AMP Elevate

# Short form application for combined life, trauma and TPD cover up to $1 million

## Information sheet

This form is to be used for AMP Elevate life, trauma and/or total and permanent disability (TPD) insurance with combined sums insured up to $1,000,000 (ie, the total AMP Life insurance sum insured being applied for across all life, trauma and TPD insurance is $1,000,000 or less).

## Your duty of disclosure

Read this if you are applying for insurance as the policy owner, or if you will be an insured person under a policy owned by someone else.

### What you need to tell us

When you apply for insurance, and up until the insurer accepts your application, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect the insurer's decision to insure you and the terms of your insurance.

This includes answering all the questions in the application honestly, making sure you include all the information we ask for.

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same duty at that time to tell us anything that may affect the insurer's decision to insure you and the terms of your insurance.

Where a policy owned by one person covers the life of another person, it's important that the other person also gives us all the information that is required under the duty. If he or she doesn't, then it can be treated as a failure by the owner of the policy to tell us something that the owner must tell us. Therefore, you must give us all the required information—whether you're the owner of the policy or a person insured under it.

### If you don't tell us something

If you don't give all the required information, and the missing information would've affected the insurer's decision to insure you or the terms of your insurance, the insurer may:

- **treat the contract (or your cover) as if it never existed** – the insurer can only do this within three years of your cover starting.
- **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would've had to pay if you'd told us everything you should've. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.
- **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't give us all the required information, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

It's fraudulent to deliberately leave out required information or give us incorrect information. In these situations the insurer may refuse to pay a claim and treat the contract (or your cover) as if it never existed.

### What you don't need to tell us

You don't need to tell us anything:

- that reduces the insurer's risk, or
- that's common knowledge, or
- the insurer knows or should know as an insurer, or
- we've told you that you don't need to tell us.

**Genetic test approach**

You only need to tell us about any genetic testing you've had or intend having if the total combined sum insured with all life insurers for the benefit(s) being applied for is over the Genetic Test Standard financial limits. You can choose to tell us about a genetic test that you have had where the result was favourable.

However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

**Note:** AMP Life complies with the Genetic Test Standard, a copy of the standard can be found at **fsc.org.au/resources/standards**.

If we allow you to replace an existing contract of insurance[1] held with AMP Life with the same type of cover for the same or lower amount of insurance, and you were previously underwritten by us, then you will not be required to disclose any further information relating to any matter that occurred after the commencement of the existing contract. In entering into the replacement contract of insurance, we will rely on the information that you previously provided in relation to the existing contract of insurance. For that reason, the insurer's rights in relation to a breach of your duty of disclosure (or misrepresentation made) in relation to the existing contract will be applied to the replacement contract.

1 All Life Insurance (including Life Insurance Superannuation and Life Insurance SMSF), Trauma Insurance and TPD Insurance.

Please keep this information sheet for your records—don't return it with your completed form(s).

Resolution Life

This document is issued by Equity Trustees Superannuation Limited (ETSL) ABN 50 055 641 757, AFSL No. 229757 as trustee of the National Mutual Retirement Fund (NMRF) ABN 76 746 741 299 and AMP Life Limited ABN 84 079 300 379 (AMP Life). AMP Life has proudly served customers in Australia since 1849. AMP Limited ABN 49 079 354 519 has sold AMP Life to the Resolution Life Group whilst retaining a minority economic interest. AMP Limited has no day-to-day involvement in the management of AMP Life whose products and services are not affiliated with or guaranteed by AMP Limited. 'AMP', 'AMP Life' and any other AMP trademarks are used by AMP Life under licence from AMP Limited.

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AMP Elevate

# Application for combined life, trauma and TPD cover up to $1 million

Use this form to apply for AMP Elevate life, trauma and/or total and permanent disability (TPD) insurance with combined sums insured up to $1,000,000 (ie, the total AMP Life insurance sum insured being applied for across all life, trauma and TPD insurance is $1,000,000 or less).

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

## Plan details

Plan owner type (cross one) ☐ Individual ☐ Business application ☐ SMSF (**Note:** Cover owned by an SMSF can only be held under a Life Insurance SMSF Plan.)

Are you applying for insurance through? ☐ North ☐ Summit ☐ Generations ☐ iAccess

– For superannuation plans

If applying through North, Summit, Generations or iAccess Super or Pension please provide your existing account number:

**If you nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan, all superannuation plans quoted will be owned by N.M. Superannuation Proprietary Limited as trustee of the Wealth Personal Superannuation and Pension Fund, and paid from your Superannuation/Pension account. The person insured must be the member of the nominated account.**

**If you do not nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan then all superannuation plans will be owned by Equity Trustees Superannuation Limited as trustee of the National Mutual Retirement Fund.**

– For non-superannuation or SMSF plans

If applying through North, Summit, Generations or iAccess Investment please provide your existing account number:

**If you nominate a North, Summit, Generations or iAccess Investment account, all non-superannuation or SMSF plans quoted will be paid from your investment account. To nominate an investment account, you must be authorised to transact on that account.**

Application type (cross one)

☐ Workplace Rewards and/or Family ☐ RACV Rewards

| Title | Workplace Rewards name/ Family name/RACV cardholder name | Workplace Rewards number/ Family number/RACV card number |
|---|---|---|
| | | |

For RACV, please provide 16-digit card number

☐ Business rewards

ABN (for employer/key person/business partner/trustee)

☐ Campaign ☐ New plan ☐ Increase sum insured

☐ Conversion/replace existing plan (please refer to the Important notes under Insurance details on page 3 for information regarding cancelling cover that is being converted/replaced).

OR

☐ Continuation option – existing plan number

☐ Add cover ☐ Re-submitted application ☐ Other (provide details in adviser notes)

Is this plan fee to be waived? ☐ No ☐ Yes—to which plan number?

Full name of plan owner of linked plan

Is there a concurrent application form being submitted? ☐ No ☐ Yes

If yes, to which application? ☐ Business partner(s) ☐ Spouse ☐ Children's Trauma

☐ Another AMP Life product (eg Summit, Generations)

☐ Another AMP Life application on the person to be insured

Please provide details below:

| Name of insured on concurrent application | Date of birth | Plan number/Product name |
|---|---|---|
| | / / | |
| | / / | |
| | / / | |

Are you related (mother, father, sister, brother, child or spouse), in a de facto or same sex relationship or in a business relationship with the financial adviser of this plan? ☐ No ☐ Yes

If yes, page 21 outlines how this will impact commission.

## Person to be insured

Title | Family name | Given name(s) | Previous name(s) (if applicable)

Gender ☐ Male ☐ Female | Marital status | Date of birth D D M M Y Y Y Y | Country of birth

Occupational duties (if home duties, please provide details of dependants including ages)

Hours worked in main occupation | Insurable income in last 12 months $ | Insurable income in previous 12 months $ (income after expenses but before tax)

Please give details of your specific qualifications (eg degree, trade certificate)

**Residential address**

Address

Suburb | State | Postcode | Country

Home phone number | Business phone number | Mobile phone number

Email address

**Correspondence address**

Address | Suburb | State | Postcode | Country

Do you smoke or have you ever been a smoker (including e-cigarettes and nicotine replacement products)? ☐ No ☐ Yes

Daily average | If you have stopped, when? month year

What did/do you smoke? ☐ Cigarettes ☐ Tobacco Pipes ☐ Cigars ☐ Nicotine replacement products ☐ Other, please specify

## Plan owner(s)

! Only complete this section if plan owner is a company, trustee of an SMSF or an individual other than the person to be insured.

| Title | Family/Company/SMSF | Given name(s)/ Trustee name(s)[1] | Date of birth | Plan/PremierLink name |
|---|---|---|---|---|
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |

Only provide company details and an Australian business number (ABN) if the plan owner is to be a company or a trustee: Company ABN

## Product details

AMP Elevate Desktop Insurance quote (to be submitted with the application form) from the Premium Quoting Tool must be attached to this short form application. If only the client quote has been provided, we may use the default commission structure of hybrid, unless the application is a replacement of cover.

1 The names of all trustees should be listed.

## Personal statement

**Important:** You have a duty to disclose all information relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect information may affect your entitlement to benefits. Please see the information sheet for details of your duty of disclosure.

## Contact details for the person to be insured

We may need to contact you between 8.00am to 7.00pm regarding the details of your application.

| | Hours you can be contacted | | Hours you can be contacted | | Hours you can be contacted |
|---|---|---|---|---|---|
| ☐ Home phone | | ☐ Business phone | | ☐ Mobile phone | |

## Residence and travel details

**1.** Are you an Australian or New Zealand citizen or a permanent resident of Australia? ☐ No ☐ Yes
If no, please provide details including the type of visa you hold:

**2.** Including annual holidays, are you likely to live, travel or work overseas? ☐ No ☐ Yes—detail where and duration:

## Insurance details

**3.** Other than this application, are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company** including this one? **Note:** This includes benefits under superannuation, business or credit insurance or benefits provided by an employer. If yes, please provide details. ☐ No ☐ Yes

| Name of company | Type of cover | Sum insured ($) | Date commenced | To be replaced? |
|---|---|---|---|---|
| | | | / / | ☐ No ☐ Yes |
| | | | / / | ☐ No ☐ Yes |
| | | | / / | ☐ No ☐ Yes |

**Important notes:** If this application for insurance is intended to replace the existing plan(s) listed in the table above:

1. When the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim you make to AMP Life for the insurance applied for and accepted may not be considered.
2. Under takeover terms, the insurance cover to be replaced must have been fully underwritten and not have been accepted under modified or limited underwriting requirements or on takeover terms previously.

**4.** Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way? ☐ No ☐ Yes—please provide full details including reason, date, company name and type of cover:

**5.** Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings? ☐ No ☐ Yes—please provide details:

| Company/benefit type | Reason | Benefit amount ($) | Date |
|---|---|---|---|
| | | | / / |
| | | | / / |

## Health details

**6.** How many standard drinks containing alcohol do you consume per week on average? [standard drink = 1 nip spirits (30ml), 100ml wine, 10oz/250ml beer] ______ standard glasses per week

**7.** Have you ever used cocaine, marijuana, ecstasy, heroin or any other recreational drugs, or drugs not prescribed by a doctor? (You do not need to tell us about any paracetamol, anti-histamines or any other over-the-counter medication) ☐ No ☐ Yes
If yes, please give details:

**8.** What is your: Height ______ Weight ______

**Health details** continued

**9.** At any time in your life have you **ever** suffered from, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

a. Arthritis, bone fracture, joint injury, eg **hip, ankle, knee, elbow, wrist, shoulder**, or experienced symptoms of experienced symptoms of muscle or joint disorder, gout, tendonitis or tenosynovitis ☐ No ☐ Yes

b. Heart condition, rheumatic fever, chest pain, **high blood pressure, raised cholesterol**, vein or circulatory disorder ☐ No ☐ Yes

c. Cancer, tumour of any kind, **cyst**, growth, breast lump, **mole** or **skin lesion** ☐ No ☐ Yes

d. Anaemia, leukaemia, haemophilia or any other blood disorder ☐ No ☐ Yes

e. **Asthma**, bronchitis, lung condition, breathing or respiratory disorder, sleep apnoea ☐ No ☐ Yes

f. Disorder of the kidney, bladder, urinary complaint or kidney stone ☐ No ☐ Yes

g. **Back** or **neck disorder, spinal condition, sciatica** or **whiplash** ☐ No ☐ Yes

h. **Depression, adjustment disorder, post-traumatic stress disorder, post natal depression, major depression major depression** or any other **mood or depressive disorder** ☐ No ☐ Yes

i. **Panic attacks, anxiety, attention deficit disorder, eating disorder, obsessive compulsive disorder** or any other **anxiety disorder** ☐ No ☐ Yes

j. **Schizophrenia, psychotic or personality disorder, manic or bipolar disorder** or any other **mental health disorder** ☐ No ☐ Yes

k. **Stress, fatigue, insomnia** or **sleeplessness** ☐ No ☐ Yes

l. **Chronic fatigue**, fibromyalgia, fibrositis, myalgia or **chronic pain syndrome** ☐ No ☐ Yes

m. Diabetes, sugar in the urine or raised blood sugar levels or thyroid disorder ☐ No ☐ Yes

n. Indigestion, gastric or duodenal ulcer or hernia ☐ No ☐ Yes

o. Bowel disorder, irritable bowel syndrome, colitis or Crohn's disease ☐ No ☐ Yes

p. Gall bladder or liver disorder, haemochromatosis, hepatitis (please advise type eg A, B, C or other ______ ) ☐ No ☐ Yes

q. **Epilepsy**, stroke, headaches, migraines, disorder of the brain or nervous system, dizziness, fainting or memory loss ☐ No ☐ Yes

r. Disorder of the ears, eyes or speech including hearing loss or tinnitus ☐ No ☐ Yes

s. Psoriasis, eczema, dermatitis or other skin condition ☐ No ☐ Yes

t. Any sexually transmitted infection or disease ☐ No ☐ Yes

u. Any other illness, injury, operation, disability or hospitalisation not already mentioned ☐ No ☐ Yes

**Males only**

v. Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or undescended testicle? ☐ No ☐ Yes

**Females only**

w. Are you currently pregnant? If yes, please advise expected date of delivery D D M M Y Y Y Y ☐ No ☐ Yes

x. Have you ever had any complications with pregnancy or childbirth? ☐ No ☐ Yes

y. Have you ever had an **abnormal cervical screening or pap smear test**, **positive HPV test** or biopsy of the cervix or uterus, breast ultrasound or mammogram? ☐ No ☐ Yes

**10. In addition** to the conditions you have already mentioned in this application, have you in the last five years (not including colds or flu):

a. Had any blood test, counselling of any kind, review of a previously diagnosed condition or any diagnostic test of any nature eg X-ray, medical test? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. ☐ No ☐ Yes

b. Used or are you currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition? ☐ No ☐ Yes

! If you answered '**YES**' to any of 9 or 10 above, please provide details in the table below, **EXCEPT** for any conditions in bold text for which you should complete the relevant health questionnaire that your adviser can obtain from **amplife.com.au/planners** under forms.

| Item no. eg 'b' | Date | Details of condition, advice or symptom including nature of treatment | Name and address of doctor, hospital or health professional consulted | Date treatment or medication ceased (if applicable) | Time off work | Degree of recovery (%) |
|---|---|---|---|---|---|---|
| | / / | | | / / | | |
| | | | | | | |
| | | | | | | |
| | / / | | | / / | | |
| | | | | | | |
| | | | | | | |

## Doctor details

**11.** Please provide the details of the general practitioner/medical centre you would normally consult for medical conditions or advice, including the details of your last consultation.

Name of general practitioner/medical centre

Correspondence address | Suburb | State | Postcode

Phone number | Fax | How long have you been his/her patient? years

Please provide the date of your last consultation, the reason and the result.

**12.** Are you contemplating, awaiting or being advised to seek any medical advice, investigation or treatment including surgery?

☐ No ☐ Yes—please provide details:

## Family history details

**13.** Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted—go to next question.

☐ Yes—please cross all that apply and provide the details further below:

- ☐ Breast and/or ovarian cancer
- ☐ Lynch syndrome, familial polyposis or bowel/colon cancer
- ☐ Diabetes
- ☐ Heart attack
- ☐ Haemochromatosis
- ☐ Multiple sclerosis
- ☐ Motor neurone disease
- ☐ Alzheimer's disease or any other type of dementia
- ☐ Any hereditary disorder or condition that runs in families
- ☐ Prostate cancer
- ☐ Polycystic kidney disease, renal cell cancer or kidney cancer
- ☐ Stroke
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Any other cancer or any other heart condition

Provide details for each box you've crossed:

| Family member (eg mother, brother) | Condition | If cancer, type/site | Age at diagnosis | Age at death (if applicable) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**14.** a. Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection?

☐ No ☐ Yes For example, some signs are: unexplained weight loss, swollen glands or persistent diarrhoea.

b. In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?

☐ No ☐ Yes **Note:** HIV risk situations include but are not limited to, sex with or as a sex worker, sex with an intravenous drug user, contact with someone else's blood (for example, through injection or scratch with a used needle), anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least three years).

(If you answered '**Yes**' to any part of question 14 we will send you a confidential questionnaire to complete).

## Sports and pastimes details

**15.** Have you in the last 12 months, do you currently, or do you intend to take part in aviation (other than a fare paying passenger on a licensed public service), motor racing (including car, bike and boat), underwater diving, football, motor bike riding (including trail bike riding, quad bike riding and commuting), any other hazardous activity, pursuit or sport (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports)? ☐ No ☐ Yes

If yes, please complete the pursuits questionnaire that your adviser can obtain from **amplife.com.au/amp/advisers** under forms.

## Employment details

**16.** In the last five years have you worked in a different occupation or job, had any period unemployed, travelling, studying etc or do you have any other jobs or occupations? ☐ No ☐ Yes—please provide details:

| | From | To | Occupation | Employer |
|---|---|---|---|---|
| Previous occupation | / / | / / | | |
| | | **Cross which is applicable** | ☐ Employed by own company ☐ Partnership ☐ Employee | ☐ Self-employed ☐ Contractor |
| Other occupation | / / | / / | | |
| | | | ☐ Employed by own company ☐ Partnership ☐ Employee | ☐ Self-employed ☐ Contractor |

Other occupation specific duties and details

**17.** a. Have you or any business with which you have been associated ever been made bankrupt, entered into a personal insolvency arrangement or placed in receivership, involuntary liquidation or under administration?

☐ No ☐ Yes—please provide details: When D D M M Y Y Y Y Date of discharge D D M M Y Y Y Y

b. If you are self-employed, an employee of your own company or in a partnership, has your business had a net operating loss over either of the last two financial years?

☐ No ☐ Yes—please provide full copies of company accounts for the last two years, including associated entities.

☐ Not self-employed

Resolution Life

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## Medical authority

Before you complete this page please read the privacy disclosure statement in the product disclosure statement.

### Authority for AMP Life to release medical information to usual doctor

Only complete this section if you authorise AMP Life to release medical information to your doctor upon an adverse assessment of your application.

Print full name of person to be insured

I, ______________________ authorise AMP Life to advise Doctor ______________________ of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise AMP Life to provide copies of the relevant health evidence to the doctor noted above.

Signature of person to be insured

✗

Date signed

D D M M Y Y Y Y

Resolution Life

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AMP Life
Part of the Resolution Life Group

To be completed if you are applying for a non-superannuation or SMSF insurance plan not paid from a North, Summit Generations or iAccess account. ☐

Where a FlexiLink plan and/or PremierLink option is applied for and linked to North, Summit, Generations or iAccess, the payment authorities below must be completed.

# Non-superannuation or SMSF application

## Non-superannuation or SMSF payment authorities

**Before you complete this page**, please read the 'Paying your premiums' section in the general terms and conditions in the product disclosure statement.

### Payment method

Select method of payment:

☐ Direct debit by credit card (please list insurance plans paid by credit card below and complete **option 1**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Direct debit by bank account (please list insurance plans paid through bank account below and complete **option 2** on the next page)

| | | |
|---|---|---|
| | | |
| | | |

☐ Receive payment due notices (only available for quarterly, half-yearly and yearly payments)

### Option 1: Direct debit by credit card

Only complete this section to pay your insurance premiums by credit card.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by credit card, you may choose a date for deduction, between 1st to 28th only

Credit card type: ☐ MasterCard ☐ Visa

Credit card number

Expiry date

Name as shown on credit card

Cardholder's signature

✗

Date signed

D D M M Y Y Y Y

**Should your credit card details change at any time (eg card number or expiry date) then we will be unable to process your payment.**

**You will need to complete a new direct debit authority form or provide the new credit card details over the phone. To do this, please contact our Customer Service Centre.**

## Option 2: Direct debit by bank account

Only complete this section to pay your insurance premiums by direct debit.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by bank account, you may choose a date for deduction, between 1st to 28th only

**Note**: Please refer to your financial institution to check your account offers direct debiting.

BSB number

Account number

Bank/financial institution name

Bank/financial institution branch name

Account in name of (name in full)

If company account Australian business number (ABN)

### Account holder signature(s)

Signature—account holder 1

✗

Date signed

D D M M Y Y Y Y

Signature—account holder 2 (if applicable)

✗

Date signed

D D M M Y Y Y Y

To be completed if you are applying for a Life Insurance Plan, including plans where the insurance will be paid from a North, Summit, Generations or iAccess investment account. ☐

Do not complete if you are applying for the Life Insurance SMSF plan as any claim will be paid to the Trustee of the SMSF or Small APRA Super Fund.

## Non-superannuation application – Nomination of beneficiaries

### Nominate beneficiaries

You can choose who and how your death benefit is paid in the event of the death of the person to be insured.

Do you wish to make a nomination? ☐ No ☐ Yes—please nominate the beneficiaries to receive the payment of benefits below.

**1.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**2.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**3.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**4.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**5.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**Total percentage** **100%**

1 Percentages must be whole numbers.

### Plan owner declaration

I/We Plan owner family name ______ Given name(s) ______,

the plan owner(s), nominate the person(s) named above to receive any proceeds that may become payable under this plan, as a result of the death of the person to be insured. I understand that:

- payment of benefits will be made on the basis of the latest nomination received in writing by AMP Life
- if there is no nomination, or the nomination has been revoked, benefits will be paid to the plan owner (or their estate)
- nominated beneficiaries should seek advice from their taxation adviser regarding the potential taxation implication of any benefit received
- if a nominated beneficiary predeceases the person insured, then that nominated beneficiary's benefit will be paid to the plan owner (or their estate)
- the plan owner may vary the nomination at any time by completing a Nomination of beneficiary form and forwarding it to AMP Life.

Signature of plan owner ✗

Date signed D D M M Y Y Y Y

## Non-superannuation or SMSF insurance application and signatures

**To be completed if you are applying for a non-superannuation or SMSF plan including plans where the insurance will be paid from a North, Summit, Generations or iAccess investment account and also where a FlexiLink plan and/or PremierLink TPD option is applied for.**

**Before you sign this application form, you should:**

- be aware that your financial adviser is obliged to have provided you with the product disclosure statement(s) and other information relevant to special offers and/or member discounts for the product(s) you are applying for
- **read the product disclosure statement** because it contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- **read the Your duty of disclosure** and the **Declarations and consent sections** (including the 'Privacy – use and disclosure of personal information') in the product disclosure statement and understand the terms outlined.

**If you have applied for a Life Insurance SMSF Plan**

Are the premiums being paid by your employer? ☐ No ☐ Yes

If yes, has your employer agreed to pay for premium increases due to indexation? ☐ No ☐ Yes

### Signature of person to be insured

**If the person to be insured is the same person as the plan owner, go to 'Signature of plan owner(s) – only for individuals'.**

Print full name of person to be insured

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

### Signature of plan owner(s) – only for individuals (including individual trustees of an SMSF)

Print full name of SMSF or Trust (if applicable)

**For plan owner(s) (must be aged 16 years or over)**

Print full name of plan owner/Trustee

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

Plan owner/Trustee (delete one)

Print full name of plan owner/Trustee

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

Plan owner/Trustee (delete one)

- For SMSFs, if there are more than two trustees required as signatories, please provide their full name(s) and signature(s) at the bottom of this page.

**Signatures of plan owners – only for companies** (including company trustees of an SMSF)

Company seal

Print full name of company

Signature 1

✗

Director/Sole Director
and Secretary (delete one)

Signature 2

✗

Director/Secretary
(delete one)

Date signed

/ /

Print full name(s) of person signing for and on behalf of the above company

To be signed by:

- For any company, either two directors of the company or a director and company secretary, or
- For a proprietary company, one signature as 'sole director and secretary' where the company has only one director who is also the sole company secretary.

**Note:** If the company constitution mandates the use of a company seal then it must be provided along with the relevant signatures outlined above.

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To be completed if you are applying for a Life Insurance Superannuation Plan held through Super Directions. ☐

Where a FlexiLink plan and/or a PremierLink option is applied for, please also complete the Non-superannuation payment authorities.

# Superannuation application

## Superannuation payment authorities

**Before you complete this page**, please read the 'Paying your premiums' section in the general terms and conditions in the product disclosure statement.

### Payment method

Select method of payment:

☐ Direct debit by credit card (please list insurance plans paid by credit card below and complete **option 1**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Direct debit by bank account (please list insurance plans paid by bank account below and complete **option 2** on the next page)

| | | |
|---|---|---|
| | | |
| | | |

☐ Receive payment due notices (only available for quarterly, half-yearly and yearly payments)

☐ Partial rollover from a complying super fund (please complete and return the **Enduring rollover authority** form – eligibility criteria applies)

### Option 1: Direct debit by credit card

Only complete this section to pay your insurance premiums by credit card.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by credit card, you may choose a date for deduction, between 1st to 28th only

Credit card type: ☐ MasterCard ☐ Visa

Credit card number | Expiry date | Name as shown on credit card

Cardholder's signature

✗

Date signed

D D M M Y Y Y Y

**Should your credit card details change at any time (eg card number or expiry date) then we will be unable to process your payment. You will need to complete a new direct debit authority form. To do this, please contact our Customer Service Centre on 133 731.**

To be completed if you are applying for a Life Insurance Superannuation Plan held through Super Directions. ☐

Where a FlexiLink plan and/or a PremierLink option is applied for, please also complete the Non-superannuation payment authorities.

## Superannuation payment authorities continued

### Option 2: Direct debit by bank account

! Only complete this section to pay your insurance premiums by direct debit.

**Note**: Please refer to your financial institution to check your account offers direct debiting.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by bank account, you may choose a date for deduction, between 1st to 28th only

BSB number

Account number

Bank/financial institution name

Bank/financial institution branch name

Account in name of (name in full)

If company account Australian business number (ABN)

**Account holder signature(s)**

Signature—account holder 1

✗

Date signed

D D M M Y Y Y Y

Signature—account holder 2 (if applicable)

✗

Date signed

D D M M Y Y Y Y

## Superannuation application – Nomination of beneficiaries

**To be completed if you are applying for a Life Insurance Superannuation Plan held through Super Directions. If you are applying for nomination through North, Summit, Generations or iAccess, your nomination of dependants or any changes to your nomination of dependants for distribution of your death benefits requires the completion of the appropriate death benefit nomination form available under North, Summit, Generations or iAccess, as applicable. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.**

**1.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[2] ☐ Child | % of death benefit[1] %

**2.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[2] ☐ Child | % of death benefit[1] %

**3.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[2] ☐ Child | % of death benefit[1] %

**4.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[2] ☐ Child | % of death benefit[1] %

**5.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[2] ☐ Child | % of death benefit[1] %

**Total percentage** **100%**

or ☐ My Legal Personal Representative (eg the executor of your will)

1 Percentages must be whole numbers.

2 Interdependency Relationship.

## Superannuation application – Nomination of beneficiaries continued

☐ Binding death benefit nomination

I acknowledge that I have read the **Holding your policy in superannuation** section of the **product disclosure statement** concerning binding nominations and accept the conditions relating to binding nominations.

☐ Non-binding death benefit nomination

I acknowledge that I have read the **Holding your policy in superannuation** section of the product disclosure statement concerning non-binding nominations.

☐ No nomination

Print full name of member

Date of birth D D M M Y Y Y Y

Signature of member ✗

Date signed D D M M Y Y Y Y

**If you have crossed 'binding nomination', the section below must also be completed.**

### Witness signatures

I acknowledge that I am 18 or over, that I am not a nominee on this form and that the above notice was signed and dated by the applicant in my presence.

| **Witness 1**—full name | Signature | Date signed |
|---|---|---|
| | ✗ | D D M M Y Y Y Y |

| **Witness 2**—full name | Signature | Date signed |
|---|---|---|
| | ✗ | D D M M Y Y Y Y |

## Superannuation application

**To be completed by the person to be insured only if applying for the Life Insurance Superannuation Plan.**

### Superannuation membership

Are you applying for insurance through? ☐ North ☐ Summit ☐ Generations ☐ iAccess

If applying through North, Summit, Generations or iAccess Super or Pension please provide your existing account number:

**If you nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan, all superannuation plans quoted will be owned by N.M. Superannuation Proprietary Limited as trustee of the Wealth Personal Superannuation and Pension Fund, and paid from your Superannuation/Pension account. The person insured must be the member of the nominated account.**

**If you do not nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan then all superannuation plans will be owned by Equity Trustees Superannuation Limited as trustee of the National Mutual Retirement Fund (NMRF).**

Are you applying for insurance through superannuation that is not attached to North, Summit, Generations or iAccess?

☐ No ☐ Yes—this will be through the NMRF.

**1.** Current employment status

☐ Employee, go to question **2** ☐ Self employed (sole trader, partnership) ☐ Employed by own company, go to question **3**

**2.** Does your employer contribute to an existing super fund on your behalf? ☐ No ☐ Yes

**3.** Have you selected an employer supported plan (ie your employer pays part or all of your premiums)? ☐ No ☐ Yes

If yes, please complete employer details below and question **4**

Company name

Company address

**4.** Please confirm that your employer has agreed to pay for premium increases due to indexation. ☐ No ☐ Yes

**To be completed by the person to be insured**

Print full name of person to be insured

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

### Insurance in super election

To prevent your super balance from being reduced by the cost of insurance, under super laws, you now need to make an election to include additional insurance cover inside your super. To apply for insurance cover (including any additional insurance), please read the **important detail**s at **amplife.com.au/whyinsurance** and then complete the election below.

☐ I'd like the insurance cover (including any additional insurance) to be provided and kept within my super account, even if:

- I'm under 25,
- my balance is below $6,000, or
- my account doesn't receive a contribution or rollover for 16 months.

### Superannuation insurance application and signatures

**Before you sign this application form, you should:**

- be aware that your adviser is obliged to have provided you with the product disclosure statement(s) and other information relevant to special offers and/or member discounts for the product(s) you are applying for
- **read the product disclosure statement** because it contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- **read the Your duty of disclosure** and the **Declarations and consent sections** (including the 'Privacy – use and disclosure of personal information') in the product disclosure statement and understand the terms outlined.
- read and understood the important details provided at **amplife.com.au/whyinsurance**

Signature of person to be insured

✗

Date signed D D M M Y Y Y Y

## Superannuation application

### Employer details (for employer supported plans)

Employer name

Address | Suburb | State | Postcode | Country

## Tax file number (TFN)

**Only complete this section if you are applying for superannuation cover that is not being paid from a North, Summit, Generations or iAccess account.**

I have read the information (below) and agree to provide my TFN (cross one only) ☐ No ☐ Yes

TFN | Signature ✗ | Date signed D D M M Y Y Y Y

### TFN notification

Under the *Superannuation Industry (Supervision) Act 1993*, your superannuation fund is authorised to collect your TFN, which will only be used for lawful purposes.

These purposes may change in the future as a result of legislative change. The trustee of your superannuation fund may disclose your TFN to another superannuation provider, when your benefits are being transferred, unless you request the trustee of your superannuation fund in writing that your TFN not be disclosed to any other superannuation provider.

It is not an offence not to quote your TFN. However giving your TFN to your superannuation fund will have the following advantages (which may not otherwise apply):

- Your superannuation fund will be able to accept all types of contributions to your account(s).
- The tax on contributions to your superannuation account(s) will not increase.
- Other than the tax that may ordinarily apply, no additional tax will be deducted when you start drawing down your superannuation benefits.
- It will be easier to trace different superannuation accounts in your name so that you receive all your superannuation benefits when you retire.

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# Financial adviser and commission details

**(To be completed by advisers)**

## Underwriting and financial requirements

Have you spoken to our Underwriting Department for pre-assessment advice? ☐ No ☐ Yes

If yes, who did you speak to (or contact), what did you discuss and on what date did this occur? If you were provided with a request ID or service request ID number, please provide this number.

Have you arranged for any mandatory medical examinations or pathology tests to be completed? ☐ No ☐ Yes

If yes, please provide details:

## Adviser checklist

If changes have been made to the application, has the person to be insured initialled all changes? ☐ No ☐ Yes ☐ Not applicable

Is there any other documentation attached to this proposal? ☐ No ☐ Yes, please cross one: ☐ Health questionnaire ☐ Pursuits questionnaire

Are there multiple payment methods? Examples include FlexiLink or PremierLink TPD option, life super paid via Summit, Generations or North and trauma by direct debit or credit card, or life super paid by credit card.

☐ No ☐ Yes—please specify which benefits are to be paid by which payment method in the adviser notes below.

Has this application been faxed prior to sending? ☐ No ☐ Yes

## Duty of disclosure

Has a copy of the insurance quote report been included with this application? ☐ No ☐ Yes

Have the client and the person to be insured read the Your duty of disclosure section? ☐ No ☐ Yes

Have you explained to the client and the person to be insured the possible implications on the contract of any non-disclosure? ☐ No ☐ Yes

Are there any other circumstances or facts, such as the client's background, not fully covered by answers provided herein which you feel may assist our assessment of this application? ☐ No ☐ Yes—please provide details:

## Adviser notes

## Principal servicing adviser details

Account/Adviser name

Account/Adviser number

Business phone number

Mobile phone number

Fax number

Email address

**Note:** if the plan owner or person insured on this application is related (mother, father, sister, brother, child or spouse), in a de facto or same sex relationship or in a business relationship with the adviser listed above, flat commission will be paid on the accepted cover.

## New plan commission splits

**Note:** Standard commission splits are not available for Rewards (Workplace/Family/Memberships) applications.

| Account/Adviser name | Account/Adviser number | % split[1] | State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | **Total** | **100%** | |

## Renewal business commission splits

| Account/Adviser name | Account/Adviser number | % split[1] | State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | **Total** | **100%** | |

**Adviser reference only**

Any commission style or dial down commission must be selected in the Premium Quoting Tool.

1 Percentage must be whole numbers.

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