but before tax, over the last two financial years? (Complete the table below)

Description	Year end 30/06/	Year end 30/06/
Gross Business Income		
Less Expense		
Net Income		
Your share of Net Income		
<b>Add Backs:</b>		
Personal salary <input type="checkbox"/>	\$	\$
Wages <input type="checkbox"/>	\$	\$
Directors fees <input type="checkbox"/>	\$	\$
Payments to Spouse including super (income splitting) <input type="checkbox"/>	\$	\$
<b>Total</b>	\$	\$

3) Are you currently generating a total monthly income at the same rate as shown for the most recent financial year (ii) above?

Yes  No ► Reason for change

Current total net earned income \$

4) If you became disabled would any part of your income continue beyond 30 days?

No  Yes ► Please complete table:

Source of income (e.g. – sick pay, pension, company profit)	Amount of income	How long would this continue	
		Years	Months
	\$	Years	Months
	\$	Years	Months

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## 5) Employees only (i.e., no ownership in employers business)

In respect of your principal occupation, what has been the total value of remuneration paid by your employer for 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)

Please complete table:

Description	Year end 30/06/	Year end 30/06/
Wages and salary received	\$	\$
Allowances, car, director's fees, etc	\$	\$
Superannuation	\$	\$
Bonus, commission, overtime	\$	\$
<b>Total</b>	\$	\$

## 6) \*\* ONLY COMPLETE THIS QUESTION IF YOU HAVE APPLIED FOR INCOME PROTECTION BENEFITS IN EXCESS OF \$15,000 PER MONTH.

Do you receive other income from investments (e.g. interest, dividends, net rental income), which exceeds 25% of your current annual earned income?

No  Yes ▶ Please complete table:

Dividends and interest	Amount p.a

## Part 8. Declaration, Agreement and Consent

**Your 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 have 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 extend, renew, vary or reinstate a contract of insurance.

**Non-disclosure** - If you fail to comply with your duty of disclosure and the Insurer would not have entered into a contract on any terms if the failure had not occurred, the Insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract from its inception at any time. An Insurer who is entitled to avoid a contract of insurance may, within three 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 contribution that would have been payable if you had disclosed all relevant matters to the Insurer.

### General Declarations

- I agree that any personal statements made together with other relevant documents shall form the basis of the proposed contract of insurance with the Insurer.
- I consent to the Insurer collecting sensitive information that is, health information about me for the purposes of the performance of this contract.
- I agree that cover will not commence until the premium is paid and the proposal is accepted by the Insurer.
- I have read the Duty of Disclosure notice and understand what is meant by that notice.
- I also understand that my duty of disclosure continues after I have completed this application until the Insurer has accepted the risk.

I consent to the Insurer contacting me for further information where required.

Please provide day time phone number

Signature of person to be insured

Date



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## ADDITIONAL INFORMATION

Please use this section to assist with clarification of any issue

Please attach additional pages if there is insufficient room. Are you attaching additional information?  Yes

Lined area for providing additional information.

## ADDITIONAL HEALTH QUESTIONNAIRES

### 1) Skin Lesion/Skin Cancer/Sun Spots/Cysts

a.  Cyst  Mole  Sunspot  Skin lesion  Melanoma

Other (please specify): \_\_\_\_\_

b. Location of growth(s) (e.g. face, back, right arm): \_\_\_\_\_

c. Have you been advised that your growth(s) or skin lesion(s) were cancerous or malignant?  No  Yes

d. Have all or growths or skin lesions been removed or treated?  No  Yes ► Please specify:

Surgically removed/cut out  Frozen/burnt off  Topical cream

e. Were any further tests, investigations, treatments or follow ups recommended?

No  Yes ► Please provide dates and details of any recommended tests or treatment

\_\_\_\_\_

\_\_\_\_\_

f. Is your treating doctor different from the last doctor you consulted?

No  Yes ► Please provide doctor's contact details below:

Name of doctor or medical centre \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Facsimile \_\_\_\_\_

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## ADDITIONAL HEALTH QUESTIONNAIRES (continued)

### 2) High blood pressure questionnaire

- a. When were you first diagnosed with this condition?  Within the last 12 months  More that 12 months ago
- b. Do you have problems or complications resulting from this condition?  
(e.g. heart disease, kidney disorder)  No  Yes
- c. Are you taking regular medication for this disorder?  No  Yes
- d. Is your blood pressure being monitored by your doctor and considered to be well controlled?  
(e.g. less than 140/90)  No  Yes
- e. Is your treating doctor different from the last doctor you consulted?  
 No  Yes ► Please provide doctors contact details below:

Name of doctor or medical centre

Address

Phone  Facsimile

### 3) Raised cholesterol questionnaire

- a. When were you first diagnosed with this condition?  Within the last 12 months  More that 12 months ago
- b. Do you have problems or complications resulting from this condition? (e.g. heart disease)  No  Yes
- c. Are you taking regular medication for this disorder?  No  Yes
- d. When was your last cholesterol reading?  Within the last 12 months  More that a month ago
- e. What was the result of your last cholesterol reading?  
 Under 5.7  5.8 – 7.0  7.0 or above  Don't know?
- f. Is your treating doctor different from the last doctor you consulted?  
 No  Yes ► Please provide doctors contact details below:

Name of doctor or medical centre

Address

Phone  Facsimile

### 4) Asthma, bronchitis or any other lung complaint questionnaire

- a.  Asthma  Bronchitis  Other (please specify):
- b. Frequency of symptoms in the last 2 years?  Daily  Weekly  Occasionally (e.g. seasonal)  
 One off episode  None – childhood only
- c. Severity of the symptoms  Mild – infrequent attacks, exercise induced or seasonal  
 Moderate – frequent symptoms, no specific triggers, occasional steroid therapy  
 Severe – very frequent attacks with almost constant wheezing, restriction of work duties & frequent use of oral steroids
- d. In the last 12 months has this caused you to have time off work?  No  Yes ► Please provide details:  
Total number of days off work in the last 12 months
- e. Is your treating doctor different from the last doctor you consulted?  
 No  Yes ► Please provide doctors contact details below:

Name of doctor or medical centre

Address

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## ADDITIONAL HEALTH QUESTIONNAIRES (continued)

### 5) Anxiety/depression questionnaire

a. Please provide details of the condition (doctors diagnosis)

b. When did your symptoms start?

Within the last 6 months  6 – 12 months ago  12 – 24 months ago  More than 2 years ago

c. Have you ever been hospitalised for this condition?  Yes  No

d. Have you ever attempted suicide or had suicidal thoughts?  Yes  No

e. Are you still undergoing treatment, experiencing symptoms or have any residual restrictions to your work duties or lifestyle?  Yes  No ▶ When did your symptoms cease?

Within the last 6 months  6 – 12 months ago  12 – 24 months ago  More than 2 years ago

f. In the last two years has the condition caused you to lose time off work?  No  Yes ▶ Please provide details

Total number of days off work in the last 2 years

Is your treating doctor different from the last doctor you consulted?

No  Yes ▶ Please provide doctors contact details below:

Name of doctor or medical centre

Address

Phone

Facsimile

### 6) Joint/Musculoskeletal/Arthritis questionnaire

a. Nature of complaint (doctors diagnosis), e.g. back pain, sciatica, broken bone, dislocated shoulder?

b. What part of the body was affected, e.g. neck, back, arm?

c. Is the nature of the condition arthritic, degenerative or a disc problem?  Yes  No

d. When did your symptoms first occur?

Within the last 6 months  6 – 12 months ago  12 – 24 months ago  More than 2 years ago

e. In the last 12 months has this caused you to have time off work?  No  Yes ▶ Please provide details

Total number of days off work in the last 12 months

f. Are you experiencing symptoms or have any residual restrictions or limitations to your work?

Yes  No ▶ When did your symptoms cease?

Within the last 6 months  6 – 12 months ago  12 – 24 months ago  More than 2 years ago

g. In the last two years has the condition caused you to lose time off work?  No  Yes ▶ Please provide details

Total number of days off work in the last 2 years

Is your treating doctor different from the last doctor you consulted?

No  Yes ▶ Please provide doctor's contact details below:

Name of doctor or medical centre

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## ADDITIONAL HEALTH QUESTIONNAIRES (continued)

### 7) Any other condition questionnaire

- a. Name of condition
- b. The cause
- c. Describe symptoms
- d. Date symptoms commenced
- e. Date symptoms ceased
- f. How often do/did you have symptoms?
- g. Have you required any time off work due to this condition?  No  Yes ► Please provide details  
Total number of days off work in the last 12 months
- h. Have you had any treatment for this condition?  No  Yes ► Please provide details

Is your treating doctor different from the last doctor you consulted?

No  Yes ► Please provide doctor's contact details below:

Name of doctor or medical centre

Address

Phone  Facsimile

## ACTIVITIES QUESTIONNAIRES

### 1) Underwater diving questionnaire

- a. At what level do you participate?  Recreational only (non-competition)  Recreational only (with competition)  
 Semi-professional/professional
- b. How many times per year do you participate in this activity?  per year
- c. Do you ever dive:  
alone? e.g. without a buddy  No  Yes ► Please provide details  
over 40 metres in depth?  No  Yes ► Please provide details  
in wrecks, caves or potholes?  No  Yes ► Please provide details

- d. Have you ever had a diving accident, suffered from decompression sickness or the bends?

No  Yes ► Please provide details:

- e. What type of qualification do you hold?  No qualification  PADI  NAUI  BSAC  
 Other (please specify):

### 2) Motor sports questionnaire

- a. What type of motor activity do you engage in?
- b. What type of vehicle is used?
- c. At what level do you participate?  Recreational only (non-competition)  Recreational only (with competition)  
 Semi-professional/professional

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## ACTIVITIES QUESTIONNAIRES (continued)

### 2) Motor sports questionnaire (continued)

d. Have you ever been involved in any accidents whilst practising, testing or racing?

No  Yes ► Please provide details of when this occurred and whether you have any restrictions of your work duties or activities as a result

e.

Category (e.g. touring cars)	Class (e.g. AA/D)	Vehicle & type of fuel	Engine Capacity	No. of vehicles in event	Max speed km/hr

f. How many times per year do you participate in this activity? \_\_\_\_\_ per year

### 3) Flying questionnaire

a. What type of flying (private, commercial, agricultural etc)? \_\_\_\_\_

b. What type of aircraft (light aircraft, microlight etc)? \_\_\_\_\_

c. Total number of hours flown as a pilot? \_\_\_\_\_ Hrs

d. Number of hours in past 12 months Fixed Wing \_\_\_\_\_ Hrs Helicopter \_\_\_\_\_ Hrs

e. Number of hours expected in the next year as a pilot? Fixed Wing \_\_\_\_\_ Hrs Helicopter \_\_\_\_\_ Hrs

f. Geographical location \_\_\_\_\_

g. What class of license do you hold? \_\_\_\_\_

h. Do you intend to change the scope of your present license?  No  Yes ► Please provide details

### 4) Football questionnaire

a. What type of football code do you participate in?  Rugby League  Rugby Union  AFL

Touch football/Oztag  American Football  Soccer  Other

b. At what level do you participate?  Recreational only (non-competition)  Recreational only (with competition)

Semi-professional/professional

c. Do you receive payment from participating in this activity  No  Yes ► Please provide details

Amount per year \$ \_\_\_\_\_

d. In the last two years have you had a sporting injury eg (joint, back or head injury) that required time off work?

No  Yes ► Please provide details:

### 5) Other sports or hazardous activities questionnaire

a. Please name the sport or activity that you engage in? \_\_\_\_\_

b. Do you receive payment from participating in this activity  No  Yes ► Please provide details

Amount per year \$ \_\_\_\_\_

c. In the last two years have you had a sporting injury eg (joint, back or head injury) that required time off work?

No  Yes ► Please provide details:

d. How many times per month, or year do you engage in this activity? \_\_\_\_\_ per month \_\_\_\_\_ per year