# *Bar Cover - Proposal*

**PLEASE DO NOT SEND PAYMENT WITH THIS PROPOSAL.**

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


*Bar Cover*
Barristers' Sickness & Accident Fund Pty Ltd ACN 000 381 617
Trustee for the Barristers' Sickness & Accident Fund 1961 ABN 78 600 371 397
P.O. Box 42 Lindfield NSW 2070. DX: 23403 Lindfield. NSW Tel (02) 9413 8481
Fax (02) 9413 8483 Email: office@bsaf.com.au


## 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

DX

1d) Office telephone number

1e) Fax number

1f) Mobile telephone number

1g) Email

1h) Private address

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## 2 Professional details

2a) Are you currently a person whose principal occupation is the practise 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 (per week)

Past 12 months (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

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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 or disability 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

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## 5 Health

**Have you been diagnosed as having contracted, or sought advice concerning any of the following?**
**(IF YES, DETAILS TO BE PROVIDED ON PAGE 5)**

| Condition | Response |
|---|---|
| 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 apnoea | 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 psychological or psychiatric condition including depression, anxiety, bipolar disorder, stress disorder | Yes ☐ No ☐ |
| 5n) Any blood disorder | Yes ☐ No ☐ |
| 5o) Hepatitis, HIV or AIDS, or chronic infection | Yes ☐ No ☐ |
| 5p) If female, any gynecological disorder including abnormal pap smear or HPV or breast lump | Yes ☐ No ☐ |
| 5q) Any other illness or injury | Yes ☐ No ☐ |

**If your answer is YES to any of the questions in section 5 above, please provide details <u>for 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.

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**Unless disclosed above,**

5r) Have you been prescribed any medications in the last 5 years? Yes ☐ No ☐

**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

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? Yes ☐ No ☐

If yes, please provide details

5t) Have you in the last 5 years taken time off work for more than 3 consecutive days for any illness or injury Yes ☐ No ☐

If yes, please provide details

5u) Are there any other circumstances with which Bar Cover should be made acquainted in order to form a proper estimate of risk? Yes ☐ No ☐

If yes, please provide details

## 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 https://barcover.com.au/

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

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## STATUTORY NOTICES AND DECLARATION

**TERMS AND CONDITIONS**

Our website https://barcover.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*.

**YOUR DUTY OF DISCLOSURE**

Before you enter into an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

**If you do not tell us something**

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

Notification of the above is given for the purpose of section 21 and 22 of the Insurance Contracts Act, 1984.

**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.

**Dated:……………………………………… Signed: ……………………………………………………………………**

Approved

Date: ________________________ Director: _________________________________