

Benefits Required				
Type of Cover (choose one)	24 Hours (365 days) <input type="checkbox"/>	Outside working Hours (leisure time only) <input type="checkbox"/>		
	Sum Insured			
Capital Benefits (including Death Benefit)	\$	Conditions 1-30 <input type="checkbox"/>	Death only <input type="checkbox"/>	
Weekly Benefit - Injury	\$	Benefit Period	weeks	
Weekly Benefit - Illness	\$	Benefit Period	weeks	
Excluded Period of Claim	week(s)			

Note: As a guide to selecting a Capital Benefit sum insured, use a multiple of your weekly benefit and the benefit period, (e.g. Weekly benefit of \$1,000 multiplied by the benefit period of 104 weeks equalling \$104,000).

Insurance Details	
Is the Person to be insured entitled to claim benefits from Workcover?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Is the Person to be insured entitled to claim benefits from any other existing or intended injury or illness insurance policy?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Has any policy, or application, for injury or illness insurance concerning the Person to be insured ever been declined, modified, accepted at an increased premium, cancelled or refused renewal?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Has the Person to be insured ever claimed benefits from Workcover?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Has the Person to be insured ever claimed benefits under any injury or illness insurance policy?	No <input type="checkbox"/> Yes <input type="checkbox"/>
If the answer is 'Yes' to any of the above questions concerning past claims or other insurance, please provide details:	

Medical Details	
Has the Person to be insured in the last 10 years received treatment or advice from a Registered Medical Practitioner (including but not limited to a doctor, chiropractor, physiotherapist, psychiatrist or naturopath) in relation to:	
Heart, arteries, high cholesterol or high blood pressure or disorders of the circulatory system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Lungs, asthma, tuberculosis or disorders of the respiratory system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Kidney, bladder, liver, spleen, bowel or disorders of the genito-urinary system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Brain, Epilepsy or disorder of the central nervous system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Stomach, oesophagus or disorders of the digestive system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Head, back, neck or spine or any disorder of the musculoskeletal system?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Depression, psychological, psychiatric or personality disorder?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Drug or alcohol dependence?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cancer or tumour?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Diabetes?	No <input type="checkbox"/> Yes <input type="checkbox"/>
HIV, AIDS or AIDS related conditions?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any Disorder of the Eyes or Ears?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Hepatitis?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any hernia or associated condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Ulcers?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Arthritis or rheumatism?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Physical impairment or deformity?	No <input type="checkbox"/> Yes <input type="checkbox"/>
If the answer is 'Yes' to any of the above, please provide details as to the nature of the illness or injury and the treatment or advice given, including: when identified and treated, duration, cause, nature of treatment, current condition, name and addresses of doctors and hospitals consulted (if there is insufficient space, please attach details)	

Medical Details (continued)

Does the Person to be insured currently have any symptoms of ill health or injury?
(Note: It is not necessary to answer 'Yes' if only for colds or flu)

No Yes

If 'Yes' , please provide details below:

Is the Person to be insured taking any prescription medications?
(Note: It is not necessary to answer 'Yes' if only for colds or flu)

No Yes

If 'Yes', please state name of medication, dosage (if known) and the condition it is treating:

Activity Details

Does the Person to be insured participate in any hazardous pursuits or activities, including but not limited to motor sports in any form, rock climbing or mountaineering, water skiing, snow skiing, snow boarding, horse riding, canyoning, motor cycling, parachuting, abseiling, kite surfing, mountain biking, scuba diving, football of any code or any other body contact sports?

No Yes

If 'Yes', please provide details:

Duty of Disclosure

Under the Insurance Contracts Act 1984 (the Act), you have a Duty of Disclosure. The Act requires that before a Policy is entered into, you must give us certain information we need to decide whether to insure you and anyone else to be insured under the Policy, and on what terms. Your Duty of Disclosure is different, depending on whether this is a new Policy or not.

New business

Where you are entering into this Policy for the first time (that is, it is new business and is not being renewed, varied, extended or reinstated) you must tell us everything you know and that a reasonable person in the circumstances could be expected to tell us, in answer to the specific questions we ask.

When answering our questions you must be honest.

- **Who needs to tell us**

It is important that you understand you are answering our questions in this way for yourself and anyone else whom you want to be covered by the Policy.

- **If you do not tell us**

If you do not answer our questions in this way, we may reduce or refuse to pay a claim, or cancel the Policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the Policy as never having worked.

- **You do not have to tell us about any matter:**

- that diminishes the risk
- that is of common knowledge
- that we know or should know in the ordinary course of our business as an insurer, or
- which we indicate we do not want to know.

- **If you do not tell us**

If you do not comply with your Duty of Disclosure we may reduce or refuse to pay a claim or cancel your Policy. If your non-disclosure is fraudulent we may treat this Policy as never having worked.

Privacy

QBE includes information about how we manage your personal information in our Product Disclosure Statement and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our www.qbe.com or contact the Compliance Manager on 02 9375 4656 or email compliance.manager@qbe.com for further information.

Declaration and Authorisation

Please remember we will treat a statement or claim or an act or omission by any one of the applicants as a statement or claim or an act or omission by all of the applicants.

1. I/We have received a copy of the combined PDS and Policy Terms and Conditions.
2. I/We declare that all answers and statements made in the application are true, correct and complete in every respect.
3. I/We authorise QBE Insurance (Australia) Limited ABN 78 003 191 035 to give to or obtain from other insurers or insurance reference bureaus or credit reporting agencies, any information about this insurance or any other insurance of mine including this completed application and my insurance claims history and my credit history.

Signature of Applicant

X

Date

Signature of Person to be insured

X

Date

Office Use Only

	Premium		
Total Premium	\$	Occupational Code	
GST	\$	Class	
Government Stamp Duty	\$	Workers' Compensation Discount Allowed?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Total Amount Payable	\$		
Accepted by		Authorisation No.	
Special attention		Replaced Policy Number	
Clause codes			