Application to amend your Insurance

Personal Protection Portfolio and Life Cover Super

Issue 21 | Preparation date: 1 July 2025

Important information

Before you complete this application form, please read the relevant Product Disclosure Statements (PDSs) and any supplementary PDS. These documents will help you understand the different products, how they work and decide if they are appropriate for you. The PDSs relevant to you are:

- For Personal Protection Portfolio and Life Cover Super – Personal Protection Portfolio and Life Cover Super Product Disclosure Statement (Insurance PDS), issued by the insurer, Nippon Life Insurance Australia and New Zealand Limited (the Insurer).
- For Life Cover Super – please also read the Smart Future Trust – Retail Insurance in Super: for Life Cover Super and Protection*first* Super Product Disclosure Statement (Super PDS), issued by the Trustee, Equity Trustees Superannuation Limited.

This application form is jointly issued by the insurer and the trustee for the purpose of collecting information that each requires to be able to provide the insurance and super products you want.

Information about genetic tests

If you have had a genetic test, you only need to disclose this to us if your total combined insurance cover (including cover under super, cover held with other life insurers, and cover you've applied for with us) will be more than any one of the following:

- $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 cover, salary continuance cover 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.

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.

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
Nippon Life Insurance Australia and New Zealand Limited
ABN 90 000 000 402 AFSL 230694

Insurance is issued by the Insurer. The Insurer is part of the Nippon Life Group.

Your duty to take reasonable care not to make a misrepresentation continued

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 need help 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, and what you can do if you disagree.

For completion by the Financial Adviser

Section 1 Cover details

Existing policy number(s)

Please list all policy numbers held, and indicate which are impacted by this application. Refer to the Reason for application to indicate all changes required to the policy/ies

Policy Number	Update required (yes/no)

Reason for application (tick all that apply)

Change	Sections to be completed	Quote	Select
Adding a new Benefit or Option or applying for new Insurance	All sections to be completed	Yes	☐
Increase in sum insured	All sections to be completed	Yes	☐
Reducing your Waiting Period or Increasing your Benefit Period	All sections to be completed	Yes	☐
Increasing your Waiting Period or reducing Benefit Period	Sections 1, 2, 3 and 22	Yes	☐
Change in Occupation group (Special Risk and C Class Occupations only) For all other occupations please complete the Change your occupation details form.	All sections to be completed	Yes	☐
Change in premium structure*	Sections 1, 2, 3 and 22	Yes	☐
Change your benefit from Standard to Plus (not available for Income Protection)	All sections to be completed	Yes	☐
Change your benefit from Plus to Standard (not available for Income Protection)	Sections 1, 2, 3 and 22	Yes	☐
Review of a medical loading	Sections 1, 2, 3, 7, 8, 13 to 21 and 22	No	☐
Review of a medical exclusion	All sections to be completed including any relevant questionnaires	No	☐
Review of a non-medical exclusion	Requirements will depend on reason for exclusion. Please contact Acenda to confirm	No	☐
Transfer of ownership from or to a superfund	Sections 1 - 5 and 22 required	Yes	☐
Exercise an increase under Business Safeguard Option (available only if BSO is attached to your policy)	Sections 1, 2, 3, 9 and 22	Yes	☐

*Note: Not all premium structures are available for all insurances. Please read the relevant Product Disclosure Statement for more details.

For scenarios where not all sections are required please also complete sections 4-6 if you need us to make a change to the information already set up on your policy.

☐ Please tick this box to confirm that a copy of the Premium illustration (quote) from us has been attached to this application form. **It forms part of the application form where noted in the table above, your application cannot be assessed without it in those circumstances**

For completion by the Financial Adviser

Section 1 Cover details continued

Summary of change

Where the change is an increase in sum insured, addition of a new benefit, change in waiting period, benefit period, occupation group or premium structure, please provide a summary of the change in the table below.

Benefit	Current Sum insured, occ class, premium structure etc	New Sum insured, occ class, premium structure etc

Policy 1 Purpose of cover

☐ **Personal Protection needs:**
- ☐ Individual/Family Protection
- ☐ Estate Protection (Estate equalisation, Estate debts)

☐ **Business Protection needs:**
- ☐ Asset (Debt) Protection
- ☐ Revenue Protection
- ☐ Business Expenses
- ☐ Ownership Protection – has a Succession Agreement (Buy/Sell Agreement) been entered into or is one being legally drafted? ☐ Yes ☐ No

Policy 2 Purpose of cover

☐ **Personal Protection needs:**
- ☐ Individual/Family Protection
- ☐ Estate Protection (Estate equalisation, Estate debts)

☐ **Business Protection needs:**
- ☐ Asset (Debt) Protection
- ☐ Revenue Protection
- ☐ Business Expenses
- ☐ Ownership Protection – has a Succession Agreement (Buy/Sell Agreement) been entered into or is one being legally drafted? ☐ Yes ☐ No

Policy 3 Purpose of cover

☐ **Personal Protection needs:**
- ☐ Individual/Family Protection
- ☐ Estate Protection (Estate equalisation, Estate debts)

☐ **Business Protection needs:**
- ☐ Asset (Debt) Protection
- ☐ Revenue Protection
- ☐ Business Expenses
- ☐ Ownership Protection – has a Succession Agreement (Buy/Sell Agreement) been entered into or is one being legally drafted? ☐ Yes ☐ No

Business partnership (if application is for Business Protection needs)

Is more than one business partner applying for a policy at the same time as this application?

Yes ☐ ▶ Please complete the details below

Company

Partnership/Trust name

Business partner name	Date of birth (DD/MM/YYYY)	Application or policy number (if known)
1		
2		
3		

If there are more than three partners, please attach a photo copy of this page with additional information.

No ☐ ▶ Go to Section 2

For completion by the Life Insured

Section 2 Life Insured's details

Do the requested changes include a change in policy owner?

No ☐ Please go to Life Insured's details

Yes ☐ Please go to next question

Has a claim been made on the existing policy which is currently being paid or assessed, or is there an intention to make a claim?

No ☐

Yes ☐ NOTE: We cannot change the ownership of the benefits currently being claimed until that claim has been finalised.

Please provide details

Life Insured's details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

First name

Middle name

Family name

Previous name (if applicable)

Gender

☐ Male ☐ Female

Date of birth (DD/MM/YYYY)

Residential address

Your residential address cannot be a PO Box

Unit number | Street number | Street name

Suburb | State | Postcode | Country

Postal address

☐ Same as residential address

Complete postal address **only** if the Life Insured is also the Policy Owner of this application and the postal address is different from the residential address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Mobile phone number | Business telephone

Email (Please provide your email so notices about your application can be sent to you.)

If you are applying for a Personal Protection Portfolio policy and there is more than one Life Insured, use this form for one person and a new form for each additional person.

For completion by the Policy Owner

Section 3 Policy Owner details

If you wish to amend or apply for two or more policies, please complete details for Policy 1, Policy 2 and Policy 3 as required.

Do the requested changes include a change in policy owner?

No ☐ Continue to policy owner details

Yes ☐ Please acknowledge the following

☐ I acknowledge and understand that if a claim is made for an insured event which results in a benefit being payable to the existing policy owner and not to the new policy owner under the replacement policy, even when the claim is made after the existing policy is cancelled.

Owner details for Policy 1

Is this Policy 1 application for:

Life Cover Super ☐ Cover is issued to Equity Trustees Superannuation Limited and held in the Smart Future Trust. If you are only applying for this policy, please go to Section 4, otherwise go to Policy 2.

Personal Protection Portfolio (SMSF) ☐ Cover can be owned by a self-managed super fund. Please complete the details under 'Who owns this policy?' below.

Who owns this policy?

☐ **Self-managed super fund (SMSF)** Please complete the 'SMSF name' under Policy Owner 1A. If the trustee of the SMSF is a company, please also complete 'Company/Trust Company name' in Policy Owner 1A. If the SMSF has individual trustees, please complete the 'Individual details' for all trustees in Policy Owner 1A and Policy Owner 1B sections. If there are more than two individual trustees, please provide additional details on a separate sheet and sign and date it.

Personal Protection Portfolio ☐ Cover can be owned by individual(s), a business partnership, company or trust. Please complete the details under 'Who owns this policy?' below. Please note for Income Protection Insurance, the Life Insured must be the sole Policy Owner - unless the Policy Owner is a business of which the Life Insured owns at least 25%.

Who owns this policy?

☐ **Life Insured**. You don't have to complete Policy Owner details. If you are only applying for this policy, please go to Section 4, otherwise go to Policy 2.

☐ **Individual(s) other than the Life Insured**. Please complete the 'Individual details' in Policy Owner 1A and Policy Owner 1B (if applicable) sections. If more than two individuals are to own this policy, please provide additional details on a separate sheet and sign and date it.

☐ **Business Partnership**. Please provide the 'Business Partnership/Trust name' under Policy Owner 1A. Please also provide details of all persons that comprise the partnership in the 'Individual details' in Policy Owner 1A and Policy Owner 1B sections. If more than two partners are to own this policy, please complete additional details on a separate sheet and sign and date it. If the partnership is a company, please also complete 'Company/Trust Company name'.

☐ **Trust**. Please complete the 'Business Partnership/Trust name' under Policy Owner 1A and also complete the 'Individual details' section for all relevant parties in Policy Owner 1A and Policy Owner 1B (if applicable) sections. If more than two individuals are to own this policy, please complete additional details on a separate sheet and sign and date it.

☐ **Company (including a Trust Company)**. Only one corporate entity can own this policy. Please complete the 'Company/Trust Company name' and also complete the 'Individual details' section for all relevant parties in Policy Owner 1A and Policy Owner 1B (if applicable) sections.

Policy Owner 1A

Company/Trust/SMSF details

Please also ensure details of the Director and Company Secretary, all individual Trustees or all Partners are provided in the 'Individual details' section below.

Business Partnership/Trust name

Company/Trust Company name

SMSF name

Section 3 Policy Owner details continued

SMSF address

Is this the same address as Policy Owner 1A? If yes, you do not need to complete the address below.

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Individual details (including Individual Trustees, Partners, Directors or Company Secretaries)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Individual / Partner / Director or Secretary / Individual Trustee

First name | Middle name

Family name | Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Policy Owner 1A

Postal address

Please note: This is the address we will send all policy information to.

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Mobile phone number | Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Policy Owner 1B (Second Individual / Partner / Director or Secretary / Individual Trustee)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Individual / Partner / Director or Secretary / Individual Trustee

First name | Middle name

Family name | Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Section 3 Policy Owner details continued

Policy Owner 1B

Postal address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Mobile phone number | Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Owner details for Policy 2

Only complete this section if you're amending or applying for two policies.

Policy 2

Cover can be owned by individual(s), a business partnership, trust or company. Please complete details under 'Who owns this policy?' below. Please note for Income Protection insurance, the Life Insured must be the sole Policy Owner - unless the Policy Owner is a business of which the Life Insured owns at least 25%.

Who owns this policy? (Non Super policy only)

- ☐ **Life Insured**. You don't have to complete Policy Owner details. Please go to Section 4.
- ☐ **Individual(s) other than the Life Insured**. Please complete the 'Individual details' in Policy Owner 2A and Policy Owner 2B (if applicable) sections. If more than two individuals own this policy, please provide additional details on a separate sheet and sign and date it.
- ☐ **Business Partnership**. Please provide the 'Business Partnership/Trust name' under Policy Owner 2A. Please also provide details of all persons that comprise the partnership in the 'Individual details' in Policy Owner 2A and Policy Owner 2B sections. If more than two partners own this policy, please complete additional details on a separate sheet and sign and date it. If the partnership is a company, please also complete 'Company/Trust Company name'.
- ☐ **Trust**. Please complete the 'Business Partnership/Trust name' under Policy Owner 2A and also complete the 'Individual details' section for all relevant parties in Policy Owner 2A and Policy Owner 2B (if applicable) sections. If more than two individuals own this policy, please complete additional details on a separate sheet and sign and date it.
- ☐ **Company (including a Trust Company)**. Only one corporate entity can own this policy. Please complete the 'Company/Trust Company name' and also complete the 'Individual details' section for all relevant parties in Policy Owner 2A and Policy Owner 2B (if applicable) sections.

Policy Owner 2A

Is this the same Policy Owner as 1A ☐ or 1B ☐? If yes, you do not need to complete Policy Owner details

Company/Trust details

Please also ensure details of the Director and Company Secretary, all individual Trustees or all Partners are provided in the 'Individual details' section below.

Business Partnership/Trust name

Company/Trust Company name

Individual details (including Individual Trustees, Directors or Company Secretaries)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Individual / Partner / Director or Secretary / Individual Trustee

First name

Middle name

Family name

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Policy Owner 2A postal address

Unit number

Street number

PO Box

Street name

Suburb

State

Postcode

Country

Contact details

Home telephone

Mobile phone number

Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Policy Owner 2B (Second Individual / Partner / Director or Secretary / Individual Trustee)

Is this the same Policy Owner as 1A ☐ or 1B ☐? If yes, you do not need to complete Policy Owner details.

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Individual / Partner / Director or Secretary / Individual Trustee

First name

Middle name

Family name

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Policy Owner 2B postal address

Unit number

Street number

PO Box

Street name

Suburb

State

Postcode

Country

Contact details

Home telephone

Mobile phone number

Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Section 3 Policy Owner details continued

Owner details for Policy 3

Only complete this section if you're amending or applying for three policies.

Policy 3

Cover can be owned by individual(s), a business partnership, trust or company. Please complete details under 'Who owns this policy' below. Please note for Income Protection insurance, the Life Insured must be the sole Policy Owner - unless the Policy Owner is a business of which the Life Insured owns at least 25%.

Who owns this policy (Non Super Policy only)?

- ☐ **Life Insured**. You don't have to complete Policy Owner details. Please go to Section 4.
- ☐ **Individual(s) other than the Life Insured**. Please complete the 'Individual details' in Policy Owner 3A and Policy Owner 3B (if applicable) sections. If more than two individuals own this policy, please provide additional details on a separate sheet and sign and date it.
- ☐ **Business Partnership**. Please provide the 'Business Partnership/Trust name' under Policy Owner 3A. Please also provide details of all persons that comprise the partnership in the 'Individual details' in Policy Owner 3A and Policy Owner 3B sections. If more than two partners own this policy, please complete additional details on a separate sheet and sign and date it. If the partnership is a company, please also complete 'Company/Trust Company name'.
- ☐ **Trust**. Please complete the 'Business Partnership/Trust name' under Policy Owner 3A and also complete the 'Individual details' section for all relevant parties in Policy Owner 3A and Policy Owner 3B (if applicable) sections. If more than two individuals own this policy, please complete additional details on a separate sheet and sign and date it.
- ☐ **Company (including a Trust Company)**. Only one corporate entity can own this policy. Please complete the 'Company/Trust Company name' and also complete the 'Individual details' section for all relevant parties in Policy Owner 3A and Policy Owner 3B (if applicable) sections.

Policy Owner 3A

Is this the same Policy Owner as 1A ☐, 1B ☐, 2A ☐ or 2B ☐? If yes, you do not need to complete Policy Owner details.

Company/Trust details

Please also ensure details of the Director and Company Secretary, all individual Trustees or all Partners are provided in the 'Individual details' section below.

Business Partnership/Trust name

Company/Trust Company name

Individual details (including Individual Trustees, Directors or Company Secretaries)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other:

Individual / Partner / Director or Secretary / Individual Trustee

First name

Middle name

Family name

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Section 3 Policy Owner details continued

Policy Owner 3A postal address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Mobile phone number | Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Policy Owner 3B (Second Individual / Partner / Director or Secretary / Individual Trustee)

Is this the same Policy Owner as 1A ☐, 1B ☐, 2A ☐ or 2B ☐? If yes, you do not need to complete Policy Owner details.

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Individual / Partner / Director or Secretary / Individual Trustee

First name | Middle name

Family name | Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Policy Owner 3B postal address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Mobile phone number | Business telephone

Email (Please provide your email so notices about your application, including mandatory notices, can be sent to you.)

Section 4 Payment Authorities

If the person paying the premium is not the Life Insured or the Policy Owner, please complete the following details.

This section is only required where there is a change to or from super and non-super, or where a new policy is to be issued.

For increases or alterations to existing benefits the payment authority section does not need to be completed, unless you wish to change your existing payment arrangements.

If the payer is an Individual:

Name

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

Date of birth (DD/MM/YYYY)

If the payer is a Company:

Please note: If we already have your Company details, please only complete 'Name of Authorised Person'.

Company name

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

ABN | Name of Authorised Person

How do you wish to pay?

Payment Method	Complete section	Policy 1	Policy 2	Policy 3
Direct debit request / Credit card deduction	4A			
Payment by cheque	4B			
Rollover from external super fund – annual premium for Life Cover Super only	4C			

Please note: If we do not receive your payment (direct debit request, credit card deduction, cheque, or rollover from external super fund), Interim Accident Insurance cannot commence.

If you wish to use the same payment method but with a different account for the second or third policies, please attach a photocopy of this section with the additional details and specify which policy this applies to.

Section 4 Payment Authorities continued

4A Direct Debit Request / Credit Card Deduction

Only complete this section if you want to pay your premiums by automatic deduction from your nominated Financial Institution account or credit card.

Direct Debit Request details

If you're with one of the smaller banks or a credit union you need to check if they can accept a direct debit request from the Bulk Electronic Clearing System (BECS). This information should be available on your recent bank statement, on the bank's website, or call their customer service number.

I/We,

Family name (or company/business name) | Given name(s) (or ABN)

Family name | Given name(s)

request and authorise **the Insurer ABN 90 000 000 402 User ID 534289** to arrange, through its own financial institution, a debit to my/our nominated account any amount the Insurer has deemed payable by me/us. This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from my/our account held at the financial institution I/we have nominated below and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.

Name of Financial Institution | Name of account to be debited

Address of Financial Institution | State | Postcode

BSB number – | Account number

Please note: Direct debiting is not available on the full range of Financial Institution accounts. If in doubt, please refer to your Financial Institution before completing this Request.

Is this Direct Debit Request for?

☐ both the **initial and ongoing premiums**

☐ **ongoing premiums** only — please ensure you have completed payment details for the initial premium

How frequently will premiums be paid?

☐ Monthly ☐ Half-yearly ☐ Yearly

Preferred draw date of the month

Credit Card Deduction details

I (Name as it appears on the card) authorise the Insurer (ABN 90 000 000 402) (AFSL 230694) to charge my

☐ Mastercard ☐ Visa

Card number | Card expiry date (MM/YY)

/

or any replacement/substituted card, for the premiums due on the policy.

Is this Credit Card Deduction for?

☐ the **initial premium** only — please ensure you have completed payment details for the ongoing premium

☐ both the **initial and ongoing premiums**

☐ **ongoing premiums** only — please ensure you have completed payment details for the initial premium

How frequently will premiums be paid?

☐ Monthly ☐ Half-yearly ☐ Yearly

Preferred draw date of the month

To be completed for all Direct Debit Requests / Credit Card deductions

I/We acknowledge that this Direct Debit Request is governed by the terms of the Direct Debit Request Service Agreement in Section 23 of this form and the terms and conditions of the policy to which this application relates. I have read and agree to the terms and conditions.

Signature(s) of Financial Institution account holder(s) or cardholder

X Date (DD/MM/YYYY)

X Date (DD/MM/YYYY)

4B Payment by cheque

Only complete this section if you want to pay your premiums direct to us.

How frequently will premiums be paid? ☐ Half-yearly ☐ Yearly

We will send you notices for premiums prior to the due date.

4C Rollover from external super fund – enduring authority

Only complete this section if you want to pay your premium by an ongoing annual deduction from your external super account. Please note you can only request one Life Cover Super policy to be paid by rollover by any one external super fund.

This section is a direction to the trustee of your nominated external super fund to rollover funds to the Smart Future Trust and a direction to the Trustee to apply those funds in payment of premiums for your insurance policy.

Please read – Important information

- The member must be the same for both the Life Cover Super policy and the external super fund account.
- If the rollover request is rejected by the external super fund for any reason the Trustee will request alternative payment details from you, otherwise the policy will lapse.
- An amount equal to the annual premium payable will be requested as a rollover from your external super account proximate to the annual anniversary date for your insurance policy. We will notify you of the amount of annual premium required prior to requesting the rollover from your nominated external super fund.
- You agree that if the Fund or the Trustee change at any time, then this enduring rollover authority applies to authorise the trustee and administrator of the successor fund, to continue the ongoing annual deduction from your external super account to pay your premium.

Your responsibility

- It is your responsibility to determine the impact the rollover may have on any entitlement you have in the external super fund.
- Please ensure the account balance with the external super fund is sufficient to allow for the rollover of the required amount and ensure you meet any minimum balance requirements of the external super fund.
- You authorise the trustee of the external fund to deduct any applicable fees or charges which may be payable as a result of the rollover from your external account.
- You discharge the trustee of the external super fund from any further liability in respect of rollover benefit once the amount is transferred to the Smart Future Trust.

Termination of arrangements

- You must notify the Trustee in writing if you wish to terminate the ongoing annual rollover arrangement. Until such time, this direction and authority remains valid.
- The Trustee may, at its discretion or as may be required by law or regulations, terminate arrangements for annual rollover of funds from a nominated external super fund.
- The Trustee may be able to claim a tax deduction for the premium it pays for your insurance and, at its discretion, may pass some or all of the benefit of this tax deduction to you by reducing the amount of the rollover required to meet the premium, when the roll over comes from a taxed source.

Rollover details

Transferring from

Please complete details of the super fund from which the rollover payment is being requested.

Please contact your existing super fund (transferring fund) to confirm if they have any additional requirements, such as proof of identify documentation, before they can action this rollover authority. Please complete all details and ensure you provide the fund's Australian Business Number (ABN) and Unique Superannuation Identifier (USI).

The Trustee cannot accept certain rollovers, such as pension or super amounts transferred from the UK or New Zealand Kiwi Saver or untaxed amounts. It is your responsibility to ensure these types of amounts do not form part of your benefit in your nominated external super fund account.

Transferring from (Please tick one box only):

☐ External Super Fund

External Fund Name

External fund product name

External membership account number

Unique Superannuation Identifier (USI)

External fund ABN

☐ Self-managed Super Fund (SMSF)

SMSF Name

Electronic Service Address (ESA)

BSB

Account Number

ABN

Section 4 Payment Authorities continued

Transferring to

The requested rollover payment will be transferred to Acenda Life Insurance Unique Super Identifier (USI) – 68964712340017.

The Trustee will request the exact amount applicable to pay the insurance premium for the Life Cover Super policy number listed in this form. Please note you can only request one Life Cover Super policy to be paid by rollover by any one external fund.

Authority and Declaration

Until further notice in writing:

- I direct and authorise the trustee of my nominated external super fund (listed in section 4D) to effect the annual rollover of funds (as may be requested by the Trustee on my behalf).
- I give my nominated external super fund named in section 4D of this form, and the Trustee authority to exchange relevant information to facilitate the requested rollover of funds, including disclosing my tax file number; and
- I authorise the Trustee to apply those funds to pay for premiums for my Life Cover Super policy.

I declare:

- The information provided in this form is true and correct.
- I have read the Important information section of section 4D.

Full name of member

Signature of Life Insured/Member

X

Date (DD/MM/YY)

Section 5 Life Cover Super

Only complete this section if the application is for Life Cover Super.

Contributions

Please specify what type of contributions will be made by you or on your behalf. Please tick one box only.

☐ Employer ☐ Personal ☐ Spouse ☐ Salary Sacrifice

If you do not tick a box your contributions will be recorded as 'Personal'.

If Employer, please complete the following:

Company name

Company address

Suburb | State | Postcode | Country

ABN | Name of Authorised Person

Contact details — Tax File Number (TFN) details

Please provide your TFN:

When collecting your TFN we 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, and
- 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 6 Beneficiary Information

Please note: Beneficiary nominations apply to your death benefit only.

For Alterations and Increases to Life Cover you only need to complete this section if you wish to change existing beneficiary arrangements.

Are you applying for?

☐ **Personal Protection Portfolio (SMSF)**

- You cannot make a nomination for this insurance. The benefits of this insurance will be paid to the trustee of the super fund. You will need to contact the administrator of your super fund who will provide details of the forms to be completed if you wish to make a nomination of the proceeds from your super fund.
- Please go to Section 7.

☐ **Personal Protection Portfolio**

- If you wish to make a beneficiary nomination, please complete Section 6A.
- If you do not wish to make a beneficiary nomination, the death benefit will be paid to the Policy Owner(s) for Personal Protection Portfolio and you can go to Section 7.

☐ **Life Cover Super**

- Please go to Section 6B or 6C.

☐ **Both Personal Protection Portfolio and Life Cover Super**

- Please complete Section 6A if you wish to make a beneficiary nomination for your Personal Protection Portfolio policy. If you do not wish to make a beneficiary nomination, the death benefit will be paid to the Policy Owner(s) for Personal Protection Portfolio.
- Please go to Section 6B to make a nomination for your Life Cover Super policy.

Please note if you're applying for Life Cover Super and wish to make a beneficiary nomination, it is important that you read the beneficiaries section as well as the taxation section of the Super PDS before completing this section.

Section 6 Beneficiary Information continued

6A Nomination of a Beneficiary – Personal Protection Portfolio – must be nominated by the Policy Owner

Please note: For Personal Protection Portfolio, nominations **cannot** be made by trustees of a trust or a self-managed super fund.

Beneficiary nomination for Personal Protection Portfolio

Complete this section to nominate who you wish the death benefit to be paid to. Leave this section blank if you wish the death benefit to be paid to the Policy Owner(s).

Please nominate your preferred beneficiary(ies) and the portion you would like each to receive. You may nominate up to six beneficiaries, including your legal personal representative (Estate of the Life Insured).

	Name and address of beneficiary	Date of birth	Relationship to you	Portion of total benefit*
1				%
2				%
3				%
4				%
5				%
6				%
7	Legal personal representative (Estate of the Life Insured)			%
* The sum of your nominations must equal 100%. You can nominate a percentage up to two decimal places.			**Total:**	**100%**

If you are applying for additional Personal Protection Portfolio policy(ies) and you wish to also nominate a beneficiary(ies) for the policy(ies), please attach a photocopy of the above table specifying details of the beneficiary(ies) you wish to nominate.

6B Nomination of Beneficiary Form – Life Cover Super – must be nominated by the Life Insured

Non-binding death benefit nomination for Life Cover Super

☐ Tick this box and complete the table below if you wish to indicate to the Trustee your preferred beneficiary(ies) of your death benefit. It is the Trustee's ultimate decision who the benefits will be paid to and in what portions. Your nomination will be taken into account by the Trustee. The Trustee will ultimately be restricted to paying the death benefits to your dependants and/or your legal personal representative (estate).

Non-lapsing binding death benefit nomination for Life Cover Super

☐ Tick this box and complete the table below if you wish to indicate to the Trustee who your death benefit MUST be paid to. Your nominated beneficiary(ies) must be a dependant(s) or your legal personal representative (estate). The Trustee will pay the benefits to your nominated beneficiaries and in the portions indicated, providing that you satisfy the requirements in making this nomination, and at the date of death the beneficiaries are your dependants or legal personal representative (estate). Your signature is required and must be witnessed by two adult persons.

Section 6 Beneficiary Information continued

Complete this table for all beneficiary nominations for Life Cover Super.

Please nominate your beneficiary(ies) and the portion you would like each to receive. You may nominate up to 6 beneficiaries, including your legal personal representative (Estate of the Life Insured). If seeking a non-lapsing binding death benefit nomination, your nomination must also be witnessed, signed and dated by two adult witnesses (page 21).

	Name and address of beneficiary	Date of birth	Relationship to you	Portion of total benefit*
1			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
2			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
3			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
4			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
5			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
6			☐ Spouse ☐ Child ☐ Financial dependant ☐ Interdependency relationship ☐ Other dependant [1]	%
7	Legal personal representative (Estate of the Life Insured)			%
	* The sum of your nominations must equal 100%. You can nominate a percentage up to two decimal places.		**Total:**	**100%**

1 Please note: For non-lapsing binding nominations, the selection of 'Other dependant' is not valid. If you do select a binding nomination and tick 'Other dependant', your nomination will not be valid.

Section 6 Beneficiary Information continued

Application agreement and declaration

(Only required when making a non-lapsing binding beneficiary nomination for Life Cover Super.)

I request that the Trustee accept my beneficiary nomination for my Life Cover Super policy.

I have read and understand the information provided in the Super PDS on beneficiary nominations.

I understand I should review my nomination regularly as my circumstances change (eg marriage, marriage breakdown, birth of a child, or my benefit being affected by a payment split) to ensure my nomination is always up to date.

Signature of Life Insured

X Date (DD/MM/YYYY)

Witness declaration

Only required when making a non-lapsing binding death benefit nomination for Life Cover Super. Must be signed and dated by two adult witnesses.

I declare that:

- I am over 18 years of age
- I am not already a nominated beneficiary of the Life Insured and I am not one of the beneficiaries named above, and
- this form was signed and dated by the Life Insured in my presence.

Witness 1

First name

Middle name(s)

Family name

Signature of witness

X Date (DD/MM/YYYY)

Witness 2

First name

Middle name(s)

Family name

Signature of witness

X Date (DD/MM/YYYY)

Personal Statement Information

Section 7 Underwriting Options

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 Acenda to arrange any required tests?

Yes ☐ No ☐

Fast tracking follow-up information

If further information is required to assess your application, we can collect this information over the phone. Do you permit Acenda 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.

Yes ☐ I am contactable on (Phone number) ☐☐☐☐☐☐☐☐☐☐ between the hours of ☐☐:☐☐ and ☐☐:☐☐ (8:30am to 6pm AEST/AEDT Monday to Friday)

No ☐

Section 8 Disclosure

We have explained to you earlier in this application, your duty to take reasonable care not to make a misrepresentation that you are under when applying for cover with us, and want to take a moment to explain why it is so important.

You and your family's future and your ability to earn an income or maintain your business are worth protecting. To help ensure you and your loved ones are covered, we need to ask the following questions on your health and individual circumstances.

Please ensure that all your answers are accurate and correct. Failure to provide the correct information on any question may result in the company altering or voiding your policy, which may mean a claim will not be payable when you and your family need it most.

Declaration

Do you declare that:

- you will provide honest answers throughout this application, and
- you are aware that Acenda can check your answers at any time after the policy is issued, and
- providing false or incorrect information may result in Acenda altering or voiding your policy.

I, ☐ have understood and agree to the above declaration

Section 9 Other Insurance(s)

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 us (other than this application), including benefits under super 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 ☐

Section 10 Residency and Travel

Residency

1 Are you a permanent resident of Australia?

Yes ☐ Please go to question 3

No ☐ Please complete the table below:

How long have you lived in Australia?	Last country of residence	How long did you live there?	Visa type	Visa expiry date (DD/MM/YYYY)

2 Have you applied for permanent residency?

Yes ☐ Please provide details:

No ☐ Reason for not applying:

Travel

3 Do you intend to reside or travel outside 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 11 Occupation and Financial

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

☐ Go to Section 12

5 Your job and industry details

a Main job

b Industry

c Name of employer or trading name

d Professional or trade qualifications

6 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%**

7 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		
Total	**100%**	

8 In your main job, on average:

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

Section 11 Occupation and Financial continued

9 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.

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

Yes ☐

No ☐ Please provide details

11 Do you have another job?

Yes ☐ Please complete **a**–**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 9 of this application? ☐ Yes ☐ No

12 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, 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 ☐

13 Are you applying for Total and Permanent Disability, Income Protection or Business Expenses insurance?

Yes ☐ Please go to question 14

No ☐ Please go to question 22

Section 11 Occupation and Financial continued

14 In the last 2 years 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

15 Changes to your work situation and taking extended leave.

a) Over the next 12 months, do you plan or expect to:

- Change the type of work you do Yes ☐ No ☐
- Change your job duties, or work hours Yes ☐ No ☐
- Be made redundant, or become unemployed Yes ☐ No ☐
- Become self-employed Yes ☐ No ☐

If you answered Yes to any of these questions, please provide details below

Type of change	Reason for change	Date change will start

b) Over the next 12 months, do you plan or expect to:

- Take extended leave (for example, parental leave, study leave, sabbatical)? Yes ☐ No ☐

OR

- Are you currently on extended leave (for example, parental leave, study leave, sabbatical)? Yes ☐ No ☐

If you answered Yes to any of these questions, please provide details below

Type of leave	Reason for leave	Date leave will start	Expected length of leave

16 Do you work from home?

Yes ☐ Percentage of time you work from home? ____ %

No ☐

17 Are you self-employed, an employee of your own company or trust, or do you own all or part of the business in which you work?

No ☐ Go to question 18

Yes ☐ Please complete questions **a** to **h** below

a What is your workplace address

Postcode

b Have you been self-employed in your current business for more than 12 months? Yes ☐ No ☐

c On what basis do you operate your business? (tick all the apply)

Sole Trader ☐ Company ☐ Partnership ☐ Trust ☐

d Do you own 100% of the business?

Yes ☐ go to **f**

No ☐ go to **e**

e Provide details of your business partner(s

Business partner	Share ownership	Role in business

f Does the business have any employees, not including yourself?

Yes ☐ Provide details below

No ☐

Note: Some employees produce revenue, without them business revenue would decrease. Examples of revenue producing employees include doctors, salespeople, tradies.

Number of employees	Role	Income producing
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

g What percentage of the business revenue do these employees generate? %

h Has your business been trading profitably in each of the last two financial years?

Yes ☐

No ☐ Please provide last two years' financial accounts for all entities

17 *Continued from previous page*.
Are you self-employed, an employee of your own company or trust, or do you own all or part of the business in which you work?

Yes ☐ Please complete questions **i** to **l** below

i 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 Profit and Loss accounts, tax statements or other financial records.

- Do not include investment income
- Provide pre-tax figures
- If you earn commissions, include 100% of initial commissions, but only 50% of renewal commissions
- Depending on the structure of your business, some of these income types may not apply to you

Income type	Last financial year	Financial year prior
Your share of net profit		
Your personal salary/wage, directors fee or management fee		
Salary/wage paid to non-working spouse		
Super Guarantee Contribution paid for non-working spouse		
Depreciation		
Personal use motor vehicle cost*		
Voluntary Super Contributions		
Other (please specify)		
Total Earnings		
Your Super Guarantee Contribution**		

* Personal use motor vehicle cost: If the motor vehicle is a tool of trade, only include 30% of the motor vehicle cost. Otherwise, include 100% of the motor vehicle cost.

** If you are an employee of your own company or trust.

The following questions help us to understand the impact on your business if you can't work due to illness or disability. Please consider the specific circumstances of your business.

j Would your business continue if you were unable to work in the business?

Yes ☐

No ☐ Go to **l**

k If you were unable to work due to illness or disability:

i) For how many months would your business continue to generate any form of revenue? ☐

ii) What percentage of the business earnings would you continue to receive? ☐

iii) For how long would you continue to receive business earnings? ☐

l If you were unable to work due to illness or disability, would your business hire someone to perform your role?

Yes ☐ Provide details below

No ☐

Estimated monthly cost of a replacement $ ☐

Section 11 Occupation and Financial continued

18 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? _____

19 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		

20 Do you receive, or expect to receive, income of more than $10,000 per year (after deducting expenses related to that income) from other sources, for example rental properties, dividends, interest?

Yes ☐ Provide details below

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

No ☐

Section 11 Occupation and Financial continued

21 Business Expenses insurance only

Only complete this section if you are applying for Business Expenses insurance. (Refer to list of eligible business expenses in the Product Disclosure Statement (PDS)). If you are not applying for Business Expenses insurance, please go to question 22.

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?

$ ____

Section 12 Claims History

22 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 benefit ceased

Section 13 Sports and Pastimes

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

Yes ☐ Please tick all that apply and provide details 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 in the Supplementary Underwriting Questionnaires

Section 14 Doctor's details

24 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

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

years months

When did you last attend?

What was the reason for your last visit to this practitioner?

26 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

When did you last attend?

What was the reason for your last visit to this practitioner?

Section 15 Height and Weight details

27 What is your height?

cm **or** feet/inches

What is your weight?

kg **or** stone/pounds

28 Have you undergone surgery to reduce your weight in the last five years?

Yes ☐ Please provide details, including date of surgery and how much weight has been lost.

No ☐

29 Has your weight changed by more than 10kg (or 22lbs) in the last 12 months?

Yes ☐

No ☐

Section 16 Habits and Lifestyle

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

30 In the last 12 months, have you been a:

Please select all that apply.

☐ Regular smoker (smoke each day)	Go to **30a**
☐ Occasional smoker (smoke each week/ month / year)	Go to **30a & 30b**
☐ Social smoker (smoke with friends / family / colleagues)	Go to **30a & 320b**
☐ User of e-cigarettes or vaping	Go to **30c**
☐ User of nicotine-replacement products like patches, gum, etc.	Go to **30c**
☐ Non-smoker (you have not smoked at all)	Go to **31**

30a How many cigarettes, including roll-ups, cigars or pipes do you smoke on average?

Please do not guess.

☐ 41 or more a day ☐ 31-40 a day ☐ 21-30 a day ☐ 11-20 a day ☐ 1-10 a day

☐ Less than 7 a week ☐ Less than one a month

30b When was the last time you smoked tobacco, cigarettes, cigars, or any other nicotine containing substances?

☐ In the past month ☐ In the past 6 months ☐ In the past 12 months ☐ 1-5 years ago ☐ 6-10 years ago

☐ More than 10 years ago ☐ Never

30c How often do you use nicotine replacement products (eg patches, gum, mints, other nicotine containing products like e-cigarettes)?

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Twice a year

☐ Yearly Other ☐ I don't use these products

Section 16 Habits and Lifestyle continued

31 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 ☐

32 How often do you have six or more standard drinks on one occasion?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

Many people have been advised to reduce or stop drinking alcohol at some point in their lives.

33 Have you ever been concerned about your level of alcohol consumption or been advised to reduce or stop drinking alcohol by a healthcare professional for any reason?

Yes ☐ Please provide details

No ☐

Many people have tried recreational drugs, legal highs or drugs not prescribed to you by a doctor at least one point in their lifetime.

34 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) ☐ Some weekends or holidays
☐ A few times ☐ Once ☐ Never

If you have used drugs in the last 10 years please provide details including the type of drug and when you last took them:

35 In the last 10 years, have you misused or been addicted to any prescription or over-the-counter drug(s) (such as pain killers or sedatives), even if they were prescribed for you?

Yes ☐ Please provide details

No ☐

36 Have you ever received advice, counselling or treatment for drug dependence?

Yes ☐ Please provide details

No ☐

The following questions will help us understand your mental and physical wellbeing. These are important questions to answer accurately to avoid your insurance policy being altered or voided, which could result in a claim not being payable.

Please do your best to answer all questions to the best of your ability and do not guess.

Depending on the answers you provide we may need to check with your doctor.

Section 17 Supplementary Underwriting Questionnaires

Mental Health

Mental Health conditions are common, with about 8.7 million Australians experiencing mental ill health in their lifetime.

We know that mental health can change over time and can be caused by specific events or factors out of your control. Therefore, the purpose of these questions is to understand your own individual experiences with mental health.

37 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 **Q38**. If you selected any other response, please complete the **Mental Health Questionnaire**.

Physical wellbeing

We all get sick from time to time, but some illnesses can have an ongoing impact on your physical wellbeing.

The following questions will help us understand your **overall physical wellbeing** so we can accurately assess if you can be insured or if any special terms need to apply. If you answer **Yes** to any of the following questions, you must also complete the relevant **Supplementary Underwriting Questionnaires**, these can be found on our website at **acenda.com.au/forms**.

38 In your lifetime, have you had symptoms of, or been diagnosed with, or had treatment or medication for:

Please select the most relevant responses. Please do not guess.

☐ High blood pressure	Yes ☐ / No ☐	If yes, please complete the **High Blood Pressure** Questionnaire
☐ High cholesterol	Yes ☐ / No ☐	If yes, please complete the **High Cholesterol** Questionnaire
☐ Asthma	Yes ☐ / No ☐	If yes, please complete the **Asthma** Questionnaire
☐ Skin lesions such as a crusty non-healing mole, new spots, freckles or any moles changing in colour, thickness or shape over a period of weeks to months, keratosis, sunspots, Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), skin cancer or melanoma ☐ Any other skin lesion that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Skin Lesion** Questionnaire
☐ Back or neck strain/sprain or pain, sciatica, whiplash, spondylitis, fracture or spinal fusion ☐ Any other back or neck condition that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Back Disorder** Questionnaire
☐ Any bone/joint fractures, muscle, ligament or tendon injuries, repetitive strain injury (RSI), carpal tunnel syndrome, tenosynovitis, gout, arthritis, osteopenia or osteoporosis ☐ Any other bone, muscle, ligament or tendon condition that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Joint/Musculoskeletal** Questionnaire

Section 18 General

If you answer yes to any of the following questions, you must also complete the Further information table on page 37 of this Application form.

39 Have you ever had, or been told you had, or ever sought advice or treatment from a doctor, counsellor or other health professional or experienced symptoms for any of the following?

a Skin conditions such as

- ☐ Persistent rash, eczema, psoriasis, dermatitis, skin allergies
- ☐ Any other skin condition or disorder of the skin that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

b Blood or blood vessel conditions such as

- ☐ Varicose veins, deep vein thrombosis (DVT), pulmonary embolism
- ☐ Haemochromatosis, haemophilia, anaemia
- ☐ Human Immunodeficiency Virus (HIV), AIDS, or any AIDS or HIV related conditions
- ☐ Any other blood or blood vessel condition that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

c Eye or ear conditions such as

Do not include conjunctivitis with full recovery, colour blindness, or long or short sightedness that has been corrected either with surgery, contact lenses or glasses.

- ☐ Cataracts, glaucoma, blindness, keratoconus, retinal detachment, uveitis
- ☐ Tinnitus, deafness, Meniere's disease, labyrinthitis, vertigo, cholesteatoma
- ☐ Any other eye or ear conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

d Cardiovascular or heart condition such as

- ☐ Angina, heart attack, chest pain, heart murmur, heart palpitations or irregular heartbeat
- ☐ Valve diseases, stenosis, regurgitation, rheumatic fever
- ☐ Any other cardiovascular or heart conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

e Respiratory conditions such as

- ☐ Bronchitis, pneumonia, emphysema or Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Sleep apnoea
- ☐ Any other respiratory, lung or breathing disorder that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

f Stomach, bowel, colon or liver conditions such as

- ☐ Irritable bowel syndrome (IBS), bleeding from the bowel, haemorrhoids, bowel polyps
- ☐ Crohn's disease, ulcerative colitis or diverticulitis
- ☐ Reflux, hernia, ulcer or gall bladder conditions
- ☐ Hepatitis (excluding hepatitis A if fully recovered) fatty liver or cirrhosis of the liver
- ☐ Any other stomach, bowel, colon or liver conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

g **Diabetes, pancreatic or thyroid conditions such as**

- ☐ Type 1 or Type 2 diabetes, impaired fasting glucose, pregnancy related diabetes, sugar in your urine or low or high blood sugar
- ☐ Pancreatitis
- ☐ Hypothyroidism, hyperthyroidism, Graves' disease, goitre and thyroiditis
- ☐ Any other diabetic, pancreatic or thyroid conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

h **Brain, nerve or neurological conditions such as**

- ☐ Persistent headaches or migraines, fainting or dizziness
- ☐ Stroke, transient ischaemic attack (TIA), brain haemorrhage
- ☐ Paralysis, multiple sclerosis (MS) or motor neurone disease (MND)
- ☐ Neuritis, epilepsy or seizures, Alzheimer's disease or dementia
- ☐ Any other brain, nerve or neurological conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

i **Cancer or tumours such as**

- ☐ Leukaemia, lymphoma, mesothelioma, myeloma, sarcoma
- ☐ Any form of cancer or tumours (benign or malignant)
- ☐ Any other cancer condition that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

j **Automimmune conditions such as**

- ☐ Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or lupus
- ☐ Any other automimmune conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

k **Sexually transmitted infection such as**

- ☐ Gonorrhoea, herpes, syphilis
- ☐ Any other sexually transmitted infections or conditions that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

l **Males only**
Kidney, bladder or reproductive conditions such as

- ☐ Polycystic kidney disease, recurrent kidney infections, kidney stones, nephritis, urinary tract infection (UTI), cystitis or blood in urine
- ☐ Prostatitis or enlarged prostate
- ☐ Any other kidney, bladder or reproductive condition that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

m **Females only**
Kidney, bladder, breast or reproductive conditions such as

- ☐ Polycystic kidney disease, recurrent kidney infections, kidney stones, nephritis, urinarty tract infection (UTI), cystitis or blood in urine
- ☐ Polycystic ovarian syndrome, endometriosis, abnormal pap smear, polyps and fibroids, pelvic inflammatory disease
- ☐ Breast lumps, fibroadenomas or breast cysts. Excluding any normal test results that don't require follow up in the next 12 months
- ☐ Any other kidney, bladder, breast or reproductive condition that you have not already told us about

Yes ☐ Please provide details in the table on page 37
No ☐

Are you currently pregnant?

Yes ☐ Please provide due date
No ☐

Due date (DD/MM/YYYY):

Do you have a history of pregnancy complications?

Yes ☐ Please provide details in the table on page 37
No ☐

40 In the last two years, have you had any of the following irregularities or unusual changes to your body?

Irregularities or unusual changes to your body

☐ A lump in the neck, armpit or anywhere else in the body	Yes ☐	No ☐
☐ Sores or ulcers that don't heal	Yes ☐	No ☐
☐ Coughs or hoarseness that won't go away, or coughing up blood	Yes ☐	No ☐
☐ Changes in toilet habits that last more than two weeks / blood in the stools	Yes ☐	No ☐
☐ New moles or skin spots, or ones that have changed shape, size or colour, or that bleed	Yes ☐	No ☐
☐ Lumpiness or thickened area in or around your breast area	Yes ☐	No ☐
☐ Unexplained weight loss	Yes ☐	No ☐
☐ Unexplained chest pain	Yes ☐	No ☐

Further information

If you answered 'Yes' to any question in Section 18 (questions 39-40), please provide details below

Question	Symptom	Date symptom started	Date of last symptoms	Type of treatment and any test results	Degree of recovery	Time off work	Name and address of doctor, hospital or health professional consulted

Thank you for your time and answers so far. We want to now check if there is anything else we should know to help us better understand your overall wellbeing, therefore please respond to the further questions on the following page.

Section 18 General continued

Other than what you have already told us, in the last 5 years, have you

We do not need to know about:

- **Colds, flu or minor viral illnesses that were short, isolated occurrences or medications for these conditions, or annual check-ups where the results were normal.**
- **Childhood illnesses such as chicken pox, measles, mumps, tonsillitis or tonsillectomy, appendicitis or appendectomy, unless you have not made a complete recovery.**

41 Seen a doctor or other health professional* such as psychologist, osteopath, physiotherapist

Yes ☐ Please provide details in the table on page 39

No ☐

42 Required tests or investigations* such as blood test, x-ray, MRI, ECG or biopsy

Yes ☐ Please provide details in the table on page 39

No ☐

43 Had treatment, taken medication or herbal medicines

Yes ☐ Please provide details including the results in the table on page 39

No ☐

44 Had a fracture or broken bone

Yes ☐ Please provide details in the table on page 39

No ☐

45 Had surgery or an operation

Yes ☐ Please provide details in the table on page 39

No ☐

46 Had to go to hospital for an accident or medical condition

Yes ☐ Please provide details in the table on page 39

No ☐

* Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.

47 Are you waiting for any medical test or investigation results?

Yes ☐ Please provide details

No ☐

48 In the **last 12 months**, have you been referred to a specialist or for medical tests, treatment or surgery?

Yes ☐ Please provide details

No ☐

Section 18 General continued

If you answered 'Yes' to any question in Section 18 (questions 41–46), please provide details below

Question	Condition, reason or test	Date started	Date of last symptoms	Type of treatment and any test results	Degree of recovery	Time off work	Name and address of doctor, hospital or health professional consulted

49 In the next 12 months, do you plan to:

☐ Seek medical advice	Yes ☐	No ☐
☐ Have tests and or investigations* such as blood test, x-ray, MRI, ECG or biopsy	Yes ☐	No ☐
☐ Have treatment	Yes ☐	No ☐
☐ Have surgery or an operation	Yes ☐	No ☐

* Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.

50 When do you plan on seeking medical advice? (DD/MM/YYYY)

51 What is the reason(s) for these tests, treatment(s) or surgery/operation?

Section 19 Family history

52 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
- ☐ Breast or ovarian cancer
- ☐ Melanoma
- ☐ Bowel cancer
- ☐ Familial Polyposis (FAP)
- ☐ Any other cancer not otherwise listed (specify type and site)
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Haemochromatosis
- ☐ Muscular dystrophy
- ☐ Polycystic Kidney Disease (PCKD)
- ☐ Huntington's disease
- ☐ Motor neurone disease
- ☐ Any other hereditary disorder

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

Section 20 Further Information

If you use this page to provide further information, please note the page and question number the additional information refers to.

Page no.	Question no.	Further information

53 Have you answered yes to any of the conditions in Question 40.

Yes ☐ please ensure you complete and attach the relevant questionnaire. The questionnaires are available on our website **acenda.com.au/forms**

No ☐ Please go to the next question.

Section 21 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 four 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 21 Authority to Release Medical Information continued

Authority 1

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)

Signature of Life Insured

✗

Date (DD/MM/YY)

Authority 2

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)

Signature of Life Insured

✗

Date (DD/MM/YY)

Section 22 Declarations and Authorisations

The section immediately below must be signed by the Life Insured.

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 relevant Product Disclosure Statement (PDS) which I 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 the Insurer 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 issues a policy (or, in the case of an addition to an existing policy, 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 existing insurance that I hold with another insurer is to be replaced with the insurance I have applied for, I will cancel the existing insurance. If I do not, I understand that any benefit payable under any insurance issued from this application will be reduced by any benefit paid or payable for the same event under existing insurance.

10. Where I am replacing existing Acenda insurance, I authorise and request that the Insurer cancel the existing insurance that I am replacing.

11. Any loadings or exclusions that apply to the Acenda policy that is being replaced will also apply to the new policy issued from this application.

12. If business expenses protection 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 Insurance PDS 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.

13. I consent to Acenda 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 Acenda 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.

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 Acenda's decision on the application.

Signature of Life Insured

✗	Date (DD/MM/YYYY)

If the Policy Owner is different to the Life Insured, and/or you are applying for Life Cover Super, please also complete the relevant declarations on the next page.

Section 22 Declarations and Authorisations continued

Personal Protection Portfolio 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.
- If the Life Insured is under 16 years of age then a Parent or Guardian is required to sign.
- 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

Policy 1
Signature(s) of Policy Owner(s)

X Date (DD/MM/YYYY)

X Date (DD/MM/YYYY)

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

Policy 2
Signature(s) of Policy Owner(s)

X Date (DD/MM/YYYY)

X Date (DD/MM/YYYY)

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

Policy 3
Signature(s) of Policy Owner(s)

X Date (DD/MM/YYYY)

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

X Date (DD/MM/YYYY)

Declaration — Life Cover Super Only

In addition to the previous declaration, please complete this declaration if you are also applying for Life Cover Super.

a) I have read and understood the Super Product Disclosure Statement which I received in Australia.

b) I apply to become a Member of the Smart Future Trust and agree to be bound by the provisions of the Trust Deed constituting the Smart Future Trust and the Life Cover Super policy issued by the Insurer to the Trustee, as amended from time to time.

c) I understand that my Tax File Number will only be used for super and future approved purposes.

Note: The law requires that:

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 balance in this product/fund is less than $6,000 and/or I'm under 25 years old.

Signature of Life Insured

X Date (DD/MM/YYYY)

Section 22 Declarations and Authorisations continued

Marketing consent

We always seek to better understand and serve your financial, e-commerce and lifestyle needs so we can offer you other products and services that aim to meet those needs as well as promotions and other opportunities.

By giving your consent you agree to receiving information about the products and services as described in the Insurer's Privacy Policy (**acenda.com.au/privacy-policy**), including by telephone call to the numbers provided by you in this application or numbers you may provide later and by email if you have provided us with an email address. If you are applying for Life Cover Super, you are also consenting to receiving information about the products and services as described in the Trustee's Privacy Policy (**eqt.com.au/global/privacystatement**).

We will not disclose health information for marketing purposes.

Do we have your consent? If you do not mark a box your consent will be presumed.

Yes ☐ No ☐

Your consent will continue until you withdraw it. You can withdraw your consent at any time by contacting us on **13 65 25**.

Section 23 Payments by Direct Debit

Direct Debit Request Service Agreement

This Direct Debit Request Service Agreement is issued by the Insurer, ABN 90 000 000 402 (User ID no. 534289).

This Service Agreement and the Direct Debit Request Schedule in your application contain the terms and conditions by which you authorise the Insurer to draw (debit) money from your account and the obligations of us and you under this Agreement. You should read through them carefully to ensure you understand these terms and conditions before signing the Schedule. Please direct all enquiries about your direct debit to us on **13 65 25**.

Our commitment to you

We will give you at least 30 days' notice in writing if there are changes to the terms of the drawing arrangements.

We will keep the details of your nominated Financial Institution account confidential, except where provided to our bank or as required to conduct direct debits with your Financial Institution.

Where the due date is not a business day, we will draw from your nominated Financial Institution account on the business day before or after the due date in accordance with the terms and conditions of your Acenda policy.

If there is a dishonour of a draw, we may re-attempt to draw that dishonoured amount, in addition to the next payment, on the next due date. We will tell you of the proposed second attempt draw in advance of doing so.

We will not charge you for any dishonours, however:

- if your account dishonours, your Financial Institution may charge you a fee
- we reserve the right to cancel drawing arrangements if drawings are dishonoured by your Financial Institution.

Your commitment to us

It is your responsibility to:

- ensure your nominated account(s) shown in the Direct Debit Schedule are correct and that your nominated financial institution account can accept direct debits through the Bulk Electronic Clearing System (BECS)
- ensure there are sufficient funds available in the nominated account to meet each drawing on the due date
- advise us if the nominated account is transferred or closed, or the account details change
- arrange an alternate payment method acceptable to us if we cancel the drawing arrangements, and
- ensure that all account holders on the nominated Financial Institution account sign the Direct Debit Request Schedule.

Your rights

Your drawing arrangements are detailed in the Direct Debit Request Schedule of your application. They are also governed by the terms and conditions of your Acenda policy. You should contact us on **13 65 25**, providing at least seven days notice, if you wish to alter the drawing arrangements. You can:

- alter the Schedule
- cancel the Schedule
- stop an individual drawing
- defer a drawing, or
- suspend future drawings.

This section for Financial Adviser use only

This section must be completed

Email (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

Adviser Code

Mobile phone

Telephone number

Email

Distribution fee split

%

Financial Adviser 2

Name of Financial Adviser

Adviser Code

Mobile phone

Telephone number

Email

Distribution fee split

%

☐ I confirm that I have provided my client with the Product Disclosure Statement applicable at the date they have signed the Declaration.

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 ☐

Remuneration payment type:

Select payment type: Upfront ☐ Hybrid ☐ Level ☐

Please note: Class C Income Protection is paid on a level basis

This section for Financial Adviser use only

This section must be completed

Special Instructions

Equity Trustees Superannuation Limited

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Melbourne VIC 3001

Call 1300 133 472

Email enquiry@eqt.com.au

Website eqt.com.au

Acenda

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Docklands VIC 3008

Call 13 65 25
+ 61 2 9121 6500 (outside of Australia)

Email enquiries.retail@acenda.com.au

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