Application for Reinstatement

Policy numbers

Life Insured's name

Please provide **all** the policy numbers that you wish to be reinstated (including any connected policies). A separate reinstatement form will need to be completed if the request is for another Life Insured on the same policy.

For the reinstatement time frame that applies to your policy, please call us on **13 65 25**.

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

Your duty to take reasonable care not to make a misrepresentation

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.

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

If you do not meet your duty

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

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

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

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

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

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

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, including what you can do if you disagree.

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 superannuation or held with other life insurers as well as cover applied for) 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.

1. Life Insured's details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address
(Please provide your email so updates relating to your application can be sent to you)

Mobile phone number

Home phone number

Business phone number

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

PO Box number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

2. Policy Owner(s) details

Policy 1

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

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address
(Please provide your email so updates relating to your application can be sent to you)

Mobile phone number

Home phone number

Business phone number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

2. Policy Owner(s) details continued

Policy 2 (if applicable)

☐ Tick this box if Policy Owner 2 is the same as the Life Insured. If not, please fill in the details below.

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address
(Please provide your email so updates relating to your application can be sent to you)

Mobile phone number

Home phone number

Business phone number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Policy 3 (if applicable)

☐ Tick this box if Policy Owner 3 is the same as the Life Insured. If not, please fill in the details below.

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address
(Please provide your email so updates relating to your application can be sent to you)

Mobile phone number

Home phone number

Business phone number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

3. Personal statement

1. What is your height?

cm **or** feet/inches

What is your weight?

kg **or** stone/pounds

2. Have you smoked tobacco or any other substance or used e-cigarettes or any nicotine replacement products in the last 12 months?

Yes ▶ Please provide details including type, quantity per day and date last smoked.

Type	**Quantity per day**	**Date last smoked** (DD/MM/YYYY)

No

3. 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

No

4. Thinking back to the last time you were required to tell Acenda about your medical history. Since that date have you:

(Note: do not include colds, flu or minor viral illnesses that were short, isolated occurrences or annual check ups where the results were normal).

a) Had any illness or injury or consulted any doctor or health professional*

Yes ▶ Please provide details in the table on page 6

No

***Before you answer this question, please refer to page 2 of this form which relates to information about genetic testing.**

b) Required tests or investigations*? (eg blood test, x-ray, MRI, ECG or biopsy)

Yes ▶ Please provide details in the table on page 6

No

***Before you answer this question, please refer to page 2 of this form which relates to information about genetic testing.**

c) Commenced medication or treatment (or been advised to), or do you intend to undergo any medical treatment or surgery*?

Yes ▶ Please provide details in the table on page 6

No

***Before you answer this question, please refer to page 2 of this form which relates to information about genetic testing.**

d) Had any symptoms for which you intent to seek medical advice, or are you waiting for medical treatment, a medical consultation or the results from medical tests or investigations*?

Yes ☐ Please provide details in the table below

No ☐

***Before you answer this question, please refer to page 2 of this form which relates to information about genetic testing.**

If you answered 'Yes' to any question in Section 3 questions 4 a - d, please provide details below including name of condition, when first diagnosed or symptoms first appeared, results of any tests or investigations, details of treatment, degree of recovery, time off work and the name and contact details of any medical professionals consulted.

5. 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 i 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

6. Do you intend to travel, live or work outside Australia for more than 3 months in any 12 month period?

Yes ☐ Please provide details in the box

No ☐

7. Think back to the last time you, or anyone providing information on your behalf, were required to tell Acenda about your existing insurance, occupation or activities. Since that date, have you:

		If yes, please provide details:
a) Taken up, or applied for, any other insurance on your life with any company, including us (other than this application)?	Yes ☐ No ☐	
b) Had an application for insurance on your life declined, postponed, cancelled, or accepted with an exclusion or higher than standard premium, or modified in any way?	Yes ☐ No ☐	
c) Changed your i) job ii) duties performed iii) employment situation – a change in employment situation would include being made redundant, changing from employee to self-employed; and/or iv) hours worked each week	Yes ☐ No ☐	
d) Taken up any recreational, sporting or hazardous activities? These include, but are not limited to: scuba diving, base jumping, hang gliding, race car driving, flying a plane, bungee jumping or equestrian events.	Yes ☐ No ☐	

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

$ PA

Super Guarantee Contribution

$ PA

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

9. If applying to reinstate Child Critical Illness insurance for a child under age 16

Think back to the last time you, or anyone providing information on your behalf, were required to tell Acenda about your child's medical history. Since that date has the child

a) Had any illness or injury

Yes ☐ Please provide details below

N o ☐

b) Had a medical disorder requiring surgery

Yes ☐ Please provide details below

No ☐

c) Been hospitalised

Yes ☐ Please provide details below

No ☐

d) Received ongoing treatment

Yes ☐ Please provide details below

No ☐

e) Undergone tests or investigations

Yes ☐ Please provide details below

No ☐

If Yes, please provide details including the name of the insured child*

***If you need to complete details for more than one child, please copy this page and attach for each child.**

4. 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.

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/YYYY)

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/YYYY)

5. Declaration

I understand and agree that:

- I have read and understand the duty to take reasonable care not to make a misrepresentation;
- The information provided in this application is true and complete;
- I consent to Nippon Life Insurance Australia and New Zealand Limited relying on information in the previous applications for the Acenda Policy to be reinstated and confirm that the information in those applications and if applicable, the applications for increases or additions, is true and correct;
- If any answers to the questions are not in my own handwriting, I certify that I have checked them and they are correct; and
- 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 me. I also acknowledge my personal and sensitive information may be sent to my email address.

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 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)

Signature(s) of Policy Owner(s) (if different from the Life Insured)

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

Policy 1

Name

Signature of Policy Owner

X Date (DD/MM/YYYY)

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

Name

Signature of Policy Owner

X Date (DD/MM/YYYY)

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

Policy 2 (if applicable)

Name

Signature of Policy Owner

X Date (DD/MM/YYYY)

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

Name

Signature of Policy Owner

X Date (DD/MM/YYYY)

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

5. Declaration continued

Policy 3 (if applicable)

Name

Signature of Policy Owner

✗ Date (DD/MM/YYYY)

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

Name

Signature of Policy Owner

✗ Date (DD/MM/YYYY)

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

A notification about your privacy

Acenda is bound by the *Privacy Act* 1988 (Cth). Before providing us with any personal information, you should read the below information about your privacy.

We collect, use, store and disclose personal information, including sensitive information (such as health information) when required, about you in order to comply with our legal obligations and in order to provide you with insurance (eg changing your insurance cover or paying a claim).

For the purpose of providing you with insurance, we will disclose this information to your adviser if you have one (and the licensed dealer or broker he or she represents), affiliates of Acenda, to other insurers and reinsurers, to our agents, contractors, service providers and administrators, medical service partners (eg medical practitioners and health practitioners), legal representatives and other consultants, and where we are required or permitted to by law. By signing this form, you will be consenting to us, and those other organisations and professionals acting on our behalf, to collecting, and disclosing as required, the sensitive information for this purpose.

Acenda may obtain information from government offices and third parties for the purposes of providing you with insurance.

For further information about Acenda's Privacy Policy, which includes more details about how we collect, use, store and disclose your personal information, a list of countries in which recipients of your information are likely to be located, details of how you can access or correct the information we hold about you or make a complaint, please refer to **acenda.com.au/privacy-policy** contact us by telephone on **13 65 25** or email us at **enquiries.retail@acenda.com.au**

Send us your form

Please send your completed form to us at:

Acenda - Operations
PO BOX 23455
Docklands VIC 3008

Email: enquiries.retail@acenda.com.au

If you have any questions, please contact your financial adviser or call us on **13 65 25** 8:30am to 6pm (AEST/AEDT), Monday to Friday.

AC5370-1025
OCM0272 CGP-2108