Replacing your existing insurance

You should read this information before you fill in the form. It will help you understand what's involved and what you need to provide so we can process your application.

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

For Acenda Insurance and Acenda Insurance (Super) – Acenda Insurance and Acenda Insurance (Super) Product Disclosure Statement (**Insurance PDS**), issued by the insurer, Nippon Life Insurance Australia and New Zealand Limited (the insurer).

For Acenda Insurance (Super) – please also read the Smart Future Trust – Retail Insurance in Super: Acenda Insurance Super Product Disclosure Statement (**Super PDS**) issued by the trustee, Equity Trustees Superannuation Limited.

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

How to use this form

You can use this form to replace your existing insurance with an eligible Acenda policy.

If you are applying for new benefits or options, or there is no like for like option for your existing benefits, you will need to complete a new Acenda Insurance and Acenda Insurance (Super) application.

Who should complete this form?

This form needs to be completed and signed by the Policy Owner, Life Insured and your financial adviser.

Please answer all the questions and write clearly so we can read your answers.

If there isn't enough space for all your information, please write it on a separate sheet and attach it to this form.

Accuracy of information

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 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.

Replacing your existing insurance

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

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

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

If you do not meet your duty

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

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

Guidance for answering our questions

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

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

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

If you need help

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

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

What can we do if the duty is not met?

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

For example we may:

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

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

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

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

Replacing your existing insurance

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 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.

Exclusion periods for Critical Illness

If you are replacing Critical Illness type insurance held with us, the exclusion periods that apply to the critical conditions under the new Acenda policy will be waived to the extent that these conditions are covered under the insurance being replaced.

Replacing existing eligible insurance from us

Requirements

- Completed replacement application form,
- Our premium quotation, and
- Signed and dated cancellation request from the policy owner for policy being replaced (only applicable if the policy owner is different to the life insured on the policy being replaced).

Privacy

We respect your privacy and handle your information in accordance with our privacy policy. The Insurer's Privacy Policy is available at **acenda.com.au/privacy-policy**

For more information

Remember, we're here to help. If you have any questions or need any help when completing this form, please contact your financial adviser or call us on **13 65 25** between 8am and 6pm (AEST/AEDT), Monday to Friday or visit **acenda.com.au**

Send your completed form to
Acenda - Operations
PO Box 23455
Docklands VIC 3008

Please retain this page for your records.

AC5913-1025
CGP-1477 OCM0463

Replacing your existing insurance

To be completed by the Financial Adviser

Section 1: Cover details

Please tick which product you are applying for:

Policy 1: ☐ Acenda Insurance (Super) ☐ Acenda Insurance ☐ Acenda Insurance (Wrap or SMSF)

Policy 2: ☐ Acenda Insurance

Policy 3: ☐ Acenda Insurance

Please note: Select Acenda Insurance (Wrap or SMSF) if you are applying for insurance using an eligible wrap platforms account or for a self-managed super fund.

Existing policy number(s) to be replaced

Policy number	Policy number	Policy number

☐ Please tick this box to confirm that a copy of the Premium Illustration (quote) from us has been attached to this application. **It forms part of this application form and your application can't be assessed without it.**

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

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.

Section 1: Cover details (continued)

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 business partners, please attach a photocopy of this page with additional information.

No ☐ **Go to Section 2.**

To be completed by the Life to be Insured

Section 2: Life to be Insured's details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Gender

☐ Male ☐ Female

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

PO Box number | Unit number | Street number | Street name

Suburb | State | Postcode | Country

Section 2: Life to be Insured's details (continued)

Contact details

Home telephone

Business telephone

Mobile

For completion by the Policy Owner

Section 3: Policy Owner(s) details

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

Owner details for Policy 1

Is this Policy 1 application for:

Acenda Insurance (Super)

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

Acenda Insurance (Wrap or SMSF)

☐ Cover can be owned by a self-managed super fund or by using an eligible super wrap account. Please complete the details under 'Who owns this policy' below.

Who will own this policy?

☐ **Eligible super wrap account.** This policy will be owned by the trustee. If you are only applying for this policy, please go to Section 4, otherwise go to Policy 2.

☐ **Self-managed super fund (SMSF) including eligible wrap platforms self-managed super accounts**. 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.

Acenda Insurance

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

Who will own this policy?

☐ **Life to be 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 to be 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.

Section 3: Policy Owner(s) details (continued)

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

SMSF Address

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

PO Box number | Unit number | Street number | Street name

Suburb | State | Postcode | Country

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

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 1A postal address

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

PO Box number | Unit number | Street number | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone

Business telephone

Mobile

Section 3: Policy Owner(s) details (continued)

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

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 1B postal address

PO Box number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Contact details

Home telephone

Business telephone

Mobile

Owner details for Policy 2

Only complete this section if you are applying for two policies.

Is this Policy 2 application for:

Acenda Insurance ☐ Cover can be owned by individual(s), a business partnership, trust or company. Please complete details under 'Who will own this policy?' Please note that if you are applying for Income Protection insurance, the Life to be Insured must be the sole Policy Owner—unless the Policy Owner is a business of which the Life to be Insured owns at least 25%.

Who will own this policy? (Acenda Insurance only)

☐ **Life to be Insured**. You don't have to complete Policy Owner details. Please go to **Section 4**.

☐ Individual(s) other than the Life to be Insured. Please complete the 'Individual details' in Policy Owner 2A and Policy Owner 2B (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 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 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 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 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 2A and Policy Owner 2B (if applicable) sections.

Section 3: Policy Owner(s) details (continued)

Policy Owner 2A – Company/Trust

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

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

Business Partnership/Trust name

Company/Trust Company name

Residential address

Unit number

Street number

Street name

Suburb

State

Postcode

Country

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

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 2A postal address

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

PO Box number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Contact details

Home telephone

Business telephone

Mobile

Section 3: Policy Owner(s) details (continued)

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 ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 2B postal address

PO Box number | Unit number | Street number | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Business telephone | Mobile

Owner details for Policy 3

Only complete this section if you are applying for three policies.

Is this Policy 3 application for:

Acenda Insurance ☐ Cover can be owned by individual(s), a business partnership, trust or company. Please complete details under 'Who will own this policy?' Please note that if you are applying for Income Protection insurance, the Life to be Insured must be the sole Policy Owner – unless the Policy Owner is a business of which the Life to be Insured owns at least 25%.

Who will own this policy? (Acenda only)

☐ **Life to be Insured**. You don't have to complete Policy Owner details. Please go to **Section 4**.

☐ **Individual(s) other than the Life to be Insured**. Please complete the 'Individual details' in Policy Owner 3A and Policy Owner 3B (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 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 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 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 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 3A and Policy Owner 3B (if applicable) sections.

Section 3: Policy Owner(s) details (continued)

Policy Owner 3A – Company/Trust

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

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

Business Partnership/Trust name

Company/Trust Company name

Residential address

Unit number | Street number | Street name

Suburb | State | Postcode | Country

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

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 3A postal address

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

PO Box number | Unit number | Street number | Street name

Suburb | State | Postcode | Country

Contact details

Home telephone | Business telephone | Mobile

Section 3: Policy Owner(s) details (continued)

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 ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email address

Policy Owner 3B postal address

PO Box number

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Contact details

Home telephone

Business telephone

Mobile

Section 4: Payment authorities

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

If the payer is an individual

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Address (this can't be a PO Box)

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Section 4: Payment authorities (continued)

If the payer is a company/Trust/SMSF details

Note: if we already have your Company details, please only complete 'Name of Authorised Person'.

Company/Trust/SMSF name

Address

Unit number | Street number | 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			
Eligible wrap platforms account deduction	4C			
Rollover from external super fund – annual premium for Acenda Insurance (Super) only	4D			

Please note: If we do not receive your payment (Direct debit request, Credit card deduction, cheque, or an eligible wrap platforms account deduction 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.

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 credit unions you may 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 by calling their customer service number.

I/We,

Last name (or company/business name) | First name(s) (or ABN)

Last name | First 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 – | Account number

Section 4: Payment authorities (continued)

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 date (DD/MM/YYYY)

Credit Card Deduction details

I (Name as it appears on 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

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 24 of this form and the terms and conditions of the policy to which this application relates. I/We have read and agree to the terms and conditions.

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

X Date (DD/MM/YY)

X Date (DD/MM/YY)

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 Eligible wrap platforms account deduction

Only complete this section if you want to pay your premiums by a regular deduction from an eligible wrap platforms account. Please refer to acenda.com.au/using-your-insurance/how-to-pay-your-insurance-premiums **for the list of eligible accounts.**

I/We,

Last name (or company/business name)

First name(s) (or ABN)

Last name

First name(s)

request the platform administrator until further notice to debit my/our investment account any amounts which the Insurer (ABN 90 000 000 402) (AFSL 230694) may charge me/us.

4C Eligible wrap platforms account deduction continued

Name of account:

For Acenda Insurance (Wrap or SMSF) policies paid through a wrap or SMSF account (Please tick one box only):

- ☐ Expand Extra Super
- ☐ Expand Essential Super
- ☐ IOOF Personal Super
- ☐ Shadforth Portfolio Service – Super

For Acenda Insurance (outside super) (Please tick one box only):

- ☐ Expand Extra Investment
- ☐ Expand Essential Investment

Account number

How frequently will premiums be paid?

☐ Monthly ☐ Half-yearly ☐ Yearly

Preferred date (DD/MM/YYYY)

I understand and acknowledge that;

- The Insurer may, by prior arrangement or advice to me, vary the amount and frequency of future deductions, and
- The Insurer may, in its absolute discretion and at any time by notice in writing to me, terminate this request as to future deductions.

Signature(s) of the account holder(s)

X Date (DD/MM/YY)

X Date (DD/MM/YY)

4D 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 fund account. Please note you can only request one Acenda Insurance (Super) policy to be paid by rollover by any one external 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 Acenda Insurance (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 fund 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 deduction from your external account by the trustee of the external fund any applicable fees or charges which may be payable as a result of the rollover.
- 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 rollover 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 identity 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

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 Acenda Insurance (Super) policy listed in Section 1 of this form.

Please note: You can only request one Acenda Insurance (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 in 4D 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 Acenda Insurance (Super) policy.

I declare:

- The information provided section 4D is true and correct, and
- I have read the 'Important information' section of section 4D.

Full name of member

Signature of Life to be Insured/member

X

Date (DD/MM/YY)

Section 5: Acenda Insurance (Super)

Only complete this section if the application is for Acenda Insurance (Super).

Contributions

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

Note: we require all this information to be completed before we can accept contributions from you.

☐ Employer ☐ Personal ☐ Spouse ☐ Salary Sacrifice

If Employer please complete the following:

Company name

Company address

Suburb | State | Postcode | Country

ABN | Name of Authorised Person

Tax File Number (TFN) details

Please provide your TFN:

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

- The Insurer and the Trustee are authorised to collect your TFN under the Superannuation Industry (Supervision) Act 1993
- It isn't an offence to decline to notify the Insurer and the Trustee of your TFN
- If you don't notify the Insurer and the Trustee of your TFN, they may not be able to (now or in the future) locate, amalgamate and identify your benefits in order to pay you
- The Insurer and the Trustee are allowed to use your TFN for lawful purposes, in particular if paying out monies, identifying and amalgamating super benefits for surcharge purposes and for other approved purposes, 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.

Are you applying for?

☐ **Acenda Insurance (Wrap or 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 the forms you need to complete if you wish to make a nomination of the proceeds from your super fund.
- Please go to **Section 7**.

☐ **Acenda Insurance**

Please note: This includes Acenda Insurance through an eligible wrap platforms investment account (not owned by an SMSF).

- 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 Acenda Insurance.
- Please go to **Section 7**.

☐ **Acenda Insurance (Super)**

- Please complete **Section 6B**.

☐ **Both Acenda Insurance and Acenda Insurance (Super)**

- Please complete **Section 6A** if you wish to make a beneficiary nomination for your Acenda Insurance policy. If you do not wish to make a beneficiary nomination, the death benefit will be paid to the Policy Owner(s) for Acenda Insurance.
- Please complete **Section 6B** to make a nomination for your Acenda Insurance (Super) policy.

6A Nomination of a Beneficiary – for Acenda Insurance – must be nominated by the Policy Owner

Note: For Acenda Insurance, nominations cannot be made by trustees of a trust or a self-managed super fund.

Beneficiary nomination for Acenda Insurance

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(s) 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 to be 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 to be 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 more than one Acenda Insurance policy and you wish to nominate a beneficiary(s) for those policies, please attach a photocopy of the above table specifying details of the beneficiary(s) you wish to nominate.

6B Nomination of Beneficiary Form – for Acenda Insurance (Super) – must be nominated by the Life to be Insured

Non-binding death benefit nomination for Acenda Insurance (Super)

☐ Tick this box and complete the table below if you wish to indicate to the Trustee your preferred beneficiary(s) 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). It is important that you read the beneficiaries section of the Super PDS about making nominations before completing this section.

Non-lapsing binding death benefit nomination for Acenda Insurance (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(s) 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). It is important that you read the beneficiaries section of the Super PDS about making nominations before completing this section. Your signature is required and must be witnessed by two adult persons.

Complete this table for all beneficiary nominations for Acenda Insurance (Super)

Please nominate your beneficiary(s) 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 to be Insured). If seeking a Non-lapsing binding death benefit nomination, your nomination must also be witnessed, signed and dated by witnesses (page 20).

	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 Life to be Insured)			%
	* The sum of your nominations must equal 100%. You can nominate a percentage up to two decimal places.			**Total: 100%**

1 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 Acenda Insurance (Super)).

I request that the Trustee accept my beneficiary nomination for my Acenda Insurance (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 to be Insured

X Date (DD/MM/YY)

Witness declaration

Only required when making a Non-lapsing binding death benefit nomination for Acenda Insurance (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 to be Insured and I am not one of the beneficiaries named above; and
- This form was signed and dated by the Life to be Insured in my presence.

Witness one

First name

Last name

Signature of witness

X Date (DD/MM/YY)

Witness two

First name

Last name

Signature of witness

X Date (DD/MM/YY)

Section 7: Eligibility

Please check with your adviser to confirm you have an eligible product. If you do please complete the checklist below to see if you can apply using this form:

Note: you can't replace your cover if you:

- are outside maximum entry ages as listed in the Insurance PDS
- are on claim or eligible to make a claim
- have previously made a claim.

For eligible Acenda products only

For all insurances

Question	Yes	No	N/A
Are you applying for an increase in the sum insured of any existing benefits?			
Are you applying for any additional options or new benefits?			
Are you applying to change the policy structure from: • Extension/Connection to stand alone? and/or For Personal Protection Portfolio policies only • Critical Illness Standard to Critical Illness Plus?			

Section 7: Eligibility (continued)

If you're applying ONLY for Total and Permanent Disability (TPD) Insurance

Question	Yes	No	N/A
Are you applying to change from: • Any Occupation TPD to: – Own Occupation TPD, or – TPD Optimiser and/or For Personal Protection Portfolio policies only • TPD as a Critical Illness condition to TPD extension to Life Cover			
Is your current occupation different to your occupation when you took out the insurance being replaced?			

If you're applying ONLY for Income Protection

Question	Yes	No	N/A
Are you applying for: • a shorter waiting period, or • a longer benefit period			
Personal Protection Portfolio policies only Is the cover being replaced: • Income Protection Standard, or • Income Protection Plus (Farmers package)? and • Is the new cover being applied for *Income Assure*+?			
Is Booster Option to be added as part of this application?			
Is your current occupation different to your occupation when you took out the insurance being replaced?			

- **If you answered Yes to any of the questions above, the Life to be Insured must complete a new Acenda Insurance and Acenda Insurance (Super) application.**
- **If you answer either No or N/A to ALL the questions above, you may continue to complete this application form.**

Section 8: Options in underwriting your case

Fast tracking follow-up information

This facility enables faster collection of information over the phone, resulting in faster completion of your application.

I permit the Insurer to call me (the Life to be Insured) to clarify or gain further information regarding any matter relating to the assessment and processing of this application. I understand that the call may be recorded and will form part of my application and that the Duty to take reasonable care applies.

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

No ☐

Section 9: Personal Statement

1. Height and Weight details

Please do not guess.
Weigh yourself if you have not done so in the last week.

What is your height?

cm **or** feet/inches

What is your weight?

kg **or** pounds

2. In the last **12 months**, have you been a

Please select all that apply:

☐ Regular smoker (smoke each day)	Go to **2a**
☐ Occasional smoker (smoke each week/ month / year)	Go to **2a & 2b**
☐ Social smoker (smoke with friends / family / colleagues)	Go to **2a & 2b**
☐ User of e-cigarettes or vaping	Go to **2c**
☐ User of nicotine-replacement products like patches, gum, etc.	Go to **2c**
☐ Non-smoker (you have not smoked at all in the last 12 months)	Go to **3**

2a. 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 once a month

2b. 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

2c. How often do you use nicotine replacement products e.g. 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

3. Think back to when you applied for the insurance you are replacing or the last time you applied to increase or change your insurance (ie increase sum insured/monthly benefit, decrease waiting period, extend benefit period, review of loading), when you were required to tell Acenda about your occupation history.

Since that date, has there been any change to your:

a) Job

b) Duties performed

No ☐
Yes ☐ Please complete details below and on the next page

Please provide current job

Full list of duties

Section 9: Personal Statement (continued)

3. Question 3 continued.

Percentage of work performed

Type of work	Percentage of time
Sedentary/Administration: Sedentary – 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 than10kg, the operation of heavy machinery, driving a commercial vehicle.	
Total	**100%**

3a. 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 ☐ Provide details in the table below

No ☐

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

The following question is about your earnings. 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.

Are you applying to transfer Income Protection? Yes ☐ complete question 4 No ☐ go to question 6

4. 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

Section 9: Personal Statement (continued)

5. 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? $

g Has this income been included in the income shown in Question 4 of this application? ☐ Yes ☐ No

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.

6. 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 **Q7**. If you selected any other response, please complete a **Mental Health Questionnaire**.

Section 9: Personal Statement (continued)

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**.

7. Think back to when you applied for the insurance you are replacing or last time you applied to increase or change your insurance (increase sum insured/monthly benefit, decrease waiting period, extend benefit period, review of loading), when you were required to tell Acenda about your medical history .

Since that date, have you:

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

Condition	Yes/No	Further information you need to provide
a ☐ High blood pressure (hypertension) or high cholesterol	Yes ☐ No ☐	If Yes, please complete the High Blood Pressure and/or High Cholesterol Questionnaire
b **Cardiovascular or heart conditions** such as ☐ Chest pain, angina, heart attack, 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 ☐ No ☐	If Yes, please provide more detail in the table below
c **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 ☐ No ☐	If Yes, please provide more information in the table below
d **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 ☐ No ☐	If Yes, please provide more information in the table below
e ☐ 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 **Note:** Only applicable for Total and Permanent Disability (TPD) and/or Income Protection insurance	Yes ☐ No ☐	If Yes, please complete the Back Questionnaire
f ☐ 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 **Note:** Only applicable for Total and Permanent Disability (TPD) and/or Income Protection insurance	Yes ☐ No ☐	If Yes, please complete the Joint/Musculoskeletal Questionnaire

Condition	Date of first consultation (DD/MM/YYYY)	Date of last symptoms (DD/MM/YYYY)	Treatment and test results	Degree of recovery	Time off work

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

Section 10: Application for Child Critical Illness insurance

(Only complete if you are applying for the Child Critical Illness insurance at an additional cost)

Child 1

If you need to complete this application for more than one child please copy this page and attach the copy with this application. (Please note: The maximum number of children that may be insured is five.)

Name of Child to be Insured

Child's date of birth (DD/MM/YYYY)

Sex of child ☐ Male ☐ Female

What is your relationship to the child?

1. Is there any other insurance in place or being applied for in respect of this child?

☐ Yes
☐ No ▶ Please go to question 3

2. Will the total amount of Child Critical Illness insurance for all children, with all insurers, including this application, be more than $200,000?

☐ Yes ▶ Please provide total $
☐ No

3. Has the child ever had any of the following:

☐ Yes
☐ No

- ☐ Any heart condition, rheumatic fever, stroke?
- ☐ Blood disorder, haemophilia, leukaemia or cancer or tumour of any kind?
- ☐ Epilepsy, neurological disorder or any mental condition or developmental disorder?
- ☐ Diabetes, hepatitis or any disorder of the kidney, liver, bladder or bowel?
- ☐ Hearing impairment, sight impairment (not corrected with prescription lenses)?

4. Has your child had any other illness, injury or medical disorder requiring surgery, hospitalisation or ongoing treatment or is your child currently undergoing any tests or investigations?

Do not include childhood illnesses such as chicken pox, measles, mumps, tonsillitis or tonsillectomy, appendicitis or appendectomy, unless the child has not made a complete recovery.

☐ Yes ▶ Please provide details in the table below
☐ No

Condition	Date started	Date of last symptoms	Type of treatment and any test results	Degree of recovery

5. Have any of the child's immediate blood relatives (parents, brothers or sisters) had any of the following:

☐ Yes ▶ Please provide details in the table below
☐ No

- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer
- ☐ Haemophilia
- ☐ Polycystic kidney disease
- ☐ Huntington's disease
- ☐ Any other hereditary disorder

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

Section 11: Authority to Release Medical Information (to be completed in ALL cases)

Notes on releasing information about your health

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

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

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

Please read each Authority carefully and the explanatory notes below.

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

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

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

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

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

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

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

X

Date (DD/MM/YY)

Section 11: Authority to Release Medical Information (to be completed in ALL cases)

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

X

Date (DD/MM/YY)

Section 12: Declaration and authorisations

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

The Life to be 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 insurance 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 this 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. I understand no insurance 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.

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 to be Insured

✗	Date (DD/MM/YY)

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

Acenda Insurance only: Signature(s) of Policy Owner(s) if different from the Life to be Insured

Do not complete this section if you are applying for Acenda Insurance through an eligible wrap platforms super account, unless you are the trustee of your SMSF.

- If the trustee(s) of a self-managed super fund are individuals then all individuals are required to sign.
- If the Life to be Insured is under 16 years of age a Parent or Guardian is 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 of Policy Owner(s)

X Date (DD/MM/YY)

X Date (DD/MM/YY)

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

Policy 2 - Signature of Policy Owner(s)

X Date (DD/MM/YY)

X Date (DD/MM/YY)

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

Policy 3 - Signature of Policy Owner(s)

X Date (DD/MM/YY)

X Date (DD/MM/YY)

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

Declaration – Acenda Insurance (Super) Only

In addition to the previous declaration, please complete this declaration if you are also applying for Acenda Insurance (Super).

a) I have read and understood the Super PDS 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 Acenda Insurance (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 to be Insured

X Date (DD/MM/YY)

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 Acenda Insurance (Super), you are also consenting to receiving information about the products and services as described in the Trustee's Privacy Policy (**acenda.com.au/privacy**).We will not disclose health information for marketing purposes.

Do we have your consent? Yes ☐ No ☐

If you do not mark a box your consent will be presumed.

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

Section 14: 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. 460592).

This Service Agreement and the Direct Debit Request Schedule in your application contain the terms and conditions by which you authorise us 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 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
- 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 7 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
- suspend future drawings.

This section for Financial Adviser use only

This section must be completed by the Financial Adviser

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

Acenda Adviser code

Mobile phone

Telephone number

Fax number

Email

Distribution fee split

%

Financial Adviser 2

Name of Financial Adviser

Acenda Adviser code

Mobile phone

Telephone number

Fax 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.

Target Market Determination

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

Yes ☐ No ☐

Please enter the reason you recommended this product to a client who does not meet the product's Target Market Determination

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

Personal ☐ General ☐

Send us your form

Please return your completed, signed and dated form to:

Acenda - Operations
PO Box 23455
Docklands VIC 3008

Email: enquiries.retail@acenda.com.au

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