ENCOMPASS PROTECTION DATA CAPTURE FORM

Encompass PROTECTION

This form has been designed to help you capture the information required to submit an online application for an Encompass Protection policy.

All questions in this data capture form should be answered, unless it's indicated that the question is only applicable for clients applying for a particular cover type.

As the online application is dynamic, with several thousand rules designed to maximise automatic acceptance rates, the questions asked in this form are not exhaustive for all medical conditions. However, they've been designed to assist you in completing the questions required for the most commonly suffered conditions.

When entering the data collected in this form into the online application, you'll be prompted if further information is required. Our online application allows you to save the application at any point, and resume it as soon as you've gathered the additional information from your client.

Important notes

We don't accept paper applications; all data collected in this form will need to be entered into our online application system – **please don't mail this form to us.**

The answers you enter into the online application, including your client's policy declaration, form part of your client's contract of insurance with the insurer.

Once the online application has been completed and submitted, the responses entered will be immediately emailed to your client, in the form of an application summary PDF. Your client must check the application summary and inform us of any errors or omissions within five working days.

Before you use this data capture form, we recommend that you explain its purpose to your client, that their application will be submitted electronically and the importance of completing all questions honestly in line with their obligation not to make a misrepresentation. You should explain the importance of reviewing their application summary to ensure the answers they've provided have been recorded correctly.

If you're utilising our tele-interview services, please skip the following sections:

- Section 6-11
- Section 13 (Medical questionnaires)

Adviser administration

Client name

Client reference number (if applicable)

encompassprotect.com.au
GPO Box 239, Sydney NSW 2001
e: adviser@encompassprotect.com.au t: 1300 576 049

EF001_0824

1. Insured person details

Insured person's name | Title | First name | Middle name(s) | Last name

Date of birth ☐☐ / ☐☐ / ☐☐☐☐

2. Contact details

2.1 Phone and email address

Email

Telephone | Home | Mobile | Business hours

Please note that sensitive/personal information may be sent to your email address.

2.2 Residential address

Unit number | Street number | Street name

Suburb | State | Postcode | Country

2.3 Postal address

Unit number/ PO Box number | Street number | Street name

Suburb | State | Postcode | Country

3. Existing insurance details

3.1 Do you have any existing Life, Total and Permanent Disability (TPD), Critical Illness/Trauma or Income Protection insurance with another insurance company or via a group arrangement with your employer?

☐ Yes ☐ No

If **YES**, please confirm your total level of cover across all of the policies you have for each cover type:

	Total cover *(excluding any Encompass Protection cover type being applied for)*	**Is cover being replaced?**
Life Cover	**$**	☐ Yes ☐ No
TPD Cover	**$**	☐ Yes ☐ No
Critical Illness Cover	**$**	☐ Yes ☐ No
Income Protection Cover ☐ WP ☐ BP	**$**	☐ Yes ☐ No

4. Occupation and income

Occupation

Employer name / business name / industry type

Depending on the information entered, this second field may or may not be asked online

4.1 Which of the following best describes your employment situation?

- ☐ Employee – permanent full-time or part-time, or employed contractor
- ☐ Self-employed – via a partnership/company/trust structure or sole trader or self-employed contractor
- ☐ Casual worker. If selected, have you been working for the same employer for the last two years? ☐ Yes ☐ No
- ☐ Retired or unemployed

Complete only if you're an employee

4.2 What is your current annual income before tax? $

*For **employed** individuals (those that have no direct or indirect ownership in the business they are employed in) - this is your gross monthly income earned from personal exertion by way of total remuneration package including salary, regular overtime, salary sacrifice amounts, bonuses, commissions, share of profits and other fringe benefits. Bonuses, commissions, share of profits and other similar payments should only be included if they are reliably recurrent. Compulsory superannuation payments should not be included here (salary sacrificed superannuation can be included).*

*For **self-employed** individuals: This is your share of the gross monthly income generated by the business, or professional practice, as a result of your personal exertion less your share of the allowable business expenses necessarily incurred in generating that income.*

Complete only if you're self-employed

4.3 How much did you personally earn in the last full financial year? $

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

Complete only if you're an employee

4.4 How much did you personally earn in the full financial year prior to your answer to question 4.2? $

Complete only if you're self-employed

4.5 How much did you personally earn in the full financial year prior to your answer to question 4.3? $

4. Occupation and income continued

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

Complete only if you're self-employed

4.6 **Do you expect to earn at least as much in this financial year as you did last financial year? (i.e. the amount you entered into question 4.3)**

Answer ***NO*** if your earnings reduced down since the end of the last financial year to now.

☐ Yes ☐ No

If **NO**, please explain why your earnings have reduced from the LAST full financial year to now:

4.7 **In either of the last two full financial tax years, on average did you receive net passive income greater than 25% of your personal income and/or unearned income or net investment income over $20,000?**

☐ Yes ☐ No

Passive income means income which you receive that is not income earned from personal exertion, working or from the conduct of a business. Passive income includes income such as interest, dividends, net rental income, ongoing contractual royalties, annuities, or other similar income

If **YES**, please provide further details where this income is derived from, and the amount received for each of the last two years and what you expect to receive this year.

4.8 **How many hours do you work in a typical working week?** Hours

If you work less than 20 hours or more than 50 hours per week, please provide full details of your working pattern and hours worked over the last four weeks.

4.9 **Are you currently off work, working reduced hours or have you altered your work duties due to illness or injury?**

☐ Yes ☐ No

If **YES**, please confirm the reason and provide full details.

4. Occupation and income continued

4.10 **Do you have any definite plans to change your occupation, work duties, working hours or employment status or are you aware of any future change that may impact this?**

This includes any plans to start your own business, change industry, take extended leave or parental leave, within the next 12 months.

☐ Yes ☐ No

If **YES**, please describe the intended change in detail including any change in your occupation/duties, the number of hours worked or employment status:

4.11 **Do you have another occupation?**

☐ Yes ☐ No

If YES, do you spend more than 10% of your total working hours performing the duties of your second occupation?

☐ Yes ☐ No

Have you included any income from your second occupation in the income amounts you provided above for the last full financial year and the previous full financial year?

☐ Yes ☐ No

If **YES**, please provide full details of your second occupation and your duties as well as the income being included from each occupation (if any at all).

TO BE COMPLETED FOR INCOME PROTECTION ONLY

4.12 **Have you been continuously working in your occupation, trade or profession for the last two years?**

☐ Yes ☐ No

If **NO**, please explain the reason and provide a description of your previous occupation.

Complete only if you're an employee

4.13 **Do you receive any variable income (for example commission or bonuses) that would make up more than 30% of your base salary?**

☐ Yes ☐ No

If **YES**, please provide further details where this income is derived from, and the amount received for each of the last two years and what you expect to receive this year.

4. Occupation and income continued

Complete only if you're self-employed

4.14 **How many employees are there in your business (not including yourself)?**

Please answer only in whole numbers (and round up or down). For example, if you have two full-time employees and one part-time employee working three days a week (0.6 FTE), the answer would be '3'.

4.15 **How many of these are income producing employees (not including yourself)?**

An employee whose activities generate revenue for the business, that is not dependent on the involvement of the applicant?

4.16 **Has your business been trading profitably for each of the last two full financial years?**

☐ Yes ☐ No

If **NO**, please provide full details of the reason why.

4.17 **Would your business continue if you were unable to work in the business?**

☐ Yes ☐ No

If **YES**, would your income continue for more than 30 days in the event you were unable to work?

☐ Yes ☐ No

If **YES**, then please provide full details.

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

4.18 **Are you or any business you're associated with, contemplating voluntary administration, or have you or any business you're associated with been bankrupt or placed into receivership, involuntary liquidation or under administration?**

☐ Yes ☐ No

If **YES**, please provide full details including the date, the circumstances that led to this and whether it's been discharged.

4. Occupation and income continued

TO BE COMPLETED FOR ALL COVER

For occupation categories white collar (WCA) and white collar professionals (WCP) only

4.19 **Do your occupation duties include any manual work or hazardous duties?**

This includes but is not limited to regular lifting, driving heavy machinery and / or working at heights, working underground, working with explosives or underwater diving.

☐ Yes ☐ No

If **YES,** please advise what percentage of time is spent performing these duties, the type of duties performed and whether they are considered normal for the occupation you have been quoted.

Please note that for white collar (WCA) and white collar professionals (WCP), the manual duties question will only be asked for TPD and Income Protection, whereas the hazardous duties question will be asked for all benefits.

For occupation categories WCM, LBC, BC, HB, SRA, SRB, SRC, IC, UI only

4.20 **Do your occupation duties include working at heights above 10 metres, working underground, working with explosives or underwater diving?**

☐ Yes ☐ No

If **YES** to working at heights, please advise how many hours are worked at heights 10-20 metres, above 20 metres, whether this involves working outside of a fixed structure, average and maximum heights worked, and duties being performed.

If **YES** to working underground, please advise percentage of weekly working hours spent underground and the type of duties being performed.

If **YES** to working with explosives, please advise percentage of weekly working hours spent working with explosives, duties performed, details of safety measures in place and environment worked in.

If **YES** to underwater diving, please advise average depths dived at, maximum depths dived at, duties performed whilst underwater diving, percentage of weekly work spent underwater diving, whether in local Australian waters only and whether any search and rescue or salvage work.

5. Purpose of cover

5.1 **What is your purpose for applying for Encompass Protection life insurance?**

☐ Personal ☐ Business / keyman insurance ☐ Combination of personal and business

If the purpose of your insurance is to provide buy/sell cover, please explain how your business has been valued and by whom. If the purpose is for loan protection cover, please provide details of all current loan facilities and drawn down amounts. If the purpose is for key person cover, please provide an overview of the key person's duties, skills, remuneration package and any other relevant background information.

6. Personal details

6.1 **What is your height?**

Please state your height in metres and centimetres e.g. 1.75

6.2 **What is your weight?**

Please state your weight in kilograms. If you're currently pregnant, please tell us your weight immediately before your pregnancy.

7. Tobacco usage history

7.1 **Which of the following are you?**

☐ Non-smoker (life-long)
☐ Ex-smoker (please complete 7.2)
☐ Smoker (please complete 7.3)
☐ Very occasional smoker
☐ User of e-cigarettes or vapes in the last year
☐ User of other nicotine replacement products in the last year

7.2 **If you've ticked the ex-smoker box, please confirm the date you last smoked.** ☐☐ / ☐☐ / ☐☐☐☐

7.3 **If you've ticked the smoker box, please confirm what you smoke and the quantity.**

8. Family history

8.1 **Have your parents, or siblings (related by blood) had any of the following conditions before the age of 65? Please tick all applicable boxes.**

You don't need to indicate (tick) anything if your family member was 65 or older when they were first diagnosed, or they first suffered symptoms.

- ☐ Heart disease, heart attack, angina or stroke
- ☐ Cardiomyopathy
- ☐ Cerebral Aneurysm
- ☐ (Females only) Breast or ovarian cancer
- ☐ Bowel cancer
- ☐ Other cancer
- ☐ Diabetes
- ☐ Haemochromatosis
- ☐ Polycystic kidney disease (PCKD)
- ☐ Retinitis Pigmentosa
- ☐ Muscular dystrophy, Huntington's disease or Motor Neurone disease
- ☐ Parkinson's disease or multiple sclerosis
- ☐ Any other hereditary disorder
- ☐ No contact with family members/don't know
- ☐ None of the above

If you've ticked any of the boxes above with the exception of the last two check boxes, please confirm how many family members are/were affected, the condition and the age of each family member at diagnosis:

9. Medical history

Important: Please be aware that we may not pay a claim and could cancel your policies if you do not answer the following questions truthfully and accurately. We won't always write to your doctor, so make sure you answer these questions honestly and in full. If you are unsure about whether you should include information, please include it.

Last five years

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 17 of this form) for each condition you have or have previously suffered.

9.1 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Raised blood pressure or cholesterol
- ☐ Diabetes, raised blood sugar, (females: pregnancy related diabetes) or sugar in your urine
- ☐ Hypothyroidism, hyperthyroidism, Graves' disease, goitre or thyroiditis
- ☐ Anaemia haemochromatosis, varicose veins, deep vein thrombosis (DVT), pulmonary embolism, thrombosis or anything else affecting your blood
- ☐ None of the above

9.2 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Asthma, sleep apnoea, COVID-19 or anything else affecting your lungs or breathing
- ☐ (Females only) Abnormal mammogram, cervical smear, HPV test or other gynaecological disorder
- ☐ Crohn's, colitis, IBS, diverticulosis, bowel polyps, bleeding from the bowel or anything else affecting your stomach, bowel or digestive system
- ☐ Reflux, hernia, ulcer or gall bladder conditions
- ☐ (Females only) Kidney stones, kidney/urinary tract infection (UTI), nephritis, cystitis, polycystic kidney disease, blood in urine or anything else affecting your kidneys, bladder or urine
- ☐ (Males only) Kidney stones, kidney/urinary tract infection (UTI), nephritis, cystitis, polycystic kidney disease, enlarged prostate, blood in urine or anything else affecting your kidneys, bladder, urine or prostate
- ☐ Hepatitis (excluding hepatitis A if fully recovered), fatty liver or cirrhosis of the liver or anything affecting your liver or pancreas
- ☐ None of the above

9.3 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Tinnitus, labyrinthitis or anything else affecting your ears or balance
- ☐ Impaired vision, optic neuritis or anything else affecting your eyes (you don't need to disclose short-sightedness or long-sightedness corrected by glasses or contact lenses)
- ☐ Persistent headaches or migraines, fainting or dizziness, numbness pins and needles, muscle weakness or any other neurological symptoms
- ☐ Growths, lumps or cysts
- ☐ Skin lesions, moles, keratosis, sunspots, Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), skin lesion(s) for which you have sought advice or been advised to have treatment for
- ☐ None of the above

9. Medical history continued

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

9.4 **In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Fractures, muscle, ligament or tendon injuries, repetitive strain injury (RSI), carpal tunnel syndrome, tenosynovitis, gout, arthritis, osteopenia or osteoporosis or anything else affecting your bones, joints, ligaments, tendons or muscles
- ☐ Chronic fatigue syndrome, chronic pain, myalgic encephalomyelitis (ME) or fibromyalgia
- ☐ Eczema, psoriasis, dermatitis or other skin conditions
- ☐ None of the above

Lifetime

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 17 of this form) for each condition you have or have previously suffered.

9.5 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Cancer, melanoma, leukaemia, lymphoma, Hodgkin's disease or any other tumour whether malignant or benign
- ☐ Heart attack, heart disease, irregular heartbeat, angina, chest pain, heart murmur, heart palpitations, heart surgery or anything else affecting your heart
- ☐ Valve diseases, stenosis, regurgitation, rheumatic fever
- ☐ A stroke, TIA, brain haemorrhage or damage or surgery to your brain
- ☐ Multiple sclerosis, Alzheimer's disease, dementia or motor neurone disease (MND), paralysis, epilepsy, seizures or any other neurological condition
- ☐ Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, lupus or any other autoimmune conditions
- ☐ A positive test for HIV/AIDS, hepatitis screening, are you awaiting results or considering having such a test or have you been recommended to take PrEP (Pre-exposure prophylactics)
- ☐ None of the above

Please only complete question 9.6 if your total industry cover including this application exceeds any of the following amounts: Life or TPD $500,000, CI of $200,000 or Income Protection over $4,000 per month.

9.6 **Have you ever had a genetic test of any kind?**

☐ Yes ☐ No

If **YES**, please provide the type of genetic testing, reason, and the result.

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

9.7 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Back pain, sciatica, whiplash, spondylitis, fracture, or anything else affecting your back or neck
- ☐ Any back, neck or joint replacement surgery
- ☐ Any other musculoskeletal (Bone, muscle, ligament or tendon) condition requiring surgery
- ☐ Any illness or injury that required more than one month off work
- ☐ Any illness or symptoms that required medical treatment (for example medication, counselling, physio) for more than 12 months, either as one episode or in total from recurring episodes
- ☐ None of the above

9. Medical history continued

9.8 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Bipolar disorder, a personality disorder or schizophrenia
- ☐ Post-traumatic stress disorders (PTSD)
- ☐ Severe or manic depression
- ☐ Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
- ☐ An eating disorder such as anorexia or bulimia
- ☐ None of these

9.9 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Depression, anxiety or adjustment disorder
- ☐ Stress
- ☐ Current or prolonged difficulties with grief lasting more than 3 months
- ☐ Insomnia
- ☐ Prolonged fatigue lasting more than 4 weeks
- ☐ Panic attacks
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Any other symptoms that have impacted your mental health and resulted in treatment, counselling or a mental health care plan
- ☐ None of the above

Recent health

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 17 of this form) for each condition you have or have suffered.

9.10 **In the last two years, have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

You don't need to indicate (tick) any of the below options if you've already told us about it/them as part of your answer to the preceding questions and your completed medical questionnaire.

The following should not be included:

- *Antibiotics for one-off chest infections*
- *Dental surgery from which you have made a full recovery*
- *Infertility treatments; and*
- *Details related to pregnancy and/or pregnancy termination (females only).*

- ☐ I've been prescribed or have received treatment for four weeks or more
- ☐ I have seen either a Chiropractor, Physiotherapist or Osteopath for treatment
- ☐ I've been asked to attend follow-ups with a GP medical practice, specialist, hospital or clinic
- ☐ I've been referred to a specialist or advised to have tests or investigations
- ☐ I've had surgery or an operation
- ☐ None of the above

9. Medical history continued

9.11 **Have you had any of these in the last three months?**

You don't need to indicate (tick) any of the below options if you've already told us about it/them as part of your answer to the preceding questions and your completed medical questionnaire.

- ☐ Persistent cough lasting more than three weeks
- ☐ Onset of fits or seizures
- ☐ A mole or skin lesion/blemish which is new or has changed in appearance or that bleeds
- ☐ Bleeding from the bowels or change in bowel habit
- ☐ A lump or growth including swelling or hardening of any kind
- ☐ Unexplained weight loss
- ☐ None of the above

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

9.12 **Are you pregnant (females only)?**

☐ Yes ☐ No

If **YES**, please advise how many weeks you're into your pregnancy and whether you've had any complications or if you're waiting on any investigations outside routine pre-natal screenings.

10. Insurance and claims history

10.1 **Have you ever had an application for Life, TPD, Critical Illness/Trauma or Income Protection insurance declined or accepted on modified/revised terms?**

☐ Yes ☐ No

If **YES**, please provide details of the reason for the decline or for the modified/revised terms, including the name of the insurance company, cover type, date declined/revised and details of any premium loading or exclusion(s) applied.

10. Insurance and claims history continued

TO BE COMPLETED FOR TPD, CRITICAL ILLNESS AND INCOME PROTECTION COVER ONLY

10.2 **Have you ever made a claim for any type of accident, illness or injury?**

☐ Yes ☐ No

If **YES**, please tell us the condition you claimed for, the type of claim you made (for example, an accident, illness or injury, or workers compensation claim), the date you applied for the claim and how long you received claim payments for (if applicable).

11. Lifestyle details

Travel and residency

11.1 **Do you have any definite plans to travel outside of Australia within the next 12 months?**

☐ Yes ☐ No

If **YES**, please list the countries/regions you intend to travel to and when this is expected to occur and the duration of travel.

11.2 **Do you intend to live outside of Australia?**

☐ Yes ☐ No

If **YES**, please provide full details including whether this is for employment purposes, whether you've an employment contract in place, where you'll be residing and whether you intend to return to Australia in the next five years.

If you're applying for Income Protection Cover, please also confirm whether you'll be employed full-time in the same occupation and earning equal to or greater than your current salary.

11.3 **Are you a citizen or permanent resident of Australia?**

☐ Yes ☐ No

If **NO**, please advise how long you've been in Australia, your future intentions and whether you've applied for permanent residency.

11. Lifestyle details continued

Activities

11.4 **Do you participate in any of the following activities?**

The following should not be included:

- *flying as a fare-paying passenger or cabin crew on a scheduled or charter aircraft*
- *recreational skiing or snowboarding within ski resort boundaries*
- *'track' or 'one-off experience' days*
- *a one-off parachute jump*
- *a one-off scuba dive*

☐ Australian defence force reserve
☐ Scuba diving
☐ Private flying, gliding, parachuting or ballooning
☐ Emergency aviation/flying services, e.g. evacuation, rescue, medical/CareFlight, firefighting that includes aviation activities
☐ Motor car or motorcycle sport
☐ Mountaineering or rock climbing
☐ Sailing at sea or powerboat racing
☐ Martial arts or combat sports
☐ Competitive horse riding
☐ Football (any code)
☐ Professional or semi-professional sport
☐ Extreme sports including base jumping, ice climbing and free soloing
☐ None of the above

If **you've ticked any of the boxes above**, please provide full details of the activities you participate in, how often you do them and where:

Alcohol

11.5 **How many standard drinks do you consume in a typical week?**

1 standard drink = 375ml mid-strength beer, 100ml serve of wine, 1 nip of a spirit.
1 schooner of full strength beer = 1.5 standard drinks.

Recreational drugs

11.6 **In the last 10 years, have you used recreational drugs or drugs not prescribed by a doctor?**

This includes any drug swallowed, inhaled or injected, but does not include vitamins, supplements, over the counter medications or the oral contraceptive pill. If you smoke cannabis, please also confirm whether you use tobacco products.

☐ Yes ☐ No

If **YES** please confirm which drugs you've taken, whether you've injected them, when you last took each of them and the quantity taken.

11. Lifestyle details continued

11.7 **In the last 10 years, have you misused or been addicted to any prescription or over-the-counter drugs (such as pain killers or sedatives), even if they were prescribed for you?**

☐ Yes ☐ No

If **YES**, please confirm which drugs you've taken, whether you've injected them, when you last took each of them and the quantity taken.

11.8 **Have you ever been advised by a medical professional to reduce, stop or seek support for any drug or alcohol consumption?**

☐ Yes ☐ No

If **YES**, please confirm the type of advice received and the first and last date you received any treatment and/or advice.

11.9 **Final acknowledgement**

Important: Please be aware your policy and/or cover could be cancelled and/or avoided (treated as if it never existed), or its terms may be changed if you do not answer the following questions truthfully and accurately.

This may also result in a claim being declined or a benefit being reduced.

Finally, please confirm the following statement is true and correct:
I have understood all the questions asked during the application process and have answered the questions truthfully and accurately.

☐ Agree ☐ Disagree

12. General practitioner details

Name of general practitioner

Street address

Unit number | Street number | Street name

Suburb | State | Postcode

Telephone number

13. Medical questionnaires

Condition one

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling?
   If **YES**, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type, the frequency and when you last had treatment.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings.
   If yes, what were they and what were the results?

13. **Medical questionnaires** continued

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

Condition two

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

13. **Medical questionnaires** continued

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling?
   If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type, the frequency and when you last had treatment.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings.
   If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

13. Medical questionnaires continued

Condition three

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling?
   If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type, the frequency and when you last had treatment.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings.
   If yes, what were they and what were the results?

13. Medical questionnaires continued

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

Condition four

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

13. **Medical questionnaires** continued

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling?
   If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type, the frequency and when you last had treatment.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings.
   If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

14. Policy details

NON-SUPER

Policy owner

Owner name	Title	First name	Middle name(s)	Last name
Contact number				
Email address				
Street address	Unit number	Street number	Street name	
	Suburb	State	Postcode	

Beneficiaries (Life Cover only)

Section 48A of the Insurance Contracts Act 1984 allows you to nominate a person, persons or certain legal entities to receive the **death benefits** available under Life Cover.

The following restrictions apply to such a nomination under this cover type:

1. you may only nominate up to five beneficiaries to receive the benefit payable as a result of a death claim (but not a terminal illness claim) under **Life Cover**; and
2. you must be both the policy owner and the insured person in order to make a valid nomination.

Please ensure percentages are entered as whole numbers and that the total percentage share is equal to 100%.

Full name of beneficiary	Address	Date of birth	Relationship to insured person*	(%) of death benefit
		DD/MM/YYY		
		DD/MM/YYY		
		DD/MM/YYY		
		DD/MM/YYY		
		DD/MM/YYY		

*Options available spouse, de facto, child, interdependency relationship, financial dependent, legal personal representative, not applicable.

Payment details

We accept premium payments via credit card (MasterCard and Visa only) or via direct debit from your nominated bank account.

By providing your details below, you're requesting that we debit your credit card/bank account for all future premium payments. This request is governed by the Direct Debit Service Agreement outlined in the Encompass Protection Product Disclosure Statement, available at www.encompassprotect.com.au/pds

Credit card details

Name on card

Credit card number

Expiry date M M / Y Y Y Y

Bank account details

BSB number - Account number:

Bank name

Account name

14. **Policy details** continued

SUPER

Policy owner

Owner name: Title | First name | Middle name(s) | Last name

Contact number

Email address

Street address: Unit number | Street number | Street name

Suburb | State | Postcode

Fund name

Fund ABN

Fund USI*

Member account number

Payment details

We accept premium payments via credit card (MasterCard and Visa only) or via direct debit from your nominated bank account.

By providing your details below, you're requesting that we debit your credit card/bank account for all future premium payments. This request is governed by the Direct Debit Service Agreement outlined in the Encompass Protection Product Disclosure Statement, available at www.encompassprotect.com.au/pds

Credit card details

Name on card

Credit card number

Expiry date: M M / Y Y Y Y

Bank account details

BSB number - Account number:

Bank name

Account name

encompassprotect.com.au
GPO Box 239, Sydney NSW 2001
e: adviser@encompassprotect.com.au **t:** 1300 576 049