Barristers Sickness
and Accident Fund Pty Ltd.

Proposal Form
19 March 2024

Barristers' Sickness & Accident Fund Pty Ltd ACN 000 381 617
as Trustee for the Barristers' Sickness & Accident Fund 1961 ABN 78 600 371 397

T: (02) 9413 8481 | E: office@bsaf.com.au | W: www.bsaf.com.au
Level 21, 264 George St Sydney NSW 2000 | GPO 3973 Sydney NSW 2001

PROPOSAL

PLEASE DO NOT SEND PAYMENT WITH THIS PROPOSAL.

WE WILL NOTIFY YOU OF THE AMOUNT REQUIRED ONCE YOUR PROPOSAL HAS BEEN ACCEPTED.

ALL QUESTIONS MUST BE ANSWERED
If there is insufficient space, please attach details.

1. Contact Details

1a) Name in full:
1b) Preferred title for mailing purposes:
1c) Professional address:
1d) Chambers:
1e) Office telephone number:
1f) Mobile telephone number:
1g) Email:
1h) Private address:

2. Professional Details

2a) Are you currently a person whose principal occupation is the practice of law as a barrister?	Yes☐ No☐
2b) If yes, city where your practice is based? And date when you were admitted to practice?	______________ ____ / ____ / ____
2c) Are you currently an Ordinary Member Class A or Class B of the NSWBA?	Yes☐ No☐
2d) If yes, please provide your membership number:	
2e) If no, what is the status of your application?	
2f) Are you currently in your first year as a reader?	Yes☐ No☐
2g) If yes, date you were admitted as a reader:	____ / ____ / ____

3. Personal

3a) Your date of birth:	____ / ____ / ____
3b) Your height:	
3c) Your weight:	
3d) Your current BMI:	
3e) Are you available to be examined by a doctor of our choosing (within Australia), if so required by us?	Yes☐ No☐
3f) Have you smoked (tobacco) in the last 12 months?	Yes☐ No☐
3g) If yes, please provide details of usual use:	
3h) What is your approximate average alcohol consumption: Past month (number of standard drinks per week): Past 12 months (number of standard drinks per week):	
3i) Have you used any other recreational drugs or non-prescription drugs in the last 5 years?	Yes☐ No☐
3j) If yes, please provide details of drugs used and how often:	

3k) Have you, in the last 5 years received professional advice and/or counseling for drug use or excess alcohol consumption?	Yes☐ No☐
3l) If yes, please provide details including: (When and from whom)	
3m) Do you, or do you intend to, participate in hazardous sporting, recreational or other activities?	Yes☐ No☐
3n) If yes, please provide details:	
3o) So far as you are aware, do you have a family history of any significant illness including cancer or heart disease?	Yes☐ No☐
3p) If yes, please provide details:	
3q) If female, are you pregnant?	Yes☐ No☐
3r) If yes, please indicate the due date and any known complications:	

4. Other insurance for Sickness & Accident (or similar)

4a) Do you currently hold any other disability or income protection insurance?	Yes☐ No☐
4b) If "Yes", please provide details including - Name of insurer: Benefit amount: Benefit duration: Waiting period: Special conditions:	
4c) Has any application you have made for life, disability or income protection insurance, been declined, accepted on terms or, subsequently cancelled?	Yes☐ No☐
4d) If yes, please provide details:	
4e) Have you claimed benefits on any insurance policy arising out of illness or injury?	Yes☐ No☐
4f) If yes, please provide details:	

5. Health

Have you ever had, or been told you have had, or sought or received any advice or treatment for any of the following? IF YES - DETAILS TO BE PROVIDED ON PAGE 5	
5a) Heart condition or risk factors including hypertension or lipid problems?	Yes☐ No☐
5b) Prostate or kidney or other urinary condition, or liver disorder?	Yes☐ No☐
5c) Gastrointestinal condition including colitis, Crohn's disease or coeliac disease?	Yes☐ No☐
5d) Diabetes or glucose intolerance or thyroid problem or metabolic disorder?	Yes☐ No☐
5e) Malignancy including skin or hematological cancer?	Yes☐ No☐
5f) Respiratory disorders including asthma or sleep apnea?	Yes☐ No☐
5g) Any neurological disorder including epilepsy, recurrent headaches, vertigo or balance disorder, TIA or stroke?	Yes☐ No☐
5h) Neck or back pain or spine disorder?	Yes☐ No☐
5i) Joint disorder including osteo arthritis, rheumatoid arthritis, or gout?	Yes☐ No☐
5j) Autoimmune disorder including Lupus, other autoimmune disorder(s)?	Yes☐ No☐
5k) Chronic or recurrent skin condition such as eczema or psoriasis?	Yes☐ No☐
5l) Dental conditions including oral and maxillofacial disorders?	Yes☐ No☐
5m) Any mental health, psychological or psychiatric condition or disorder?	Yes☐ No☐
5n) Any symptoms negatively affecting your mental health and your usual work and social activities or relationships, including depression, low mood, anxiety, stress, fatigue, panic, and disturbed sleep?	Yes☐ No☐
5o) Any blood disorder?	Yes☐ No☐
5p) Hepatitis, HIV or AIDS, or chronic infection?	Yes☐ No☐
5q) If female, any gynecological disorder including abnormal pap smear or HPV or breast lump?	Yes☐ No☐
5r) Any other illness or injury?	Yes☐ No☐

If your answer is YES to any of the questions in section 5 above, please provide details for <u>each such illness or injury or circumstance.</u> **If additional space is required, please attach a separate sheet and include the following information:**
The name(s) of each such illness or the injury, and/or further information in relation to the circumstance:
When the illness or injury was first suffered or diagnosed:
Information as to treatment including for recurrences:
Your current condition/status in relation to the illness or injury:
Names and addresses of doctors and hospitals consulted, and information as to recurrences and their duration:

Unless disclosed above:	
5r) Have you been prescribed any medications in the last 5 years? Other than: Medication/treatments for minor illnesses such as upper respiratory tract infections Medication/treatments for short-term Musculo-skeletal injuries or contraceptives If yes, please provide details:	Yes☐ No☐
5s) Have you in the last 12 months had symptoms or signs for which you have been advised to seek assessment or for which, you intend to do so? If yes, please provide details:	Yes☐ No☐
5t) Have you in the last 5 years taken time off work for more than 3 consecutive days for any illness or injury? If yes, please provide details:	Yes☐ No☐
5u) Are there any other circumstances with which Bar Cover should be made acquainted in order to form a proper estimate of risk? If yes, please provide details:	Yes☐ No☐

6. Weekly Benefit Required $100 to $10,000 per week (in increments of $100)

6a) State the amount of your Weekly Benefit required:	
6b) Will the weekly benefit required exceed your average gross weekly income earned from the practice of the profession of barrister in the past 12 months?	Yes☐ No☐
6c) If "Yes", please explain why you are seeking a higher benefit: See: "Limitations on Benefits Paid", in the Product Disclosure Statement (PDS), which can be viewed on our website barcover.com.au	

PLEASE NOTE THAT DEPENDING ON YOUR RESPONSES,
FURTHER INFORMATION MAY BE REQUESTED.

Statutory Notices and Declaration

Terms and Conditions

Our website www.bsaf.com.au contains further information about the Fund, including the Product Disclosure Statement (PDS), setting out the terms and conditions of your cover.

Notification of the above is given for the purpose of section 35 of the Insurance Contracts Act, 1984.

Duty to take reasonable care not to make a misrepresentation

You have a duty under the Insurance Contracts Act 1984 to take reasonable care not to make a misrepresentation to us.

This duty applies when you first take out cover with us and also when renewing, extending, varying or reinstating your existing policy/coverage with us.

If the duty is not met

Cover could be avoided and treated as if it never existed, terms may be altered, or a claim may be rejected, or a benefit reduced.

Declaration

1. I am the insured and all of the answers to the questions in this application are true to the best of my knowledge and belief.
2. I have read the notices set out above.
3. I agree to be bound by the provisions of the Trust Deed dated 23 March 1962 as amended, and made between the New South Wales Bar Association, Barristers' Sickness and Accident Fund Pty. Limited and such persons that become Contributors to the Fund.

Date	**Signed**

APPROVED (OFFICE USE ONLY)

Date	**Director**