

Data collection

You may use this form to collect client information for later completion of the Macquarie Life online application. At time of data collection, you may also obtain in writing client declarations (and superannuation beneficiary nominations if applicable) by using the New Business Application Authorisation form available on our website.

Privacy reminder: The information on your client captured in this form is of a highly personal and sensitive nature. Accordingly, we remind you of your obligations to respect the privacy and sensitivity of that information, ensure the information is properly secured and use that information only for the purposes for which it has been collected.

Personal details			
Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Date of birth:		/	/
Surname:		First name:	
Are you a smoker or have you smoked in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, how many cigarettes do you smoke per day?			
Occupation			
What is your occupation?			
If you are self employed or own any part of the business you are working in, please indicate the ownership structure.			
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Sole Trader	<input type="checkbox"/> Partnership	Other <input type="text"/>
Do you have a recognised university degree in an appropriate discipline (if applicable)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential address			
Address 1:	Street address:		
	Suburb:	State:	Postcode:
Postal address			
Address 1:	Street address:		
	Suburb:	State:	Postcode:
Work phone:	Home phone:	Mobile phone:	
Email address:			
Payment method			
How would you like to pay for your premiums?		<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Regular collection date (dd/mm/yy): / /			
Credit card:	Credit card type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Credit card number:	
	Credit card expiry date (mm/yy): /	Name on card:	
Direct debit from bank account:	Bank account name:		
	Bank account BSB:	Bank account number:	
For applications to join the insurance-only division of the Macquarie Superannuation Plan			
What type of contributions are being made to fund insurance premiums? <input type="checkbox"/> Personal <input type="checkbox"/> Employer <input type="checkbox"/> Spouse			
Please provide your Tax File Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

Nominated beneficiaries (non-superannuation death benefit)

The total of percentages must be 100%

Name

Relationship

Percentage of benefit* %

* Enter 0 or leave blank if you do not wish to nominate your estate.

Name

Relationship
 Spouse Child Dependant
 Interdependant Brother Sister
 Mother Father Nephew Niece
 Legal guardian Other, please specify

Sex
 Male Female

Date of birth / /

Percentage of benefit %

Name

Relationship
 Spouse Child Dependant
 Interdependant Brother Sister
 Mother Father Nephew Niece
 Legal guardian Other, please specify

Sex
 Male Female

Date of birth / /

Percentage of benefit %

Name

Relationship
 Spouse Child Dependant
 Interdependant Brother Sister
 Mother Father Nephew Niece
 Legal guardian Other, please specify

Sex
 Male Female

Date of birth / /

Percentage of benefit %

Name

Relationship
 Spouse Child Dependant
 Interdependant Brother Sister
 Mother Father Nephew Niece
 Legal guardian Other, please specify

Sex
 Male Female

Date of birth / /

Percentage of benefit %

Occupation details

How many hours do you work per week?	<input type="text"/>
What percentage of your work involves manual work (including driving)?	<input type="text"/>
Do you work at heights above 10m, in a hazardous environment or with hazardous materials, offshore or underground?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details of your work environment:	
How long have you been in your current occupation?	<input type="checkbox"/> Less than 12 mths <input type="checkbox"/> 12 mths or more
What is your work history for the last 5 years?	
Have you or any entities owned or controlled by you ever been declared bankrupt or insolvent, or are you or any entities owned or controlled by you currently being declared bankrupt or insolvent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you self employed or do you own any part of the business you are working in?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your current annual income from personal exertion (after deducting business expenses but before tax and superannuation contributions)?	\$ <input type="text"/>
What was your annual income from personal exertion (after deducting business expenses but before tax and superannuation contributions) for last year?	\$ <input type="text"/>
What was your annual income from personal exertion (after deducting business expenses but before tax and superannuation contributions) for the year before last?	\$ <input type="text"/>

Occupation details (For self employed only)

How long have you been self employed/owned your own business?	<input type="checkbox"/> Less than 12 mths <input type="checkbox"/> 12 mths or more
What percentage of the business do you own?	
How many people do you employ and/or supervise?	
In the event of your disablement, would your income continue for greater than 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For what period of time would your income continue?	

Please tick if contributions are only superannuation guarantee (SG) of 9%

Existing or pending cover

Excluding this application, do you have or are you applying for Life Cover, Critical Illness, Total and Permanent Disablement, Income Protection or Active cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any proposals for Life, Critical Illness, Total Permanent Disablement, Income Protection or Active cover on your life ever been declined, deferred or offered on non-standard terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever received compensation payments for an accident, sickness or disability or is there a current claim being made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have or will you be applying for any other Macquarie Cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes' to any of the above, please provide details:

Type of cover	Sum insured	Company	Start date	Is policy being replaced?

Macquarie LifeConnect tele-interviewing service

Best date and time for Macquarie LifeConnect to call client to book an appointment	
Best contact telephone number	
<i>If using Macquarie LifeConnect, your data collection is now complete. We will contact your client to arrange a time to complete the balance of the personal statement over the phone.</i>	

Travel and residency

Are you a citizen of Australia or New Zealand or are you a permanent resident of Australia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you intend to reside in Australia or New Zealand permanently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you any intention of living, working or travelling outside of Australia or New Zealand in the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your reason for travelling (eg holiday, business)?	
Which country are you travelling to or going to live in?	
When do you intend to travel?	
How long will you be travelling?	

Hazardous pursuits

Do you, or are you likely to, take part in any hazardous activities? Examples of hazardous activities include: private aviation, motor sports, scuba diving, sailing, body contact sports such as martial arts or football and recreations involving heights or underground activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', what hazardous activities do you take part in?	
Are you a member of the armed forces either full or part-time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please provide details of your main duties:	

Alcohol and drugs

On average how many standard glasses of alcohol do you consume per day?
A standard drink is 1 single pub measure of spirits, a small (125ml) glass of wine or a 1/2 pint (250ml) of standard strength beer, lager or cider.

Have you ever used or injected any drugs not prescribed by a medical attendant or received advice and/or counselling for excess alcohol consumption from any health professional? Yes No

If 'Yes', provide details of type, quantity, frequency, last use:

Height/weight

What is your height? cm / feet

What is your weight? kg / lb

Has your weight changed by more than 10kgs in the last 12 months? Yes No

If 'Yes', Was this change due to healthy lifestyle changes? Provide details below:

Family history

Have any of your natural parents or siblings suffered or died from any of the following conditions before the age of 60? Note – you are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, sister, brothers)?

- | | |
|---|--|
| <input type="checkbox"/> Ischaemic heart disease and/or cerebrovascular disease
(eg heart attack, angina, stroke, TIA, hypertension) | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Huntington's disease |
| <input type="checkbox"/> Hypertrophic cardiomyopathy | <input type="checkbox"/> Adult polycystic kidney disease |
| <input type="checkbox"/> Colo-rectal cancer (including polyposis of the colon) | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Other cancer (eg bowel, prostate) | <input type="checkbox"/> Any other hereditary disorder |
| | <input type="checkbox"/> None |

If 'Yes' to any of the above, please complete the following schedule of family history

Parent or sibling	Condition	Age diagnosed

Medical history

Do you have, or have you ever had, any of the following medical conditions? Check all for which the answer is 'Yes', or if none apply, check 'None of the above'.

1. Any disorder or disease of the heart, circulatory problems or chest pains including high blood pressure, stroke, brain haemorrhage, embolism, irregular heartbeat, heart murmur or raised cholesterol.	<input type="checkbox"/>
2. Asthma, bronchitis, sleep apnoea, any other lung, respiratory or breathing disorder.	<input type="checkbox"/>
3. Pain or problems relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, sciatica, rheumatism, gout or any other muscular problems or repetitive strain injuries?	<input type="checkbox"/>
4. Pain or problems relating to your joints including rheumatoid arthritis, arthritis or gout.	<input type="checkbox"/>
5. Any psychiatric condition, eg nervous or mental illness including anxiety, depression, stress, insomnia, nervous breakdown, dementia, panic attacks, schizophrenia, post-natal depression, eating disorders or suicide attempt?	<input type="checkbox"/>
6. Any endocrine disorder, eg diabetes mellitus, raised blood sugar levels, sugar in the urine, glandular or thyroid disorders.	<input type="checkbox"/>
7. Any kidney, urinary, prostate or bladder disorders including blood or protein in the urine, urinary infections or kidney stones.	<input type="checkbox"/>
8. Any disorder of the digestive system, eg stomach, bowel, pancreas or liver disorders including hepatitis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, polyps, hernia or irritable bowel syndrome.	<input type="checkbox"/>
9. Any benign or malignant cancer, tumour, lump, cyst or growth.	<input type="checkbox"/>
10. Any form of skin lesion or skin cancer (eg squamous cell carcinoma, basal cell carcinoma, melanoma), mole or freckle that has bled, become painful, changed colour or increased in size.	<input type="checkbox"/>
11. Any other disorder of the skin including psoriasis, eczema or dermatitis.	<input type="checkbox"/>
12. Epilepsy, fits, convulsions, blackouts or migraines or persistent headache.	<input type="checkbox"/>
13. Any neurological complaint or disorder of the nervous system including multiple sclerosis, Parkinson's disease, muscular dystrophy, motor neuron disease, paralysis, cerebral palsy, dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face or problems with balance and/or co-ordination.	<input type="checkbox"/>
14. Alzheimer's disease, dementia or any other disorders of the brain and nerves.	<input type="checkbox"/>
15. Any disorder of the blood including anaemia, haemochromatosis or haemophilia.	<input type="checkbox"/>
16. Any disease or disorder of the eye or ear (other than minor defects corrected by spectacles, lenses) eg iritis, glaucoma, optic neuritis, strabismus, blurred, double vision or hearing loss or tinnitus.	<input type="checkbox"/>
17. Chronic pain syndrome, fibromyalgia, fibrositis, chronic fatigue syndrome or myalgia.	<input type="checkbox"/>
None of the above	<input type="checkbox"/>

Females only

18. Have you ever had any complications with pregnancy or childbirth eg ectopic pregnancies or miscarriages, and/or undergone IVF?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Have you ever had any symptoms of or sought advice or treatment for any condition of the cervix, ovary, uterus, fallopian tubes, breast and endometrium?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Are you currently pregnant? If 'Yes', please advise of your due date and return to work date: Due date: <input type="text"/> / <input type="text"/> / <input type="text"/> Return to work date: <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other medical questions

22. Have you ever tested positive for HIV/AIDS, Hepatitis B or C, or any Sexually Transmitted Illness or are you awaiting the results of such a test (other than for this application)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Have you in the last five years been absent from work or your place of study for a period of greater than five days through any illness or injury not previously disclosed in this application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Have you in the last five years undergone or have you been advised to undergo any medical investigation or test (eg colonoscopy, ultrasound, blood test or ECG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Have you in the last five years sought treatment from a physiotherapist, chiropractor or massage therapist that you have not already disclosed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Do you contemplate seeking medical advice, investigation or treatment (including surgery) for any current health problem not already disclosed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Are you currently experiencing any symptoms of illness, undergoing counselling, taking medication, or do you have a physical defect or infirmity not already disclosed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Doctor's details

Surname:		First name:	
Clinic/Surgery name:			
Street address:			
Suburb:		State:	Postcode:
Phone number: ()		How long have you been consulting with this doctor:	

Child Trauma

Existing Child Trauma cover: Do any of the children for whom Child Trauma Insurance is being applied for have any existing cover with another company? Yes No

If 'Yes', provide the following details for each child.

Child's full name (first name, surname)	Gender	Date of birth	Relationship to applicant
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	

Child Trauma family history: Do any of the children for whom Child Trauma Insurance is being applied for have an immediate biological family member(s) (father, mother, sibling) who suffer or has suffered from cancer, heart disease, diabetes mellitus, any kidney disorder, Huntington's disease or any other genetic/hereditary disease? Yes No

If 'Yes', to any of the above, please complete the following details for each:
 Note – you are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, sister, brothers).

Child's name	Parent or sibling	Condition	Age diagnosed

Child Trauma medical history: Have any of the children that are applying for Child Trauma cover ever had or currently have any of the following medical conditions?

- | | |
|--|---|
| <input type="checkbox"/> Any disorder of the heart or blood vessels | <input type="checkbox"/> Any disorder of the kidneys or bladder |
| <input type="checkbox"/> Cancer, cyst, lesion or tumour of any kind | <input type="checkbox"/> Any disorder of the stomach, bowels, liver or pancreas |
| <input type="checkbox"/> Diabetes mellitus or any other endocrine disorder | <input type="checkbox"/> Any form of incapacity, mental or developmental issue |
| <input type="checkbox"/> Severe asthma or any other ongoing lung disease | <input type="checkbox"/> Any ongoing disorder of the brain or nerves |
| <input type="checkbox"/> Epilepsy, fainting attacks or fits of any type | <input type="checkbox"/> Undergone or had advice to undergo any surgical procedure |
| <input type="checkbox"/> Any blood disorder eg anaemia, haemophilia | <input type="checkbox"/> A reactive blood test to the HIV or Hepatitis B or C virus |
| <input type="checkbox"/> Any physical defect or major injury | <input type="checkbox"/> Ongoing medical treatment for any condition not listed above |
| <input type="checkbox"/> Any loss of hearing, speech or vision | <input type="checkbox"/> None |

Macquarie Life

New Business Application Authorisation and Superannuation Beneficiary Nomination



For use with the Macquarie Life Active PDS or the FutureWise PDS dated 12 May 2012, where the application is to be submitted via the online platform.

1 Appointment of adviser as agent to apply for my insurance

- The person identified below is my adviser, and I hereby appoint my adviser as my agent, authorising them to complete and lodge an application for insurance as my agent and, until further notice, otherwise act on my behalf in relation to this insurance.
- I authorise Macquarie Life to provide to my adviser personal and medical information in connection with my application for insurance and ongoing management of my insurance.

Declaration of policy owner/person to be insured Information disclosed

- I have received either a Macquarie Life Active PDS dated 12 May 2012 or a FutureWise PDS dated 12 May 2012 and agree to be bound by it.
- I have read and understood my duty of disclosure as explained in the PDS and declare that the information I have supplied to my agent in relation to my insurance application is true and correct and I have not withheld any information material to the proposed insurance application.
- I understand that my duty of disclosure continues until a written contract of life insurance has been issued by Macquarie Life.
- I acknowledge that Macquarie Life is entitled to rely on the information in the online application lodged on my behalf in assessing both the application and any future claims, and may be entitled to vary or avoid the insurance if there has been an act of non-disclosure, misrepresentation or fraud committed.
- I will review the answers provided in the online application. I further agree to inform Macquarie Life immediately if I identify there are any errors or omissions contained in the application. I understand that Macquarie Life may seek to vary or avoid the insurance if the online application contains errors or omissions.
- I have read and understood the Privacy Statement in the PDS and consent to the collection, use and disclosure of personal information in accordance with the Privacy Statement.

Medical information

- I consent to Macquarie Life seeking medical information from any doctor consulted by me any time before or during the assessment for this application or during the term of any policy issued. I authorise the giving of such information during the application process and the term of any policy issued.

Other acknowledgements/authorisations

- I authorise Macquarie Life to collect premiums from my nominated credit card or bank account in the event my application is approved. Where I have nominated a bank account, I agree to the terms outlined in the Direct Debit Service Agreement contained in the PDS.
- I have read and accept the Anti-money Laundering and Counter Terrorism Financing Terms and Conditions set out in the PDS.
- I acknowledge that policies issued by Macquarie Life are not deposits with or other obligations of Macquarie Bank Limited. Macquarie Bank Limited does not guarantee or otherwise provide assurance in respect of those obligations.
- Where I am applying to become a member of the insurance-only division of the Macquarie Superannuation Plan (Plan), I declare that I am eligible to contribute to the Plan, and I agree to advise Macquarie Life when I am no longer eligible to make contributions to a superannuation fund.

Declaration of policy owner/person to be insured – continued

- If the policy I am applying for is subject to Flexible Linking or Superannuation Optimiser, I acknowledge that the insurance under this policy will be linked to the insurance under another policy, and I have read and accept the terms that apply to the Flexible Linking or Superannuation Optimiser as set out in the PDS.
- I acknowledge that, where I am applying for a Macquarie Life Active policy, the terms and conditions of the policy are available online at macquarielife.com.au, or a copy will be sent to me upon my request.

Before you sign and date this form, be aware that the life company or your adviser is obliged to have provided you with a PDS containing the important information in relation to this product. This information will help you understand the product and to decide whether it is appropriate for your needs.

Policy owner/person to be insured

Name and title	
<input type="text"/>	
Signature (Please sign in black ink)	Date
<input type="text"/>	<input type="text"/>

Other policy owners to sign

Policy owner/trustee name and position	
<input type="text"/>	
Signature (Please sign in black ink)	Date
<input type="text"/>	<input type="text"/>

Policy owner/trustee name and position	
<input type="text"/>	
Signature (Please sign in black ink)	Date
<input type="text"/>	<input type="text"/>

Adviser use only	
Adviser code	Adviser name
<input type="text"/>	<input type="text"/>
Signature (Please sign in black ink)	Date
<input type="text"/>	<input type="text"/>
Dealer code	Dealer name
<input type="text"/>	<input type="text"/>
Application number (add after online application submitted)	
<input type="text"/>	

2 Superannuation beneficiary nominations



Only answer this question if you are applying for membership of the insurance-only division of the Macquarie Superannuation Plan.

Please ensure you consider and understand the rules set out in the PDS relating to the payment of death benefits from superannuation and the requirement that any nominee must be your dependant under superannuation law.

The total of percentages must be 100%.

Name	LEGAL PERSONAL REPRESENTATIVE
Relationship	ESTATE
Percentage of benefit*	<input type="text"/> %

* Enter 0 or leave blank if you do not wish to nominate your estate.

Name	<input type="text"/>	
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Interdependent <input type="checkbox"/> Other Dependant	
Sex	Date of birth	Percentage of benefit
<input type="checkbox"/> Male	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> %
<input type="checkbox"/> Female		

Name	<input type="text"/>	
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Interdependent <input type="checkbox"/> Other Dependant	
Sex	Date of birth	Percentage of benefit
<input type="checkbox"/> Male	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> %
<input type="checkbox"/> Female		

Name	<input type="text"/>	
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Interdependent <input type="checkbox"/> Other Dependant	
Sex	Date of birth	Percentage of benefit
<input type="checkbox"/> Male	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> %
<input type="checkbox"/> Female		

Name	<input type="text"/>	
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Interdependent <input type="checkbox"/> Other Dependant	
Sex	Date of birth	Percentage of benefit
<input type="checkbox"/> Male	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> %
<input type="checkbox"/> Female		

Please read this BEFORE signing this declaration

Your signature must be witnessed by two people, each of whom is 18 years or older and is **not** named as a beneficiary in the form.

I understand the superannuation beneficiary nomination given to MIML as trustee of the Macquarie Superannuation Plan in this section will apply to all death benefits held under my membership in the insurance-only division for FutureWise or Macquarie Life Active (as applicable) and referred to below as my FutureWise interest or Macquarie Life Active interest (as applicable), and:

- be binding on the Trustee if the Trustee consents to it,
- revokes any prior nomination made by me in respect of my FutureWise or Macquarie Life Active interest, and
- will be current until revoked or the Trustee consents to a new nomination from me, which will replace any previous nomination/s provided in respect of my FutureWise or Macquarie Life Active interest.

I understand that any nomination I provide will apply to all of my interest in FutureWise or Macquarie Life Active (as applicable, and only that FutureWise or Macquarie Life Active interest), unless I provide written instructions requesting the Trustee to consider other more complex arrangements, and the Trustee agrees.

I understand that I should review the nomination regularly and if I wish to make a new nomination in the future, I will need to complete a new form.

Name of member	<input type="text"/>
Signature of member (Please sign in black ink)	<input type="text"/>
Declaration date	<input type="text"/> / <input type="text"/> / <input type="text"/>

Witness 1	
Name of witness 1	<input type="text"/>
Signature of witness 1 (Please sign in black ink)	<input type="text"/>
This application was signed by the applicant before me and on the date indicated above as the declaration date	
<input type="text"/>	

Witness 2	
Name of witness 2	<input type="text"/>
Signature of witness 2 (Please sign in black ink)	<input type="text"/>
This application was signed by the applicant before me and on the date indicated above as the declaration date	
<input type="text"/>	

This document is current as at 12 May 2012 and is issued by Macquarie Life Limited (Macquarie Life) ABN 56 003 963 773 AFSL 237 497 and Macquarie Investment Management Limited (MIML) ABN 66 002 867 003 AFSL 237 492 ("we", "us", "our" or "Macquarie" as the context requires). Macquarie Life and MIML are not authorised deposit-taking institutions for the purposes of the Banking Act (Cth) 1959, and Macquarie Life's and MIML's obligations do not represent deposits or other liabilities of Macquarie Bank Limited ABN 46 008 583 542. Macquarie Bank Limited does not guarantee or otherwise provide assurance in respect of the obligations of Macquarie Life and MIML.

Admin/Underwriting 1800 005 057
Fax Gateway 1800 812 175
 GPO Box 5216 Brisbane QLD 4001
 insurance@macquarie.com
 macquarielife.com.au

Claims
 1800 208 130
 1800 065 145
 GPO Box 4443 Sydney NSW 2001
 insuranceclaims@macquarie.com

FORWARD thinking

