

Application to amend your insurance

Term Insurance*
Income Protection*
Income Protection Plus*
Business Expenses*

Simple LifeCover
Whole of Life (super and non-super)
Endowment (super and non-super)
Pure Endowment (super and non-super)

*Formerly National insurances

Policy number

Policy number

Policy number

Policy number

☐ Increase ☐ Alteration

We respect your privacy and handle your information in accordance with our privacy policy, available at acenda.com.au/privacy-policy

Information about genetic tests

If you've had a genetic test, you only need to disclose this to us if your total insurance cover will be more than the amounts listed below. When considering your total insurance cover amounts you need to include the cover you're applying for, your cover held in super and your cover held with other life insurers. The total insurance cover you can have and not disclose if you've had a genetic test are:

- \$500,000 life cover, or
- \$500,000 total and permanent disability cover (TPD), or
- \$200,000 critical illness (trauma) cover, or
- \$4,000 a month income protection, salary continuance or business expenses cover.

If you have had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

When to use this form

This form may only be used to:

- Increase the amount of insurance under your policy.
- Apply for the review of a loading or exclusion.
- Change the Life Insured's occupation class, Waiting Period or Benefit Period for Income Protection and/or Business Expenses insurance.
- Apply to add new benefits, and/or new features to your policy.

If you are applying for a new benefit please refer to the relevant disclosure documents relating to your product for current terms and conditions.

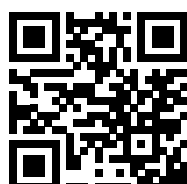
If you are applying to convert from Smoker to Non-Smoker rates, a separate short form is available at acenda.com.au

Unless otherwise stated, the premium structure and other features chosen for the existing benefit will apply to any increase.

The Trustee
Equity Trustees Superannuation Limited
ABN 50 055 641 757 AFSL 229757

The Fund
Smart Future Trust
ABN 68 964 712 340

The Insurer
Insurance is issued by Nippon Life Insurance
Australia and New Zealand Limited
ABN 90 000 000 402 AFSL 230694



Insurance is issued by Nippon Life Insurance Australia and New Zealand Limited ABN 90 000 000 402 AFSL 230694, trading as Acenda (the Insurer). The Insurer is a member of the Nippon Life Group. Any reference to 'Acenda', 'we', 'us', and 'our' means the Insurer.

Your duty to take reasonable care not to make a misrepresentation

Your policy or the policy you are applying for is a consumer insurance contract and the duty below applies to you.

About this application and your duty

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

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

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 before the contract of insurance is entered into.

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

If you do not meet your legal duty, this 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 we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- think carefully about each question before you answer. If you are unsure about any question, we are here to help and you can contact us,
- answer every question,
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it,
- review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted, and
- you must not assume that we will contact your doctor for any medical information. If you are unsure about whether you should include information or not, please include it.

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts. The duty applies when you answer questions in your application and whenever we obtain more information from you.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

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

What can we do if the duty is not met?

If the person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we may:

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

Whether we can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances;
- what we would have done if the duty had been met - for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, including what you can do if you disagree.

Section 1: Life Insured's details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

First name

Middle name

Last name

Previous name(s) (if applicable)

Gender

☐ Male ☐ Female

Date of birth (DD/MM/YYYY)

Email

Home telephone

Business telephone

Mobile

Residential address (your residential address can't be a PO Box)

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Postal address

☐ Same as residential

Unit number

Street number

PO Box

Street name

Suburb

State

Postcode

Country

Section 2: Policy Owner(s) details

Policy Owner 1 (primary contact for correspondence)

☐ Tick this box if Policy Owner 1 is the same as the Life Insured. If not, fill in the details below.

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Middle name

Family name

Company name/Trustee/Self-managed super fund trustee

Email

Home telephone

Business telephone

Mobile

Section 2: Policy Owner(s) details continued

Policy Owner 1 (primary contact for correspondence)

Postal address

Unit number	Street number	PO Box	Street name
Suburb	State	Postcode	Country

Policy Owner 2

First name	Family name

Section 3: For insurance inside super

Contributions

If you want to change the contribution type on your policy, tick one of the boxes below.

☐ Personal	☐ Spouse	☐ Child	☐ Other
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Employer Contributions

☐ Super Guarantee	☐ Salary Sacrifice	☐ Award	☐ Employer Voluntary
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If Employer please complete the following:

Company name			
Company address			
Suburb	State	Postcode	Country
ABN	Name of Authorised Person		

Tax File Number (TFN) details

Please provide your TFN:

When collecting your TFN, the Insurer and the Trustee are required to tell you:

- The Insurer and the Trustee are authorised to collect your TFN under the Superannuation Industry (Supervision) Act 1993.
- It isn't an offence to decline to notify the Insurer and the Trustee of your TFN.
- If you don't notify the Insurer and the Trustee of your TFN, they may not be able to (now or in the future) locate, amalgamate and identify your benefits in order to pay you.
- the Insurer and the Trustee are allowed to use your TFN for lawful purposes, in particular if paying out monies, identifying and amalgamating super benefits for surcharge purposes and for other approved purposes.
- Your TFN will be disclosed to the Commissioner of Taxation. Your TFN will also be passed on to another super provider if your benefits are being transferred, unless you inform the Insurer and the Trustee in writing not to pass on your TFN. Your TFN won't otherwise be disclosed to any other person.

Section 4: Reason for change

Please ensure you answer ALL questions in this section

For Whole of Life, Endowment and Pure Endowment (super and non-super)

1a If you are applying to increase the basic sum insured and/or the optional benefits on your existing insurance, please complete the following table with details of your current and proposed new sum insured amounts.

Insurance	Current Sum Insured	Proposed Sum Insured
Death Benefit	\$	\$
TPD Benefit	\$	\$
Guaranteed Insurability Benefit	\$	\$
Decreasing Extra Death Benefit	\$	\$
Level Extra Death Benefit	\$	\$

For all other insurances

1b Are you applying to increase the sum insured or monthly benefit of any of your existing insurances?

Yes ☐ Complete the following table with details of your current and proposed new sum insured

No ☐ Go to question 3

Insurance	Current Sum Insured	Proposed Sum Insured
Life Cover	\$	\$
TPD Benefit	\$	\$
Critical Illness Cover	\$	\$
Income Protection	\$	\$
Business Expenses	\$	\$

2 Is this an increase to the sum insured(s) and/or the monthly benefit(s) only, with all the other options and benefits remain unchanged?

Yes ☐ Go to Section 5

No ☐ Please ensure that a copy of the current premium quotation is attached

3 Are you applying to add a new benefit to your policy?

Yes ☐ Complete the following table with details of the benefit you wish to add. Please attach a copy of the premium quotation

Product	Benefit/Option	Sum Insured
Term Insurance	☐ Total and Permanent Disablement cover	\$
	☐ Critical Illness cover	\$
Income Protection	☐ Increasing Claim Benefit	\$
Income Protection Plus		\$
Business Expenses	N/A	\$
Simple LifeCover	N/A	\$
Whole of Life	☐ Guaranteed Insurability Benefit	\$
Endowment	☐ Total and Permanent Disablement Benefit	\$
Pure Endowment	☐ Waiver of Premium Benefit	\$

No ☐

Section 4: Reason for change continued

4 Are you applying to change the Life Insured's occupation group for Income Protection and/or Business Expenses insurance? (Your Financial Adviser will tell you this and give details.)

Yes ☐ Please complete the table below and ensure that a copy of the current premium quotation is attached

New Occupation Group			
☐ 1	☐ 2	☐ 3	☐ 4

No ☐

5 Are you applying to change the Life Insured's Waiting Period and/or Benefit Period for Income Protection and/or Business Expenses insurance?

Yes ☐ Please complete the table below and ensure that a copy of the current premium quotation is attached

New Waiting Period for Income Protection						
☐ 2 weeks	☐ 4 weeks	☐ 8 weeks	☐ 13 weeks	☐ 26 weeks	☐ 52 weeks	☐ 104 weeks
New Benefit Period for Income Protection						
☐ 2 years	☐ 5 years	☐ to age 60	☐ to age 65	☐ Lifetime* (National Income Protection Plus Only)		
New Waiting Period for Business Expenses*						
☐ 2 weeks	☐ 4 weeks	☐ 8 weeks	☐ 13 weeks			
* Available to Occupation Groups 1 and 2 only						

No ☐

6 Are you applying for the review of a medical loading or exclusion?

Yes ☐ Please also complete the relevant insurance questionnaires available at acenda.com.au

No ☐

Term Insurance, Income Protection, Income Protection Plus and Business Expenses only

7 Are you applying to add new benefits to your policy?

Yes ☐ Please ensure that a copy of the current premium quotation is attached.

No ☐

If you did not answer 'Yes' to any of questions 1–7, you may require a different form for your circumstances. Please contact us on 13 65 25 for more details.

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases)

Arranging medical tests

Medical or blood tests may be required to further assess your application. Acenda can arrange these through an independent service provider. These providers are subject to Acenda's privacy requirements to protect your confidentiality. Do you authorise us to arrange any required tests?

Yes ☐ No ☐

Telephone contact

If further information is required to assess your application, we can collect this information over the phone. Do you permit us to call you if we require further information?

- The call may be recorded
- It will form part of the application.
- Your duty to take reasonable care not to make a misrepresentation will apply to questions we ask you.

(Phone number)
Yes ☐ I am contactable on between the hours of : and :
(8:30am to 5:30pm AEST/AEDT, Monday to Friday)

No ☐

Other Insurances

8 Are you covered by, or are you applying for, any other life, disability, critical illness, income protection, salary continuance or business expenses insurance with any company, including Acenda (other than this application), including benefits under superannuation or insurance benefits provided by your employer?

Yes ☐ Please provide details below

No ☐

Company	Benefit type	Date started	Benefit amount	Waiting/ Benefit periods	Policy number	To be replaced
			\$			Yes ☐ No ☐
			\$			Yes ☐ No ☐
			\$			Yes ☐ No ☐
			\$			Yes ☐ No ☐
			\$			Yes ☐ No ☐

Travel

9 In the next 12 months, do you have definite plans to live or travel outside of Australia?

Yes ☐ Please complete the table below

Date(s) of departure(s)	Duration of stay(s)	Destination(s)	Purpose of stay(s) (eg holiday, business, residing)

No ☐

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

Occupation and Financial

10 If you are a homemaker, student, unemployed or retired.

☐ Go to question 23

11 Your job and industry details.

Main job

Industry

Name of employer or trading name

Professional or trade qualifications

12 How much did you earn in the previous full financial year from your main job?

\$ PA

Super Guarantee Contribution

\$ PA

Earnings

If you are an employee: include wages/salary, commissions, fees, regular bonuses, regular overtime, fringe benefits.

If you are self-employed in a business you directly or indirectly own or an employee of your own business, company or trust: include your share net profit generated by your personal efforts, and voluntary super contributions paid on your behalf.

- Do not include super guarantee contributions
- Do not include investment income
- Provide pre-tax figures
- If you earn commissions, include 100% of initial commissions, but only 50% of renewal commissions

13 Do you expect to earn the same amount or more in the current financial year?

Yes ☐

No ☐ Please provide details

14 Are you applying to increase or alter Total and Permanent Disability, Income Protection or Business Expenses insurance?

Yes ☐

No ☐ Please go to question 23

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

- 15 Please provide the percentage of time you spend doing the following types of work in your job. Your answer must add up to 100%.**

Type of work	Percentage of time
Sedentary/Administration: includes all general clerical, office, administration and desk duties. The emphasis is on mental rather than physical work although there may be a small element of standing/ walking, and driving to and from appointments.	
Supervision of manual workers, field work or site visits.	
Light manual work: includes light lifting of up to 10kg, using hand tools, operation of light machinery.	
Heavy manual work: includes carrying, lifting, pushing, pulling more than 10kg, the operation of heavy machinery, driving a commercial vehicle.	
Total	100%

- 16 Does your job include any hazardous types of work? Hazardous types of work may result in serious injury or death. Some common hazardous types of work are listed in the table below.**

Yes ☐ Please provide details in the table below

No ☐

Type of work	Percentage of time	Specific duties you perform
Heights over 10 metres		
Flying		
Underground work		
Offshore work – within Australian waters		
Offshore work – outside Australian waters		
Diving		
Using or handling explosives		
Using or handling chemicals, dangerous substances, or asbestos		
Other (please specify)		

- 17 In your main job, on average:**

How many hours per week do you work?	
How many weeks per year do you work?	

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

18 Do you have another job?

Yes ☐ Please complete questions a to g below

No ☐

a) Role

b) Name of employer or trading name

c) Duties

d) Hours worked per week

e) Amount of time in this job

 years months

f) How much did you earn in the previous full financial year from your second job?

 \$

Super Guarantee Contribution

 \$

g) Has this income been included in the Earnings shown in Question 12 of this application?

☐ Yes ☐ No

19 Bankruptcy, receivership and administration:

- Have you ever been declared bankrupt, or
- Have you ever had an entity or business associated with you placed in receivership, or liquidation or under administration, or
- Are you currently in the process of being assessed for bankruptcy or insolvency?
- Is any entity or business you are associated with currently being assessed for receivership, liquidation or being placed under administration?

Yes ☐ Please complete a bankruptcy questionnaire

No ☐

20 In the last 12 months have you changed the type of work you do? For example, changed from being a builder to an administrator, a truck driver to a farmer?

Yes ☐ Please provide your work history for the last 2 years:

No ☐

Role	Employer name	Date started	Date finished	Reason for change

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

21 On what basis are you employed?

a) Permanent ☐

b) Casual ☐

How long have you been working as a casual employee?

c) Contractor ☐

i) What is the remaining term of your contract?

iii) Is your contract expected to be renewed?

Yes ☐ No ☐

iii) Are you contracting back to your previous employer?

Yes ☐ No ☐

iv) How long have you been working as a contractor?

22 The following question is about your earnings from your main job. The figures provided may need to be supported by financial evidence if you make a claim. Take your time. If you are unsure, you could check your online pay slips, tax statements or other financial records.

- Do not include investment income
- Provide pre-tax figures
- If your employer pays voluntary super contributions on your behalf, provide your total earnings before these voluntary super contributions are deducted.

Income type	Last financial year	Financial year prior
Wage/salary		
Bonus		
Commission		
Other (please specify)		
Total Earnings		
Super Guarantee Contribution		

23 Do you receive, or expect to receive, income of more than \$20,000 per year (after deducting expenses related to that income) from other sources, for example rental properties, dividends, interest?

Yes ☐ Provide details below

No ☐

Source of other income	Amount per year
Interest	
Net rental income (rental income after eligible expenses have been deducted)	
Dividends	
Other (please specify)	

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

Business Expenses insurance only

- 24 Only complete this section if you are applying for Business Expenses insurance. Please refer to the list of eligible business expenses in the PDS or disclosure document for the product relevant to you. If you are not applying for Business Expenses insurance, please go to question 25.

In the event of your disability, how long will your business continue to generate an income?

No more than 60 days ☐

More than 60 days ☐ What percentage of the business income would continue to be produced? %

What would be your total share of the business expenses?

\$

Claims History

- 25 Have you ever made a claim or received benefits for any illness, injury or medical condition? (This includes Income Protection, Total and Permanent Disablement, Critical Illness, Worker's Compensation, Salary Continuance, Veteran's Affairs).

Yes ☐ Please provide details in the table below

No ☐

Benefit type	Benefit amount	Reason for claim	Time off work	Date finalised

Sports and Pastimes

- 26 Do you now or do you intend to take part in any of the following activities?

Yes ☐ Please provide details in the table below

No ☐

- ☐ Diving
- ☐ Motor car, motor cycle or motor boat racing
- ☐ Flying as a pilot or crew in an aircraft
- ☐ Football (all codes)
- ☐ Hang-gliding, paragliding, skydiving, pursuits involving heights
- ☐ Mountaineering and rock climbing
- ☐ Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain biking, downhill biking)

If you ticked any of these boxes, please complete the **Pastimes Questionnaire** located at **acenda.com.au**

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

27 Do you have a usual doctor?

Yes ☐ Please provide full name and address of your usual doctor or medical centre.

No ☐ Please provide the name and address of the last doctor you visited.

Name of doctor or medical centre

Address

Suburb

State

Postcode

Country

Telephone

Email

28 How long have you been attending this doctor / medical centre?

years months

When did you last attend?

29 If you have been attending this doctor or medical centre for less than 12 months, please also provide name and address of your previous doctor

Height and Weight details

30 What is your height?

What is your weight?

cm or feet/inches

kg or stone/pounds

Habits and Lifestyles

Individual lifestyle choices play an important part in our lives. To get to know you better, these questions will help us better understand you and your lifestyle.

They are important for us to ask to be able to give you the best possible cover for your life insurance

31 When did you last use tobacco, e-cigarettes or nicotine replacement products?

- ☐ In the last month
- ☐ In the last year
- ☐ Between 1-5 years ago
- ☐ More than 5 years ago
- ☐ Never

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

31a How many cigarettes, roll-ups, cigars or pipes do you smoke on average?

Quantity ☐ per day ☐ per week ☐ per month

32 Do you drink alcohol?

Yes ☐ How many standard drinks do you consume on average?

Quantity ☐ per day ☐ per week ☐ per month ☐ per year

A standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer

2 standard drinks = a pint (568 ml), a large glass of wine (200ml)

No ☐

33 In the last 10 years, how often have you taken recreational drugs, legal highs or drugs not prescribed to you by a doctor?

This includes any drug swallowed inhaled or injected, but does not include vitamins, supplements, over the counter medications or the oral contraceptive pill.

- ☐ Frequently (more than 6 times per year) ☐ Occasionally (more than 3 times per year)
☐ On some weekends or holidays ☐ A few times ☐ Once ☐ Never

If you have used drugs in the last 10 years, please provide details:

Mental Health

34 At any point in your life, have you experienced any of the following common symptoms related to mental health?

Common symptoms may include: stress, anxiety, depression, prolonged sadness or tearfulness, persistent sleeplessness or prolonged change in appetite, poor concentration, excessive anger, hostility or violence, thoughts of suicide, self-harm, not participating in usual enjoyable activities, relying on alcohol and sedatives, withdrawing from close family and friends, not getting things done at work/school or not going out anymore.

- ☐ At one time in my life ☐ On a few occasions in my life ☐ Regularly ☐ No

If you answered **No**, please go to **Question 35** If you selected any other response, please complete a **Mental Health Questionnaire**, available on our website.

Health – General

a	Seen a doctor or other health professional* such as Psychologist, Osteopath, Physiotherapist	Yes ☐	No ☐
b	Had or been advised to have tests or investigations* such as blood test, X-ray, MRI, ECG or biopsy	Yes ☐	No ☐
c	Had treatment, taken medication or herbal medicines	Yes ☐	No ☐
d	Had a fracture or broken bone	Yes ☐	No ☐
e	Had or been advised to have surgery or an operation	Yes ☐	No ☐
f	Had to go to hospital for an accident or medical condition	Yes ☐	No ☐
g	Suffered any illness, disease, accident, or injury?	Yes ☐	No ☐
h	Had any change in your health?	Yes ☐	No ☐

If you answered **Yes**, please give full details in the table below.

Yes ☐ Please provide details of each instance in the table below

No ☐

[illegible]

Section 5: Personal Statement Information (must be completed by the Life Insured in all cases) continued

Family History

37 Have any of your immediate blood relatives (parents, brothers or sisters) suffered from any of the following conditions?

Yes ☐ Please tick all that apply and provide details in the following table
No ☐

- ☐ Heart disease or stroke
- ☐ Any other cancer not otherwise listed (specify type and site)
- ☐ Muscular dystrophy
- ☐ Breast or ovarian cancer
- ☐ Diabetes
- ☐ Polycystic Kidney Disease (PKD)
- ☐ Melanoma
- ☐ Multiple sclerosis
- ☐ Huntington's disease
- ☐ Bowel cancer
- ☐ Parkinson's disease
- ☐ Motor neurone disease
- ☐ Familial Polyposis (FAP)
- ☐ Haemochromatosis
- ☐ Any other hereditary disorder

Family member (eg mother, brother)	Condition	If cancer, type and site	Age condition began

Section 6: Authority to Release Medical 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, **Acenda**, 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.

Section 6: Authority to Release Medical Information continued

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 **Acenda**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **Acenda** 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.
- **Acenda** 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 **Acenda** 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.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

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Signature of Life Insured

	Date (DD/MM/YY)					

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 **Acenda**, or to third parties they engage, only if **Acenda** 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:

- **Acenda** 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 **Acenda** 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.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

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Signature of Life Insured

	Date (DD/MM/YY)					

Section 7: Declarations and Authorisations

The Life Insured and the Policy Owner(s), make the following declarations and authorisations in respect of this application

1. I have read and understood the Product Disclosure Statement as applicable for the product relevant to me, which I have received in Australia.
2. I have read and understand the duty to take reasonable care not to make a misrepresentation.
3. The information provided in this application is true and complete.
4. I consent to receive the PDS and all notices electronically
5. If I am transferring existing insurance:
 - a. I consent to Acenda relying on information in the application for the existing Acenda Policy and if applicable, the applications for increases or additions to the existing Acenda policy; and
 - b. I confirm that the information in the application for the existing Acenda Policy and if applicable, the applications for the increases or additions to the existing Acenda Policy, is true and correct.
6. I understand no increase or alteration will be effective until the Insurer accepts this application and issue a revised schedule, except for Interim Accident Insurance that will apply subject to specific terms and conditions.
7. I consent to the Insurer disclosing or discussing with my financial adviser any matter relevant to the assessment of my application for insurance including financial, medical and other matters, whether disclosed in this application, obtained from third parties (eg Doctors, accountants) or otherwise discovered as part of the assessment process. If the Life Insured has withheld consent to sharing of personal medical and lifestyle information with the adviser, only basic information necessary to explain our decision will be shared.
8. I authorise the Insurer to forward any information obtained by it to any health practitioner or service, reinsurer, advisor, service provider or third party as is reasonably required for the purpose of assessing the application, administration of the insurance policy, assessment of a claim made under the policy and as otherwise may be required to comply with legal obligations.
9. If business expenses insurance has been applied for I declare that the Business Expenses monthly benefit requested does not exceed my monthly share of Covered Expenses (please refer to the PDS for the product relevant to you, for a list of expenses included and not included as Covered Expenses). I understand that Covered Expenses only include the reasonable and regular operating expenses of the business I own and manage, and can also include the net cost of a Locum.
10. I consent to the Insurer sending notices or communications regarding my application or insurance to an email address or mobile number provided by me and agree that any communications received by the Insurer from this email or mobile number will constitute valid communications or instructions from them. I also acknowledge my personal and sensitive information may be sent to my email address.
11. On 1 April 2020: insurance cover must be cancelled if:
 - your account balance in this product/fund is less than \$6,000; and
 - you have never had an account balance of at least \$6,000 on or after 1 November 2019;unless you elect in writing that you want to keep your insurance cover, even if your super account balance is less than \$6,000.
From 1 April 2020: if your account balance is under \$6,000 and/or you're under 25 years old you need to elect in writing to have insurance cover.

Completing this form will be considered your written election.

- I elect to be provided with the insurance specified in this application, and for the insured benefit to be provided, even if my account in this product/fund is less than \$6,000 and/or I'm under 25 years old.

Consent

- ☐ By selecting this check box I withhold consent for matters relating to medical and lifestyle information being discussed or disclosed to the financial adviser and/or Policy Owner (where I am not the Policy Owner).

If the Life Insured does not consent, future communications to your financial adviser will include basic information about health and lifestyle necessary to understand the Insurer's decision on the application.

Signature of Life Insured

	Date (DD/MM/YY)			

Section 7: Declarations and Authorisations continued

For insurance outside super only: Signature(s) of Policy Owner(s) (if different from the Life Insured)

- If the trustee(s) of a self managed super fund are individuals then all individuals are required to sign.
- Parent or Guardian if Life to be Insured is under 16 years of age.
- In the case where the Policy Owner or trustee is a Company:
 - (a) two directors or a director and company secretary are to sign; or
 - (b) in the case of a sole director proprietary company only, the sole director is to sign. The director must indicate that he/she is the sole director and sole secretary of the company by ticking the sole director and sole secretary box.

Name

Signature of Policy Owner

Date (DD/MM/YY)

Name

Signature of Policy Owner

Date (DD/MM/YY)

Name

Signature of Policy Owner

Date (DD/MM/YY)

☐ Sole director and sole secretary (indicate by ticking box)

Name

Signature of Policy Owner

Date (DD/MM/YY)

☐ Sole director and sole secretary (indicate by ticking box)

This section for Financial Adviser use only

Email address (contact for this application)

Financial Adviser's instructions

(Complete details relevant to this application)

Financial Adviser 1

This section is to be completed by the Servicing Adviser.
The Servicing Adviser will receive all correspondence for the policy.

Name of Financial Adviser

Acenda Financial Adviser no.

Mobile

Telephone number

Fax number

Email

Distribution fee split

 %

Financial Adviser 2

Name of Financial Adviser

Acenda Financial Adviser no.

Mobile

Telephone number

Fax number

Email

Distribution fee split

 %

Design and Distribution Obligations

Does your client meet the requirements of the Target Market Determination document for this product?

Yes ☐ No ☐

If no, please enter the reason you recommended this product to a client who does not meet the product's Target Market Determination.

In recommending this product, have you provided personal or general advice??

Personal ☐ General ☐

Send us your form

Please return your completed form to:

Acenda - Operations

PO Box 23455

Docklands VIC 3008

Email: enquiries.retail@acenda.com.au

If you have any questions, please contact your financial adviser or call us on **13 65 25**, 8.30am to 6pm (AEST/AEDT), Monday to Friday.