



# Master TRADE Cover

## Personal Accident & Sickness Insurance Application Form

### Important Information

#### Form Completion

Please answer all questions. Please tick (✓) appropriate boxes and provide details as requested. If there is not enough space provided to answer a question please use Additional information section or a separate schedule and attach it to the Application Form.

#### Your Duty of Disclosure

Prior to entering into a contract of general insurance You have a duty to disclose certain information. You have the same duty to disclose prior to renewing, extending, varying or reinstating a general insurance contract.

#### What You must tell Us

When answering Our questions, You must be honest and You have a duty under law to tell Us anything known to You, and which a reasonable person in the known circumstances would include in answer to the question. We will use the answers in deciding whether to insure You and anyone else to be insured under the Policy, and on what terms.

#### Who needs to tell Us

It is important that You understand You are answering all 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 the 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.

#### Important

This duty of disclosure applies to all the people named on the application form. Please read the Policy Disclosure Statement carefully to ensure:

- You are aware of all the contractual rights and obligations
- the Policy provides the cover You require
- You are aware of the limits regarding Policy coverage and what We will pay You under the Policy.

#### Workers' Compensation

Workers' Compensation is compulsory in all States and Territories of Australia. This policy does not include Workers' Compensation.

#### Privacy

The information collected on this application form will be used to assess your request for insurance and to provide other insurance services in accordance with our privacy policy. In addition Calliden may share your information with other third parties, as defined in the privacy policy, in order to undertake insurance services. If you do not complete the application form in full, and in accordance with your duty of disclosure, Calliden may not be able to provide you with insurance or may impose additional conditions on any cover provided.

In accordance with Calliden's privacy policy you may obtain access at any time to information that Calliden or its service providers hold on you. If you would like to contact Calliden about privacy, or would like to obtain a copy of the privacy policy you may do so through one of the following means:

- online at [www.calliden.com.au](http://www.calliden.com.au)
- by phone 02 9551 1111
- by email to [privacy@calliden.com.au](mailto:privacy@calliden.com.au)
- by letter to Privacy Officer, PO Box 348, Milsons Point NSW 1565

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**calliden**

This product is issued by Calliden Insurance Limited  
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**Calliden Insurance Limited**  
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 **Master Builders<sup>®</sup>  
Queensland**  
Insurance Services

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Services ABN 96 641 989 386 AFS Licence 246834  
**Master Builders Queensland Insurance Services**  
417 Wickham Terrace, Brisbane, QLD 4000  
PH 1300 13 13 26 Fax: 1300 13 13 29

Insured Person Details:		
Name:	Date of Birth:	
Address:		
Suburb:	State:	Postcode:
Mobile:	Phone:	Fax:
Email:		

Trade or Occupation of the Insured Person, including any other work the Insured Person is engaged in?	
Has the Insured Person ever been declared bankrupt, put into receivership or voluntary administration? (if yes, provide details)	
Has the Insured Person had any previous insurance declined, cancelled or renewal refused? (If yes, please provide details)	
Has the Insured Person ever been charged or convicted of any criminal offence, excluding traffic offences? (if yes, provide details)	
Is the Insured Person an Australian Resident?	
Does the Insured Person's work involve the use of explosives?	
Does the Insured Person's work involve external work above 5 storeys?	
In the last 5 years has the Insured Person ever suffered a material health problem, such as cancer, diabetes, high blood pressure, hernia or depression, or a material physical impairment such as any disorder of the back, spine, limbs or heart, or any other condition that required hospitalisation? (if yes, please provide details)	
Is the Insured Person currently experiencing any symptoms of ill health? (if yes, please provide details)	
Has the Insured Person ever submitted a claim for compensation under any Accident, Sickness or WorkCover insurance? (if yes, please provide details)	
Does the Insured Person require the policy to be extended to include: Motor Cycling, Football or Water Skiing? (if yes, state which of these are required – extra premium charges apply)	
What sports activities does the Insured Person participate in? (not all sporting activities are insured and extension of the policy may be required)	

Sum Insured Details: <i>(insert amount required or NIL)</i>		
Weekly Compensation Benefits due to Accident: (claims are limited to Insured Persons average pre-disability earnings for 12 months prior to claim)	\$	Per Week
Weekly Compensation Benefits due to Sickness: (claims are limited to Insured Persons average pre-disability earnings for 12 months prior to claim)	\$	Per Week
Capital Benefits: (death by accident and scheduled lesser amounts for other occurrences as per policy)	\$	
Weekly Business Expenses: (if Business Expenses are to be included, complete the Schedule on Page 3 and insert Total here)	\$	Per Week
Benefit Period for Payment of Compensation: (select either 52 weeks or 104 weeks – if a longer period required, refer to Master Builders)		Weeks
Excess / Excluded Period: (select either 2 weeks or 4 weeks – no compensation is paid for this period)		Weeks

**Business Expenses – Optional Cover Extension:**

The policy may be extended to include nominated Business Expenses which continue to be incurred during an insured period of incapacity of the Insured Person. Is this extension required?

Yes / No *(if Yes, complete Schedule below)*

**Business Expenses Schedule : *(only to be completed if Business Expenses Cover is required)***

<b>BUSINESS EXPENSES TO BE INSURED:</b>	<b>WEEKLY EXPENDITURE:</b>
Employee Wages – but only where the Insured Person is able to show that the employee is unable to work due to the Insured Persons Total Disablement.	\$ Per Week
Rental and Leasing Costs for Business Premises:	\$ Per Week
Electricity, Gas and Water Charges for Business Premises:	\$ Per Week
Business Insurance Costs:	\$ Per Week
Mortgage Repayments for Business Premises:	\$ Per Week
Council Rates for Business Premises:	\$ Per Week
Lease or Loan Repayments on Motor Vehicles or Equipment used in the Insured Persons Business:	\$ Per Week
Land Line and Mobile Telephone Costs of Insured Person:	\$ Per Week
Other:	\$ Per Week
Other:	\$ Per Week
Other:	\$ Per Week
<b>TOTAL SUM INSURED FOR BUSINESS EXPENSES:</b> Insert this TOTAL in the space provided for Business Expenses Sum Insured on Page 2.	\$ Per Week

**Additional Information Section:**

*(if insufficient space is provided in any part of this Application use this section or attach a schedule)*

**Declaration by Insured Person:**

I/We declare that:

- The answers and information given by me/us in this Application Form are true and correct in all respects.
- No information has been withheld that would affect Calliden's decision to accept this Application Form.
- Answers in this Application Form not in my/our own handwriting have been checked by me/us and I/we agree they are correct.
- I/we have read and understood the clauses detailed under the Important Information section of this Application Form;
- I/we authorise Calliden to give to or obtain from other insurers or an insurance or credit reference bureau any information relating to these insurance covers and any other insurances held by me/us and claims under those insurances.
- I/we have received a copy of the Product Disclosure Statement and Policy terms and conditions and agree to be bound by the terms and conditions therein.

Signed by Insured Person:

Date:

**PHONE: 1300 13 13 26**

