



# Personal statement and declaration of health

Complete this form to apply for, or increase, insurance cover in smartMonday DIRECT or PRIME ('the fund'). Refer to the relevant Product Disclosure Statement (PDS) for information on conditions and the cost of insurance. Insurance is subject to acceptance by the insurer and confirmation by the insurer in writing.

## 1. Your details

If you have any questions, please call us on **1300 880 588** or email [enquiries@smartMonday.com.au](mailto:enquiries@smartMonday.com.au)

For more information go to our website [smartMonday.com.au](http://smartMonday.com.au)

Please select the appropriate option below and fill in the member number if known.

smartMonday DIRECT member  smartMonday PRIME member

Employer name (if you are a member of an employer-sponsored plan in smartMonday PRIME)

Member number (if known)

Title Given names

Surname

Date of birth (DD/MM/YYYY) Sex (M or F)

Telephone

Mobile

Email

Postal address

Suburb

State

Postcode

Occupation

Industry

Send your completed form to: smartMonday, Reply Paid 1949, Wollongong DC, NSW 2500 (no stamp required).

smartMonday is the business name of the Aon Master Trust ABN 68 964 712 340 (the fund) which has been registered by Aon Hewitt Limited ABN 48 002 288 646 AFSL 236667 as sponsor of the fund. The Trustee of the fund is Equity Trustees Superannuation Limited ABN 50 055 641 757 AFSL 229757 RSE Licence L0001458. smartMonday PRIME, smartMonday DIRECT and smartMonday PENSION products are part of the fund.

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043) is the insurer for the fund.

Employment status

Full time   
  Permanent part time   
  Casual   
  Non

Total hours worked per week

Daily duties (including % time spent on each duty, eg manual duties 100%)

Your annual before-tax salary (if self employed, revenue less any business expenses but before tax)

\$

## 2. Death and total permanent disablement (TPD) cover

Please select the appropriate option below and fill in the amount of cover required and indicate whether it is new cover or an increase to existing cover.

Death cover   
 Total amount required (including any existing insurance) \$  (complete amount)

New   
  Increase

TPD cover   
 Total amount required (including any existing insurance) \$  (complete amount)

New   
  Increase

You can apply for TPD cover that is higher than death cover. Maximum limits and a premium loading apply – see the Product Disclosure Statement (PDS) more information.

Please choose a TPD definition\* that will apply to you in the event of a TPD claim (to be completed by smartMonday DIRECT members only).

Standard definitions for TPD – Apply automatically unless you choose the following definition.  
 Home duties TPD definition – Where you are wholly engaged in full-time unpaid domestic duties in your own residence.

\* For information on TPD definitions, please read the *Insurance* reference guide of the smartMonday DIRECT PDS.

## 3. Income protection insurance cover

Please select the appropriate option below and fill in the amount of cover required. Income protection cover is only available if you are gainfully and permanently employed for a minimum of 15 hours per week.

Income protection cover

Amount of income insured   
  % up to 75% of annual income  
 OR fixed amount of \$  per month  
 (monthly benefit can be up to 75% of monthly income)

PLUS (not available for Agreed Value income protection)

Superannuation contributions   
  % up to 10% of annual income  
 (these are paid directly into your super account)

Is this new cover or an increase to existing cover? *Select one option only.*

New  Increase

*If you are a smartMonday DIRECT member, you have the choice of Indemnity or Agreed Value income protection cover. Select one option only.*

Indemnity  Agreed Value

Please indicate the benefit and waiting period you require.

Maximum benefit period *(tick one box)*

Up to 2 years  Up to 5 years  To age 65

Waiting period *(tick one box)*

30 days  60 days  90 days

- see the *Insurance* reference guide of the PDS for more information
- if you do not tick the boxes above, no insurance will be provided

#### 4. Your personal history

1. Your height  cm Your weight  kg

2. Are you a permanent resident of Australia?  Yes  No

3. Do you drink alcohol?  Yes  No

If YES, what type of alcohol?

How much is your weekly intake?

4. Have you smoked any tobacco or any other substance in the last 12 months? If YES, please state forms and quantities below.  Yes  No

5. Do you intend to work, live or travel overseas? If YES, state the destination, duration, frequency and purpose of travel below.  Yes  No

6. Have you engaged or are you ever likely to engage in aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (eg motor racing, football, martial arts, scuba diving)?  Yes  No

7. Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full-time basis?  Yes  No

8. Has any company ever declined, deferred, applied special or modified conditions, or cancelled any proposal to insure you for a life or disablement policy?  Yes  No



If you answered YES to questions 4–8 above, please give full details (attach signed and dated supplementary letter if required) If you answered YES to questions 4–8 above, please give full details (attach signed and dated supplementary letter if required)

9. Do you have existing life, disability or trauma insurance cover  Yes  No  
*(including any current applications held with any insurer)?*

If YES, please provide the policy details below

Commencement date (DD/MM/YYYY)  Insurer

Type of cover  Amount of cover (\$)

To be replaced\*  Yes  No

Commencement date (DD/MM/YYYY)  Insurer

Type of cover  Amount of cover (\$)

To be replaced\*  Yes  No

Commencement date (DD/MM/YYYY)  Insurer

Type of cover  Amount of cover (\$)

To be replaced\*  Yes  No

## 5. Your medical history

### 5a. Medical details

Have you **ever** suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Asthma, chronic lung disease, sleep apnoea or other respiratory disorder.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Indigestion, gastric or duodenal ulcer, hernia/s or any bowel disorder.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Diabetes, abnormal blood sugar, gout or thyroid disorder.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Depression, anxiety/stress state, fatigue, panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder.                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness, tremor or recurrent headaches or any neurological disorder including multiple sclerosis. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Arthritis, repetitive strain injury (RSI), chronic fatigue syndrome, fibromyalgia.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Psoriasis or eczema, skin disorder, defect in hearing or sight.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Cancer, cyst or tumour of any kind.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Liver, pancreas, prostate, kidney or bladder disorder, renal colic or stone.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Hepatitis B or C or are a Hepatitis B or C carrier, Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus.                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Females only: Have you <b>ever</b> had or been advised to have treatment for:  |                              |                             |
| i. Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ii. An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| iii. Abnormal vaginal bleeding within the last 12 months or endometriosis?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Have you ever been involved in an accident that has caused you to be off work or reduce your working capacity for greater than 10 consecutive days?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. Have you consulted a chiropractor, osteopath, physiotherapist or acupuncturist?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p. Have you ever suffered symptoms of or had any other illness, disease or disorder?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q. In the last 5 years have you  |                              |                             |
| i. Had any medical examinations, consultations, X-rays, pathology tests or procedures?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ii. Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r. During the last five years have you had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s. "Are you currently under ongoing monitoring, consultations or review for any condition, complaint or finding?"  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



**5b. Answers in detail**

If you answered YES to ANY question in Your medical history, please provide details in the space below. If there is insufficient space, please provide a signed and dated supplementary letter with details.

**Reference 1**

Question number	Tests, or nature of condition or complaint
<input type="text"/>	<input type="text"/>

Full details of treatment and results (include type of operations)

Commencement date (DD/MM/YYYY)	Time off work	Degree of recovery (%)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Full name and address of doctor or hospital (if any)

**Reference 2**

Question number	Tests, or nature of condition or complaint
<input type="text"/>	<input type="text"/>

Full details of treatment and results (include type of operations)

Commencement date (DD/MM/YYYY)	Time off work	Degree of recovery (%)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Full name and address of doctor or hospital (if any)

**Reference 3**

Question number	Tests, or nature of condition or complaint
<input type="text"/>	<input type="text"/>

Full details of treatment and results (include type of operations)

Commencement date (DD/MM/YYYY)	Time off work	Degree of recovery (%)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Full name and address of doctor or hospital (if any)

**Reference 4**

Question number

Tests, or nature of condition or complaint

Full details of treatment and results (include type of operations)

Commencement date (DD/MM/YYYY)

Time off work

Degree of recovery (%)

Full name and address of doctor or hospital (if any)

**5c. Personal doctor's details (please provide current details)**

Name

Address

Suburb

State

Postcode

Telephone

Facsimile

ABN (if known)

Email

Date of last consultation (DD/MM/YYYY)

How long have you been a patient?

Please state the reasons and results of your last consultation

**5d. Family history**

Have any of your immediate family (father, mother, brother, sister) prior to age 60 (living or dead) ever suffered from heart disease, breast cancer, ovarian cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, mental disorder, stroke, Huntington’s chorea, or any hereditary disease?

Yes       No

If YES, please provide details in the schedule below.

**Relation 1**

Relationship to you	Age at onset <i>(approximately)</i>	Age at death <i>(if applicable)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Condition/illness *(for cancer, specify type)*

**Relation 2**

Relationship to you	Age at onset <i>(approximately)</i>	Age at death <i>(if applicable)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Condition/illness *(for cancer, specify type)*

**Relation 3**

Relationship to you	Age at onset <i>(approximately)</i>	Age at death <i>(if applicable)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Condition/illness *(for cancer, specify type)*

**Relation 4**

Relationship to you	Age at onset <i>(approximately)</i>	Age at death <i>(if applicable)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Condition/illness *(for cancer, specify type)*



## 6. Your income details

Only complete this section if you have applied for *Income protection insurance cover*.

What is your income from your current occupation? (*personal income is income earned by your personal exertion, do not include investments*). Please select one option below only.

Self employed (*go to page 10*)       Employee (*complete appropriate section below*)

### Employee

1. If you are an employee, your income is the total value or remuneration paid by your employer including salary, fees, regular commission, regular bonuses, regular overtime, fringe benefits and superannuation contributions (statutory or voluntary).

State your principal annual income for the **current** financial year

\$  Year ending 30 June  20  (YY)

State your principal annual income for the **previous** financial year

\$  Year ending 30 June  20  (YY)

2. How long have you been employed in your current occupation?

years and  months

3. If your current income differs from your income in the previous financial year, please state the reason for change

4. If you have a **second occupation**, please provide the following details:

Occupation

Daily duties (including % time spent on each duty, eg manual duties 100%)

**Current** hours worked per week

**Weeks** worked per year

Net income (*before tax*)

\$  Last financial year ending 30 June  20  (YY)

Net income (*before tax*)

\$  Previous financial year ending 30 June  20  (YY)

5. Do you earn commissions or bonuses?  Yes  No

If YES, please state percentage of total income  % (*complete amount*)

6. If you become disabled, would you receive income from other sources? (*Include any unearned income from investments such as rental property or dividends*)

Yes  No

If YES, state source (*eg sick leave, director's fees, salary, trail commission, salary continuance insurance, profit share from a business etc*).

Source of income

How much per month

\$ [ ] for how long? [ ] years and [ ] months

7. Do you receive other income from investments (such as net rental property income, dividends or interest).

Yes  No

If YES, how much (net of costs and expenses) \$ [ ] per month  
(do not include negatively geared investments).

8. What was your previous occupation?

[ ]

**Self employed**

1. Are you self-employed, employed by your own company or partnership?

Yes  No (If NO, go to Section 7)

If YES, date your business started [ ]

**If you are self-employed**, a working director or partner in a partnership, your income is the income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses.

		Last financial year 30 June (YY)	Previous financial year 30 June (YY)
		20	20
Gross business income/revenue	\$	[ ]	\$ [ ]
Total business expenses	- \$	[ ]	- \$ [ ]
Net business income/revenue (before tax)	= \$	[ ]	= \$ [ ]
% share of net business income (add back your own portion of personal salary/wages, superannuation contributions, spouse's income if income splitting, share of depreciation)	%	[ ]	% [ ]
<b>Total net earned income (before tax)</b>	+ \$	[ ]	+ \$ [ ]
	= \$	[ ]	= \$ [ ]

2. How long have you been self-employed?

[ ] years and [ ] months

3. How long have you been employed in your current occupation?

[ ] years and [ ] months

4. If your current income differs from your income in the previous financial year, please state the reason for change

[ ]

5. If you have a **second occupation**, please provide the following details:

Occupation	Daily duties (including % time spent on each duty, eg manual duties 100%)		
<input type="text"/>	<input type="text"/>		
<b>Current</b> hours worked per week	<b>Weeks</b> worked per year		
<input type="text"/>	<input type="text"/>		
Net income (before tax)			
\$ <input type="text"/>	Last financial year ending 30 June	<input type="text"/>	(YY)
Net income (before tax)			
\$ <input type="text"/>	Previous financial year ending 30 June	<input type="text"/>	(YY)

6. Do you earn commissions or bonuses?  Yes  No

If YES, please state percentage of total income  % (complete amount)

7. What percentage of your work is:

Freelance  %  %  
 (complete amount) (complete amount)

Contract  %

8. How many people do you employ?

9. Please provide employee details (excluding yourself) in the table below

**Employee details 1**

Occupation of all partners/employees	Family member Y/N	
<input type="text"/>	<input type="text"/>	
Daily duties		
<input type="text"/>		
Full time/part time/contractor	Monthly remuneration	% Interest in business
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Employee details 2**

Occupation of all partners/employees	Family member Y/N	
<input type="text"/>	<input type="text"/>	
Daily duties		
<input type="text"/>		
Full time/part time/contractor	Monthly remuneration	% Interest in business
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Employee details 3**

Occupation of all partners/employees  Family member Y/N

Daily duties

Full time/part time/contractor  Monthly remuneration  % Interest in business

**Employee details 4**

Occupation of all partners/employees  Family member Y/N

Daily duties

Full time/part time/contractor  Monthly remuneration  % Interest in business

**Employee details 5**

Occupation of all partners/employees  Family member Y/N

Daily duties

Full time/part time/contractor  Monthly remuneration  % Interest in business

10. Has your company had a net operating loss in the last two years? *(If YES, please provide copies of Profit & Loss Statements for all entities).*

Yes  No

11. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?

Yes  No

If YES, when?  Date of discharge

12. Do you work at home?

Yes  No

If YES, state percentage of time  % *(complete amount)*

13. If you become disabled, would you receive income from other sources? *(Include any unearned income from investments such as rental property or dividends)*

Yes  No

If YES, state source *(eg sick leave, director's fees, salary, trail commission, salary continuance insurance, profit share from a business etc).*

Source of income

How much per month

\$  for how long?  years and  months

14. Do you receive other income from investments *(such as net rental property income, dividends or interest)*.

Yes  No

If YES, how much (net of costs and expenses) \$  per month  
*(do not include negatively geared investments).*

15. What was your previous occupation?

## 7. Lifestyle Statement

1. Have you ever injected yourself with any illicit drugs not prescribed by a medical practitioner?

Yes  No

2. In the past 5 years have you:

a. Engaged in male to male sexual activity **without** a condom (except in a relationship between you and only one other person where neither of you has had sex without a condom with anyone else in the past 5 years) or

b. Had sex without a condom:

- with someone you know or suspect to be HIV positive or
- with someone who injects non prescribed drugs or
- with a sex worker or as a sex worker? (Yes/No)

I am ABLE to declare that ALL the above statements are true.

I am UNABLE to declare that ALL the above statements are true.

If you are unable to complete the AIDS declaration, please provide reason(s):

Before signing, one of the above boxes must be ticked.

Signature

Date (DD/MM/YYYY)

## 8. Declaration and agreement

### Duty of disclosure

Before you become covered by the insurer, you need to disclose to the insurer anything that you know, or could reasonably be expected to know, may affect the insurer's decision to insure you and on what terms. You also need to do so before you extend, vary or reinstate your insurance cover.

You owe the insurer a statutory duty of disclosure under the Insurance Contracts Act 1984 (Cth). If you fail to disclose these things to the insurer, this may be treated as a failure to comply with this statutory duty. The insurer may then have the rights described below. You do not need to tell the insurer anything that reduces the insurer's risk, is common knowledge, the insurer knows or should know as an insurer, or the insurer waives your duty to tell it about.

The insurer has a number of rights in the event of non-disclosure. In exercising these rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, the insurer may apply the following rights separately to each type of cover. The rights are as follows:

- If you do not tell the insurer anything you are required to, and the insurer would not have provided the insurance if you had told them, the insurer may avoid the contract within 3 years of entering into it.
- If the insurer chooses not to avoid the contract, the insurer may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if you had told the insurer everything you should have. However, if the contract 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 of insurance provided, the insurer may, at any time vary the contract in a way that places the insurer in the same position they would have been in if you had told the insurer everything you should have. However, this right does not apply if the contract provides cover on death.
- If the failure to tell the insurer is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

### Economic or trade sanctions

If you have a trade or economic sanction placed against you then you will not be eligible for insurance cover and would not be paid out on any claim received on or after that date. The insurer could be exposed to penalties or restrictions if cover was provided to a sanctioned person.

### Privacy

#### Aon

Aon is committed to protecting your personal information in accordance with the Australian Privacy Principles under the Privacy Act 1988 (Cth). We collect, use and disclose personal information to offer, promote, provide, manage and administer the many financial services and products we and our group of companies are involved in as set out in the [Aon Privacy Notice](#). In order to do this, we may also share your information with other persons or entities who assist us in providing or promoting our services as set out in the Aon Privacy Notice.

Further information about our privacy practices can be located in the [Aon Australia Group Privacy Policy Statement](#) which can be viewed on our website at [smartMonday.com.au](http://smartMonday.com.au) or a copy can be sent to you on request by your Aon representative. You may also gain access to your personal information, or modify your privacy preferences, by contacting your Aon representative or our Privacy Officer through the means set out in the [Aon Privacy Notice](#).

### AIA Australia

Your privacy is important to AIA Australia. By becoming a member, or otherwise interacting or continuing your relationship with AIA Australia directly or via a representative or intermediary, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of personal and sensitive information (“Personal Information”) in the manner described in the AIA Australia Privacy Policy on AIA Australia’s website as updated from time to time. AIA Australia’s current Privacy Policy is available at [www.aia.com.au](http://www.aia.com.au) or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia’s Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect Personal Information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your Personal Information from, and provide to, third parties in Australia and overseas, such as your representatives (including your financial adviser), the trustee and administrator of a superannuation fund, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your Personal Information under various laws including insurance, taxation, financial services and other laws set out in AIA Australia’s Privacy Policy; and
- disclose Personal Information to third parties which may be located in Australia, South Africa, the US, the United Kingdom, Europe, Asia and other countries including those set out in AIA Australia’s Privacy Policy and you acknowledge that Australian Privacy Principle 8.1 (which relates to cross-border disclosures) will not apply to the disclosure, AIA Australia will not be accountable for those overseas parties under the Privacy Act and you may not be able to seek redress under the Privacy Act.

If you do not provide the required Personal Information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your Personal Information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia’s Privacy Policy. The most recent version of the AIA Australia Privacy Policy at [www.aia.com.au](http://www.aia.com.au) applies to and supersedes all previous Privacy Policies and/or Privacy Statements and privacy summaries that you may receive or access.

### General declarations

- I declare that the above statements are true and correct (whether written in my hand or not) and that no information material to the insurance has been withheld.
- 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 appointed by the fund.
- I consent to the fund and/or the insurer collecting sensitive information, that is, health information about me for the purposes of providing insurance.
- I agree that cover will not commence until the premium is paid and the application is accepted by the insurer.
- I have read the Duty of Disclosure notice and understand it. I also understand that my duty to disclose continues after I have completed this application until the insurer has accepted the risk.
- I understand that I must advise the insurer of any material change in my health during the period between the application date below and the cover commencement date.
- I agree to be bound by the provisions of the relevant insurance policy between the insurer and the fund, the terms and conditions of which are set out in the relevant smartMonday DIRECT or smartMonday PRIME PDS.
- I have read the *Aon Privacy Notice* and the *AIA Australia Limited Privacy Policy* and consent to my personal and sensitive information being handled in accordance with the *Aon Privacy Notice* and *AIA Australia Limited Privacy Statement*.
- If I am disclosing personal information about another person, I have obtained their consent to disclose their personal information to Aon and the insurer and I have made them aware that Aon and the insurer may disclose their information to third parties that are reasonably necessary to assist in the provision of the relevant services or products. If I have not obtained the consent of the other person, I will inform Aon and the insurer of such.
- I consent to you contacting any medical practitioner, medical provider, health professional, hospital, dentist, any other person who has attended me and such other third parties as is necessary to obtain personal and sensitive information for the purpose of processing my application.

Signature

Date (DD/MM/YYYY)