

Personal Health Statement

As an alternative you may wish to apply through MemberAccess at legalsuper.com.au. This could mean a faster underwriting decision.

Instructions for completing this form

- When completing this form you should also complete and return a Superannuation Change of Details - (Insurance) form.
- You must complete each section of this form.
- Please attach a separate page if you require more space for an answer.
- Please return the completed form along with the attachments.

Please use **BLOCK LETTERS** and **BLACK INK** when completing this form.

Return this completed form to either:

Email: mail@legalsuper.com.au

OR

Post: legalsuper

Locked Bag 5081

Parramatta NSW 2124

Phone: 1800 060 312

When to use this form

Please complete this form if you are an existing member of legalsuper and you wish to apply for, or change, your:

- Salary Continuance cover; and/or
- Death only cover; or
- Death and Total and Permanent Disablement (TPD) cover.

This form must be completed in addition to the *Superannuation change details - (insurance)* form (available online at legalsuper.com.au or by calling **1800 060 312** (8am to 8pm [AEST/AEDT] Monday to Friday).

If you wish to apply for, or change, your Death only or Death and TPD cover, you must be:

- aged less than 70 years; and
- an Australian citizen, permanent resident of Australia or an eligible visa holder residing in Australia.

If you wish to apply for, or amend, your Salary Continuance cover, you must be:

- aged less than 65 years; and
- an Australian citizen, permanent resident of Australia or an eligible visa holder residing in Australia; and
- working at least 15 hours per week on a regular basis; and
- * not engaged in casual work; and
- * not be engaged in an Excluded Occupation. Please contact us for information on Excluded Occupations.

Important notice

Your application for cover will be assessed by the Insurer, and we will notify you of the outcome. The Insurer requires this Personal Health Statement, and may require other health information to determine your application.

This Personal Health Statement is confidential. Please refer to the Insurer's Privacy Statement at the end of this form.

Please refer to the legalsuper *Product Disclosure Statement and Employer Sponsored Super & Personal Super Additional Information Guide* and Target Market Determination (TMD), available online at legalsuper.com.au in respect to the Personal Division or Employer Sponsored Division (as applicable to you) for full terms and conditions that apply to your cover.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the Insurer.

To meet this duty, you must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where the Insurer later investigates whether the information given to them was true. For example, they may do this when a claim is made.

About this application

When you apply for life insurance, the Insurer conducts a process called underwriting. It's how they decide whether they can provide cover, and if so on what terms and at what cost.

The Insurer will ask questions they need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to them in response to their questions is vital to their decision.

When you apply for insurance benefits through a superannuation fund or ask to extend or make changes to existing insurance benefits, we may pass on to the Insurer personal information you provide to them. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to us.

Guidance for answering our questions

You are responsible for the information you provide to the Insurer. When answering their questions, you should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask them before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume the Insurer will ask others such as your doctor.
- review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Before your cover starts, please tell the Insurer about any changes that mean you would now answer our questions differently. It could save time if you let them know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the Insurer

If, after the cover starts, you think you may not have met your duty, please tell them immediately and the Insurer will let you know whether it has any impact on the cover.

Telephone contact

After you submit your application, the Insurer may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into also applies during any phone contact with them.

If you need help

It's important that you understand this information and the questions the Insurer asks. Ask them for help if you have difficulty answering their questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, the Insurer is here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to the Insurer. These are set out in the *Insurance Contracts Act 1984 (Cth)*. They are intended to put the Insurer in the position they would have been in if the duty had been met.

For example, the Insurer may do one of the following:

- avoid the cover (treat it as if it never existed)
- vary the amount of the cover
- vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including all of the following:

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific their questions were and how clear the information we provided on the duty was
- what the Insurer would have done if the duty had been met – for example, whether they would have offered cover, and if so, on what terms
- whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before they exercise any of these remedies, the Insurer will explain their reasons, how to respond and provide further information, and what you can do if you disagree.

The questions that you answer in section 1. of this form must be answered on the same day that you sign and date this form. This form will not be accepted if it is unsigned and undated.

1. Member details

legalsuper Membership Number (if known)

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Justice

Gender

☐ Male ☐ Female

Surname

Given Names

Date of birth (dd/mm/yyyy)

Postal Address

Town or Suburb

State

Postcode

Country

Work telephone number

Home telephone number

Mobile number

Email

Please note:

Please answer all Yes/No questions in this form by inserting a cross {X} in the relevant box.

☐ I authorise the Insurer's underwriting service representative to contact me by phone if further information is required.

I can be contacted during the following times:

☐ Monday ☐ Tuesday ☐ Wednesday

☐ Thursday ☐ Friday ☐ Any business day

Between the hours of . and .

Please tick your preferred contact method:

☐ home phone ☐ work phone ☐ mobile phone

2. Personal details

a. Height and weight

i) What is your current height? cm

ii) What is your current weight? kg

b. Smoking

i) Have you smoked tobacco or any other substance or used any form of electronic cigarette within the past 12 months, or used a nicotine replacement treatment within the past three months? ☐ Yes ☐ No

If 'Yes', please state the type and quantity consumed per day:

ii) Have you been advised to stop smoking due to a medical condition? ☐ Yes ☐ No

If 'Yes', please complete Section 6: Personal Statement – Part B.

c. Alcohol

i) Do you consume alcohol? ☐ Yes ☐ No

If 'Yes', please state the type and quantity consumed per day:

ii) Have you been advised to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No

If 'Yes', please complete Section 6: Personal Statement – Part B.

3. Residency

- i) Are you a permanent resident of Australia? ☐ Yes ☐ No
If 'No', in which country do you permanently reside?

- ii) What type of visa do you hold?

4. Occupation

- i) What is your usual occupation?

- ii) What are your normal duties of this occupation?

- iii) What is your current employment status?

- iv) How many hours (on average) do you work per week?

If you work less than 15 hours per week on a regular basis, you are not eligible to apply for Salary Continuance cover.

- v) What is your current annual income earned through personal exertion (net of business expenses, but before tax and superannuation contribution)?

- vi) Do you have more than one occupation? ☐ Yes ☐ No

If 'Yes', please specify your normal duties and the average hours your work per week in your other occupation(s):

5. Personal Statement – Part A

The Insurer will assess most applications using the information in Section 5 or Section 6 (if applicable). In some cases, the Insurer may require additional details from you such as financial information, medical reports, blood test results, and may also require you to attend a medical examination. legalsuper will advise you if the Insurer requires additional information to assess your application.

This section must be completed in all circumstances.

- a) Are you, at the date of this application, off work due to injury or illness or restricted from performing any of the usual duties of your occupation due to injury or illness (other than for colds or flu)? ☐ Yes ☐ No
- b) Are you currently receiving any form of medical treatment or taking any form of medication (other than for colds or flu)? ☐ Yes ☐ No
- c) Have you taken more than a total of seven consecutive days off work in the past 12 months due to illness or injury (other than for colds or flu)? ☐ Yes ☐ No

Have you ever received medical advice, consulted a doctor, undergone medical treatment, investigations or operations for, or suffered from any of the following:

- d) High blood pressure, high cholesterol, heart complaint, murmur, palpitations or chest pain, stroke, diabetes, thyroid or glandular disorder, cancer, tumour or growth including breast lumps or skin lesions/moles (even if you have not seen a doctor)? ☐ Yes ☐ No
- e) Back or neck pain/disorder, musculo-skeletal symptoms or any joint disorder, gout, arthritis, repetitive strain syndrome, paralysis of any kind or chronic fatigue syndrome, epilepsy or neurological disorder, mental/nervous disorder including stress, anxiety or depression? ☐ Yes ☐ No
- f) Kidney, bowel, bladder, gall bladder, liver disease or disorder, hepatitis, hernia, blood disorder, sleep apnoea, asthma, persistent cough or any lung complaint, any abnormality of hearing, speech or eyesight (excluding glasses or contact lenses)? ☐ Yes ☐ No
- g) Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related conditions? ☐ Yes ☐ No

If you answered 'Yes' to any of the questions in Section 5, please complete Section 6: Personal Statement – Part B.

6. Personal Statement – Part B

Please complete all questions in this Part B ONLY if you have answered 'Yes' to any questions in Section 2 or Section 5 and/or you are applying for:

- a total amount of Death only or Death and TPD cover (including any existing cover) exceeding \$1,000,000 – if you are aged less than 55 years; or
 - a total amount of Death only or Death and TPD cover exceeding \$750,000 – if you are aged between 55 and 69 (both inclusive); or
 - a Salary Continuance monthly benefit exceeding \$10,000 per month.
- Otherwise, please proceed to complete Sections 7 & 8.*

a. Residence and travel details

- i) How long have you lived in Australia?

 years months

- ii) Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No

If 'Yes', please proceed to Question a(iii).

If 'No', please advise what type of visa you hold:

- iii) Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No

If 'Yes', please complete the following:

Date of departure

Duration of stay

Destination(s) (country/cities)

Purpose of stay

☐ Holiday ☐ Business ☐ Residing ☐ Other (please specify)

b. Insurance details

- i) Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including the Insurer (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

- ii) Do you intend to replace all or part of an existing insurance policy or insurance policy cancelled within the past two months? ☐ Yes ☐ No

If 'Yes' to question (i) or (ii), please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

1. Name of company

Type of cover

Amount insured

Date commenced

Will this policy be discontinued/replaced? ☐ Yes ☐ No

Date last fully underwritten (replacement policies only)

2. Name of company

Type of cover

Amount insured

Date commenced

Will this policy be discontinued/replaced? ☐ Yes ☐ No

Date last fully underwritten (replacement policies only)

- iii) Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No

If 'Yes', please provide name of company, alteration, date and reason (if known).

- iv) Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If 'Yes', please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

c. Occupation details

Please identify the income producing duties of your usual occupation (stated in Section 4[i]) and the approximate percentage of time spent on each duty per week. The list below represents the physical nature of duties only.

Type of work: Sedentary/administration

% of time %

Please describe your specific duties and where they are performed. (e.g. filing, computer work, answering telephone, reception duties, etc.)

Type of work: Manual work – light

% of time %

Please describe your specific duties and where they are performed. (e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)

Type of work: Manual work – heavy

% of time %

Please describe your specific duties and where they are performed. (e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)

d. Pastimes

Have you any intention of engaging in:

- motorcycle/motor racing other than as a means of transportation to and from work? ☐ Yes ☐ No
- any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? ☐ Yes ☐ No
- aviation/flying, other than as a fare-paying passenger? ☐ Yes ☐ No

If you answered 'Yes' to any of questions above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Vehicle type

Races p.a.

Engine size

Max. speed (km/h)

Class

☐ Recreational ☐ Amateur ☐ Professional

If you answered 'Yes' to either Question f(i) or f(ii), please complete the following table.

Relation	Condition/Disorder	Age diagnosed

g. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. Asthma? ☐ Yes ☐ No
2. High blood pressure? ☐ Yes ☐ No
3. High cholesterol? ☐ Yes ☐ No
4. Diabetes? ☐ Yes ☐ No
5. Stress, anxiety, depression or any other mental health condition? ☐ Yes ☐ No
6. Back or neck pain, sciatica or any disorder of the spine or neck? ☐ Yes ☐ No
7. Arthritis, shoulder or knee pain or any other disorder of the joints? ☐ Yes ☐ No
8. Cyst, mole or skin lesion? ☐ Yes ☐ No

If you answered 'Yes' to any of the conditions above, a questionnaire will be sent to you to complete.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers, bowel trouble or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, liver or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No

19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? ☐ Yes ☐ No
20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? ☐ Yes ☐ No
22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No
23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No
24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No
25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No
26. Due to injury or illness, have you ever been off work for more than seven consecutive days (if not already mentioned)? ☐ Yes ☐ No
27. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No
28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future (e.g. x-ray, ECG, blood test, etc)? ☐ Yes ☐ No
29. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No
30. Have you ever used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice counselling or treatment for drug dependence? ☐ Yes ☐ No

31. Females only

- a. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No
- b. Are you now pregnant? ☐ Yes ☐ No
If 'Yes', please advise due date
- c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No
- d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered 'Yes' to any questions from 9–31 above, please complete the table on the following page. If there is not enough space here, please provide details on a separate page and attach to this application form.

Question number (9-31)	Conditions or symptoms	Tests performed and results	Date started	Date ceased	Treatment and type, date provided and date ceased	Time off work	Have you fully recovered?	Name and address of institution or health professional

h. Usual doctor or medical centre details

i) Full name and address of usual doctor/medical centre.

Telephone number

Fax number

How many years have you been attending this doctor/medical centre? years months

ii) Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? ☐ Yes ☐ No

If 'Yes', please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.

7. Declaration and signature

I declare that:

- If I do not complete this form correctly, do not sign and date this declaration, or do not attach any additional information requested, my application will not be considered by the Insurer.
- I have read and understood the insurance information contained in the most recent version of legalsuper's Superannuation Product Disclosure Statement, Employer Sponsored Super & Personal Super Additional Information Guide (available at legalsuper.com.au) and, if applicable to me, the Insurance Booklet related to my employer's insurance arrangements with the Trustee.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.

- I have read the Insurer's Privacy Statement set out in Section 9 of this form (the Insurer's Privacy Policy details how they manage personal information and is available at zurich.com.au/important-information/privacy). I consent to the Insurer collecting, using, storing and disclosing my personal information (including health and other sensitive information) to assess and process my application, as well as to manage and administer my insurance in accordance with the Insurer's Privacy Statement. I understand that the Insurer may not be able to process my application or administer the policy without this consent.
- If I have provided information about another person in this application, I declare that I have the consent of that person to do so. I understand that the Insurer requires me to inform the person concerned that I have done so and direct them to the Insurer's Privacy Policy which is located at zurich.com.au/important-information/privacy.

- I understand that my insurance cover (or any additional cover) will not become effective until the Insurer has accepted my application for insurance cover in writing.
- I understand that if I fail to attend any required medical appointments, my application may not be finalised and insurance cover may not be offered by the Insurer.
- I understand that insurance cover will be provided to me on the terms and conditions set out in the policy issued by the Insurer to legalsuper (as changed from time to time).
- I acknowledge that the cost of cover (or additional cover) I am applying for is as set out in the current Product Disclosure Statement and Employer Sponsored Super & Personal Super Additional

Information Guide, and the insurance fee payable will be deducted from my account.

- The answers that I have provided to all questions in this form are true and correct (including those not in my own handwriting).

Member's signature

Date (dd/mm/yyyy)

8. Consent for accessing Health Information

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, Zurich Australia Limited, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for.

This may involve, for example:

- preparing a general report and/or a report about a specific condition;

- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements.

General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Surname

Given Names

Date of birth (dd/mm/yyyy)

Super Fund/Employer details

PLEASE SIGN BOTH AUTHORITIES

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Zurich, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Zurich asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Zurich can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Zurich is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date (dd/mm/yyyy)

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Zurich, or to third parties they engage, only if Zurich has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Zurich can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Zurich is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date (dd/mm/yyyy)

9. Privacy Statement of Zurich Australia Limited

We collect your personal information (including health and other sensitive information) from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information (including health and other sensitive information).

Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from zurich.com.au/important-information/privacy

The Group Life Policy and Group Income Protection Policy are issued by Zurich Australia Limited ABN 92 000 010 195 AFSL 232510 (Zurich, the Insurer), to Legal Super Pty Ltd as policy owner.