

Electrical Contractors Division

Increase Basic Death and TSC Cover

Please complete in capital letters and in BLACK INK only

This form is to be fully completed if you wish to apply for additional units of Basic Death and/or Temporary Salary Continuance (TSC) cover.

1. Your details

Family name	<input type="text"/>	Date of birth (dd/mm/yyyy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Title	<input type="text"/> (e.g. Mr/Mrs/Ms/Miss/Dr)						
Family name	<input type="text"/>						
Given name(s)	<input type="text"/>						
Contact Details (postal address, telephone, email)							
No./Street/PO Box	<input type="text"/>						
Suburb/Town/City	<input type="text"/>						
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>		
Phone: Home no. (inc. STD/ISD)	<input type="text"/>			Business no. (inc. STD/ISD)	<input type="text"/>		
Mobile no.	<input type="text"/>			Fax no. (inc. STD/ISD)	<input type="text"/>		
E-mail address	<input type="text"/>						

Residential Address

- Same as Postal Address above
- Different from Postal Address above – you MUST complete below

No./Street	<input type="text"/>						
Suburb/Town/City	<input type="text"/>						
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>		

2. Insurance level

I wish to apply for an increase to my Basic Death and/or TSC cover:

An additional unit(s) of Basic Death Cover (maximum 3 additional units)

An additional unit(s) of TSC Cover (maximum 5 additional units)

I understand that if my application is accepted that I will be charged \$1.20 per unit per week for Death Cover and \$1.00 per unit per week for TSC Cover

Accident cover applies for a maximum of 90 days after we receive this form. It is therefore important that you forward this application to the Trustee promptly.

3. Member declaration

I	<input type="text"/>								
have fully read this form and the information completed is true and correct.									
Signed	<input type="text"/>			Date (dd/mm/yyyy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>



4. Occupation details

4.1 Self-Employed or Employee Full Time or Part Time hours p/week weeks p/year

4.2 Your Occupation Industry

4.3 Duties Performed

4.4 Annual Salary (includes packaged items but excludes Bonuses/Commission) \$

5. Group Medical Requirements

Death and Total Permanent Disability (Under 55 years of age)

Level of Cover	Initial Requirements
Up to \$1,500,000	<ul style="list-style-type: none"> Member's Personal Statement (refer to question 8 overleaf)
\$1,500,001 to \$2,000,000	<ul style="list-style-type: none"> Member's Personal Statement (refer to question 8 overleaf) Blood Tests (upon receipt of your application, you will be notified if these are required)
\$2,000,001 to \$3,000,000	<ul style="list-style-type: none"> Member's Personal Statement (refer to question 8 overleaf) Blood Tests (upon receipt of your application, you will be notified if these are required) Fast Check Medical (upon receipt of your application, you will be notified if these are required)
Over \$3,000,000	<ul style="list-style-type: none"> Please contact us for requirements

Death and Total Permanent Disability (55 years and over)

Level of Cover	Initial Requirements
Up to \$1,000,000	<ul style="list-style-type: none"> Member's Personal Statement (as above)
\$1,000,001 to \$1,500,000	<ul style="list-style-type: none"> Member's Personal Statement (as above) Blood Tests (as above)
\$1,500,001 to \$2,000,000	<ul style="list-style-type: none"> Member's Personal Statement (as above) Blood Tests (as above) Fast Check Medical (as above)
Over \$2,000,000	<ul style="list-style-type: none"> Please contact us for requirements

Group Salary Continuance (Age 16 – 65)

Monthly Benefit	Initial Requirements
Up to \$10,000	<ul style="list-style-type: none"> Member's Personal Statement (as above)
\$10,001 to \$15,000	<ul style="list-style-type: none"> Member's Personal Statement (as above) Blood Tests (as above)
\$15,001 to \$20,000	<ul style="list-style-type: none"> Member's Personal Statement (as above) Medical Examination by own Doctor (as above) Blood Tests (as above)
\$20,001 to \$25,000	<ul style="list-style-type: none"> Please contact us for requirements

6. Insurance Application

6.1 Have you ever held or applied for any life, disability, accident and sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused? No Yes

6.2 Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? No Yes

6.3 Do you have, or are you applying for, any other life or disability cover? No Yes

If Yes to 6.1, 6.2 and/or 6.3, please provide full details below:

Name of Company	Cover Type	Sum Insured	Date of Application	Accepted/Loaded Exclusion/Declined	To be Replaced?
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes



7. Habits and Activities

7.1 Do you drink alcohol? <i>If Yes, state type and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.2 Have you smoked in the past 12 months? <i>If Yes, state form and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.3 Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? <i>If Yes, state type and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.4 Do you currently, or do you intend to engage in, any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or other extreme sport? <i>If Yes, please complete a sports and pastimes statement</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.5 Do you intend travelling outside Australia within the next two years? <i>If Yes, please provide details below (where, when, duration and reason)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.6 Are you an Australian or New Zealand Citizen?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.7 Do you hold an Australian Permanent Resident's Visa?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If No to 7.6 and/or 7.7, please provide full details below:</i>	

8. Personal Statement

8.1 Please state your	Height		<input style="width: 90%;" type="text"/>	(cm)	Weight	<input style="width: 90%;" type="text"/>	(kg)
8.2 Name and Address of your usual Doctor							
Name of doctor	<input style="width: 100%; height: 20px;" type="text"/>						
Street/PO Box no.	<input style="width: 100%; height: 20px;" type="text"/>						
Suburb/Town/City	<input style="width: 100%; height: 20px;" type="text"/>						
State/Territory	<input style="width: 30px;" type="text"/>	Postcode	<input style="width: 40px;" type="text"/>	Country (if outside Australia)	<input style="width: 100%; height: 20px;" type="text"/>		
Doctor's phone no. (inc. STD/ISD)	<input style="width: 100%; height: 20px;" type="text"/>						
8.3 Details of last medical consultation with your usual Doctor							
Date (dd/mm/yyyy)	<input style="width: 20px;" type="text"/>	/	<input style="width: 20px;" type="text"/>	/	<input style="width: 40px;" type="text"/>		
Reason							
Outcome/Results							



8.4 If you have attended that Doctor for less than 12 months, please state the Name and Address of your previous Doctor

Name of doctor

Street/PO Box no.

Suburb/Town/City

State/Territory Postcode Country (if outside Australia)

Doctor's phone no. (inc. STD/ISD)

8.5 a) Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquilisers? No Yes

b) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation? No Yes

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

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

Please provide full details for all 8.5 Yes answers

Question	Dates (From/To)	Name and address of Doctor, Hospital or Clinic	Condition, Medications, Treatment and Time off work	Recover %

8.6 Have you ever had, been advised that you had, or received advice or treatment for any of the following:
Please provide details for all Yes answers in 9. General Medical Questionnaire.

a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? No Yes

b) Bowel, stomach or intestinal problem, gallbladder or liver disease? No Yes

c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks? No Yes

d) Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition? No Yes

e) Diabetes, sugar in urine, pancreatic or thyroid problems? No Yes

f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind? No Yes

g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? No Yes

h) Impairment of sight, hearing or speech? No Yes

i) Asthma, bronchitis, any lung complaint? No Yes

j) Leukaemia, haemochromatosis, any blood problem? No Yes

k) Kidney, bladder problems? No Yes



l) Psoriasis, eczema, any skin problem,? No Yes

m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? No Yes

n) To the best of your knowledge do you, or any of your current or past sexual partners, have HIV/AIDS, or are you experiencing any unexplained night sweats or unintentional weight loss, or do you/have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus? No Yes

FEMALES ONLY

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

p) Have you ever had any complications of pregnancy or childbirth? No Yes

q) Are you currently pregnant? If Yes, what is the expected delivery date? (dd/mm/yyyy) No Yes

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

8.7 Family History. *Please give details of your family medical history*

Relative	Living Relatives		Deceased Relatives	
	Current Age	Specify current state of health	Age at Death	Specify cause of death
Mother				
Father				
Sisters				
Brothers				

8.8 Have any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia? No Yes
If Yes, please provide full details below

9. General Medical Questionnaire

Please provide full details for all Yes answers in 8.6 a) to r). Please continue on a separate sheet if required

Question No.	Q	Q	Q	Q
Specific Condition				
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				



Question No.	Q	Q	Q	Q
Specific Condition				
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				
H. What advice/treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
J. Date treatment/ medication ended.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)				
M. Please supply the name and address of all documents, hospitals or other practitioners consulted.				

10. Member declaration

I acknowledge that I have read the notice in 'Important Notes' explaining my duty of disclosure overleaf and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or Personal Health Statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Applicant, authorise and direct any medical or other practitioner to divulge at any time to TOWER Australia Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TOWER Australia Limited or its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information TOWER Australia Limited collects on this form or future forms in relation to this insurance.

I hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written by me or by any person on my behalf. I also declare that I have read the Product Disclosure Statement.

Signed

Date (dd/mm/yyyy) / /



Electrical Contractors Division

Notification of Tax File Number (TFN)

Under Superannuation Law, the Trustee must request that you supply your Tax File Number for superannuation purposes. Collection of your TFN by the Trustee is authorised by tax laws, the Superannuation Industry (Supervision) Act 1993 and the Privacy Act 1988.

1. Your details. Please complete in capital letters and in BLACK INK only

Family name				Date of birth (dd/mm/yyyy)		/		/	
Title				(e.g. Mr/Mrs/Ms/Miss/Dr)					
Family name									
Given name(s)									
Contact Details (postal address, telephone, email)									
No./Street/PO Box									
Suburb/Town/City									
State/Territory		Postcode		Country (if outside Australia)					
Phone: Home no. (inc. STD/ISD)				Business no. (inc. STD/ISD)					
Mobile no.				Fax no. (inc. STD/ISD)					
E-mail address									
Residential Address									
<input type="checkbox"/>	Same as Postal Address above								
<input type="checkbox"/>	Different from Postal Address above – you MUST complete below								
No./Street									
Suburb/Town/City									
State/Territory		Postcode		Country (if outside Australia)					

2. Applicant declaration

For the purposes allowed under superannuation law:

I agree to supply my Tax File Number: - - to the Trustee.

OR

I do not wish to supply my Tax File Number to the Trustee. I understand the consequences.

Signed Date (dd/mm/yyyy) / /

Where to send this form/enquiries

Energy Industries Superannuation Scheme PO Box N835 GROSVENOR PLACE NSW 1220 website: www.eisuper.com.au	Phone: 1300 369 901 (8.30 am – 5.00 pm Mon – Fri) enquiries: info@eisuper.com.au
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DO NOT FAX THIS FORM AS YOUR ORIGINAL AUTHORISATION IS REQUIRED



IMPORTANT NOTES

You should read the Product Disclosure Statement (PDS) before completing this form. The PDS is available from Member Services and the Scheme's website.

REASONS FOR SUPPLYING YOUR TAX FILE NUMBER (TFN) TO THE TRUSTEE

We are required to tell you the following things before you provide your tax file number (TFN) to the Trustee of the Scheme. Your TFN is confidential, and you should know the following things before you decide to provide it.

We can collect your tax file number under the Superannuation Industry (Supervision) Act 1993.

If you do provide your tax file number to us, we will use it only for legislative purposes. This includes finding or identifying your superannuation benefits where other information is insufficient, calculating tax on any superannuation benefits you may be entitled to, and providing information to the Commissioner of Taxation (amongst other things to enable the Commissioner of Taxation to assess any tax payable on superannuation contributions made by or for you). These legislative purposes may change in the future.

You are not compelled to provide your TFN and deciding not to quote your TFN is not an offence. However, if you do not provide your TFN you may pay more tax on your superannuation benefits than is required – any additional tax may be reclaimed through the tax assessment process if you subsequently provide your TFN. It may also be more difficult to locate or amalgamate your superannuation benefits in the future to pay you any benefits you are entitled to.

These consequences may also change in the future due to legislative change.

If you provide your tax file number to us, we may provide it to the trustee of another superannuation fund or to an RSA provider where the RSA provider or trustee is to receive your transferred benefits in the future. We will not pass on your tax file number to such a trustee or RSA provider if you tell us in writing that you do not want us to do that. We may also give it to the Commissioner of Taxation. Otherwise your tax file number will be treated as confidential.

As a result of recent changes to legislation arising out of the 2006 Federal Budget it is important that you consider giving us your TFN.

If you or your employer do not provide your TFN to the Scheme by the end of the financial year, then all of your concessional contributions will be taxed at the top marginal tax rate, plus the Medicare levy, if they exceed \$1,000. For any accounts that begin after 1 July 2007, the \$1,000 threshold does not apply. Furthermore, your Scheme will not be able to accept any non-concessional contributions from you if we do not have your TFN.

For this reason it is crucial that you consider providing your TFN to the Scheme, either directly or through your employer, as soon as possible (if you have not already done so). You should also check your Member Benefit Statement to ensure that your TFN is correctly recorded. For more information please see the PDS or contact Member Services.

PROTECTING YOUR PRIVACY

Some of the personal information you are requested to provide is required to establish and maintain your membership in the Energy Industries Superannuation Scheme while other information is required under Australian Government Anti-Money Laundering and Counter-Terrorism Financing measures.

The Trustee is fully committed to comply with the National Privacy Principles in the way in which your personal information is stored and used. Full details of how this is achieved are contained in the Trustee's Privacy Policy, which is available from Member Services or the Scheme's website at www.eisuper.com.au.

TRUSTEE INFORMATION

Please note that the information contained in this document is of a general nature only and is not for personal advice and has not taken into account your personal objectives, financial situation or needs. Any advice in this document is provided by FuturePlus Financial Services Pty Ltd (ABN 90 080 972 630) as an Australian Financial Services Licensee (AFSL 238445) on behalf of the Trustee of the Energy Industries Superannuation Scheme, Energy Industries Superannuation Scheme Pty Ltd (ABN 72 077 947 285). Energy Industries Superannuation Scheme Pty Ltd is an APRA Registrable Superannuation Entity Licensee (RSEL: L0001373). Energy Industries Superannuation Scheme – Pool A (ABN 22 277 243 559) is a Registered Superannuation Entity (RSE: R1004861).

Members should not rely solely on this information and should consider their own personal objectives, financial situation and needs before acting on this information. Prior to making any decision you should obtain and consider the relevant Product Disclosure Statement (PDS) pertaining to your Scheme membership.

