

Macquarie Life

New business application



For use with the Macquarie Life Active PDS dated 12 May 2012 or the FutureWise PDS dated 12 May 2012.
Not to be used in conjunction with the online platform.

Your duty of disclosure

Before you enter into a contract of insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance, and if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of insurance.

Your duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows or, in the ordinary course of business, ought to know;
- where the insurer has agreed to waive your duty of disclosure.

Non-disclosure

If you fail to comply with the duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within

3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

If we are entitled to avoid a contract of insurance, we may, within 3 years of entering into it, elect not to avoid it but reduce the amount that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to us.

Please note, your duty of disclosure continues until a written contract of insurance has been issued by Macquarie Life.

Privacy reminder for advisers

The information captured in this form is of a highly personal and sensitive nature, accordingly we remind you of our obligations to:

- respect the privacy and sensitivity of that information;
- ensure the information is properly secured;
- use that information only for the purposes for which it has been collected (ie for underwriting purposes).

1 Please read this before answering the question

The person to be insured must complete Form D – the Personal statement unless you are doing a simple transfer of existing cover with Macquarie Life to FutureWise without any increase to FutureWise.

If only applying for Child Trauma Insurance or Child Cover, you must complete Form D from Question 60 on page 22.

Details of person to be insured (as per passport)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Sex

Male Female

Date of birth

 / /

Residential address

Street number and name

Suburb/Town

State

Postcode

Mailing address (PO Box address is acceptable)

Street number and name

Suburb/Town

State

Postcode

Home phone number

 ()

Work phone number

 ()

Mobile phone number

Fax number

 ()

Email address

@

2 Please read this Disclaimer before answering the question

The insurance estimate has been prepared by Macquarie Life Limited ABN 56 003 963 773 and is based on personal information you have provided to us. It is provided as an indication of the cost of insurance, using Macquarie Life's standard premium rates, and does not represent a quote for any particular person. Applications for insurance will be subject to underwriting procedures and additional premium loadings may apply. Macquarie Life Limited can decline applications for insurance cover, apply additional premium loadings or apply specific exclusions.




Please attach a quote to this application.

Transfer of existing cover

3 Is this application intended to replace existing cover with another insurer, and is the application eligible under transfer terms?

No Go to next question

Yes

 In all cases, the person to be insured must complete **Form D** in addition to those Forms indicated at Question 6. Please also attach to the application the required evidence of the existing cover to be replaced. Existing cover should not be cancelled until acceptance of this application is confirmed by Macquarie Life by issuing a written contract of insurance.

4 Is this application intended to replace existing cover with Macquarie Life?

No Go to next question

Yes Provide details below of the policies to be cancelled

I request that my existing Macquarie Life insurance policy(ies) indicated below be cancelled and I understand that the cover will be replaced with the policy(ies) now applied for, as indicated in this application. I understand that the terms under the new policy(ies) may vary from those of the policy(ies) I currently hold.

Policy owner(s) or member of Macquarie Superannuation Plan to complete

Policy number

Policy owner or member name

Signature

Date

Policy number

Policy owner or member name

Signature

Date

5 Is this application a simple transfer of existing cover with Macquarie Life to FutureWise without any increase to FutureWise?

No Go to next question

Yes Complete Forms indicated at Question 6. The insured person does not need to complete **Form D**.

6 Ownership structure

Mark all that apply and provide the purpose of the cover eg personal, key person, share purchase, business loan, etc. If Flexible Linking or Superannuation Optimiser applies, at least two policies must be applied for.

Which ownership structures apply to this application?

Mark all that apply

Non-superannuation ownership only

FutureWise (single policy only)

Purpose of cover

▶ Complete Form A

Macquarie Life Active

Purpose of cover

▶ Complete Form A

Self managed superannuation fund

FutureWise (single policy only)

Purpose of cover

▶ Complete Form B

FutureWise with Flexible TPD/Trauma (including Partial Impairment option) and/or Extra Benefits policy

Purpose of cover

▶ Complete Form A and B

Macquarie Life Active (Superannuation Optimiser applies)

Purpose of cover

▶ Complete Form A and B

Macquarie Superannuation Plan

FutureWise

Purpose of cover

▶ Complete Form C

FutureWise with Flexible TPD/Trauma (including Partial Impairment option) and/or Extra Benefits policy

Purpose of cover

▶ Complete Form A and C

Macquarie Life Active (Superannuation Optimiser applies)

Purpose of cover

▶ Complete Form A and C

Form A: Non-superannuation ownership

Use for FutureWise or Macquarie Life Active

If you wish to apply for more than one policy under non-superannuation ownership please complete and attach additional copies of **Form A** as required. Please also complete **Form B** or **Form C** as applicable if this policy is to be connected to another policy through Flexible Linking or Superannuation Optimiser.

1 Is the person named on page 1 an owner of this policy?

No **Go to next question**

Yes **Go to 5**

2 Is the first policy owner a company?

No **Go to 4**

Yes **Go to next question**

3 Company name (first policy owner)

What is the insured's relationship to the company?

Australian Business Number (ABN)

 Go to 5

4 Name of the first policy owner (as per passport)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Previous/maiden name

Nationality of passport

Sex

Male Female

Date of birth

 / /

Relationship to the insured

5 Contact details for the first policy owner

If address details are same as page 1, please tick box.

Go to 6

Residential address (for individuals) or business street address (for companies). **(PO Box address is not acceptable)**

Street number and name

Suburb/Town

State

Postcode

Mailing address (PO Box address is acceptable)

Street number and name

Suburb/Town

State

Postcode

Home phone number

 ()

Work phone number

 ()

Mobile phone number

Fax number

 ()

Email address

 @

6 Are there any additional policy owners?

No **You do not need to answer 7 to 15. Go to 16**

Yes **Go to next question**

7 Is the second policy owner a company?

No **Go to 9**

Yes **Go to next question**

8 Company name (second policy owner)

What is the insured's relationship to the company?

Australian Business Number (ABN)

 Go to 10

9 Name of the second policy owner (as per passport)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Previous/maiden name

Nationality of passport

Sex Male Female

Date of birth
 / /

Relationship to the insured

10 Contact details for the second policy owner

Residential address (for individuals) or business street address (for companies). **PO Box address is not acceptable**

Street number and name

Suburb/Town

State Postcode

Home phone number () Work phone number ()

Mobile phone number Fax number ()

Email address

@

11 Is there a third policy owner?

No **You do not need to answer 12 to 15. Go to 16**

Yes **Go to next question**

12 Is the third policy owner a company?

No **Go to 14**

Yes **Go to next question**

13 Company name (third policy owner)

What is the insured's relationship to the company?

Australian Business Number (ABN)
 Go to 15

14 Name of the third policy owner (as per passport)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Previous/maiden name

Nationality of passport

Sex Male Female

Date of birth
 / /

Relationship to the insured

15 Contact details for the third policy owner

Residential address (for individuals) or business street address (for companies). **PO Box address is not acceptable**

Street number and name

Suburb/Town

State Postcode

Home phone number () Work phone number ()

Mobile phone number Fax number ()

Email address

@

16 Would you like to nominate one or more beneficiaries to receive any death benefits payable under this policy?



Note that this facility is only available where you are to be the insured person and the sole owner of the policy. Do not use this section to make a superannuation beneficiary nomination (which can be made on page 10 of this application form).

No Go to next question

Yes Provide details below

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"/> Dependant <input type="checkbox"/> Interdependant <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other, please specify <input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Date of birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Percentage of benefit	<input type="text"/> %

Name	<input type="text"/>
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dependant <input type="checkbox"/> Interdependant <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other, please specify <input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Date of birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Percentage of benefit	<input type="text"/> %

Name	<input type="text"/>
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dependant <input type="checkbox"/> Interdependant <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other, please specify <input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Date of birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Percentage of benefit	<input type="text"/> %

Name	<input type="text"/>
Relationship	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dependant <input type="checkbox"/> Interdependant <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other, please specify <input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Date of birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Percentage of benefit	<input type="text"/> %

17 Would you like to nominate a date of the month different from the cover start date for the ongoing deduction of the premium?

No Premiums will be deducted on the same date of each month/year as the cover start date.

Go to next question

Yes Please provide preferred date of the month. If the nominated date falls on a weekend or public holiday, the premium will be deducted on the next business day.

Preferred date eg 1st, 15th

18 Would you like to pay your premiums by direct debit from an account?

No **Go to next question**

Yes Provide details below

<input type="checkbox"/> Direct debit from Macquarie Investment Manager, Investment Accumulator or Investment Consolidator account
Account number <input type="text"/>
<input type="checkbox"/> Direct debit from bank account – Provide details below
Bank account name <input type="text"/>
Bank account BSB <input type="text"/> - <input type="text"/>
Bank account number <input type="text"/>

By electing to have my/our premium deducted from my/our account by direct debit, I/we agree to the terms outlined in the Direct Debit Service Agreement contained in the Product Disclosure Statement. I understand premiums will be deducted monthly or yearly as indicated on the quote attached to this application.

Signature 1	
<input type="text"/>	
Name <input type="text"/>	Date <input type="text"/> / <input type="text"/> / <input type="text"/>

Signature 2	
<input type="text"/>	
Name <input type="text"/>	Date <input type="text"/> / <input type="text"/> / <input type="text"/>

19 Would you like to pay your premiums by credit card?

No Go to next question

Yes Provide details below

Credit card type	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>
Credit card number		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Expiry date	Name on card	
<input type="text"/>	<input type="text"/>	
I acknowledge that it is my responsibility to notify Macquarie Life of any change in credit card details, including new expiry date. I authorise Macquarie Life to charge any amounts that become payable in relation to my policy to my credit card, the details for which are shown above. I understand premiums will be deducted monthly or yearly as indicated on the quote attached to this application.		
Signature		
<input type="text"/>		
Name	Date	
<input type="text"/>	<input type="text"/>	

20 Declaration of policy owner(s)

Information disclosed

- I have received a PDS for the product I am applying for (either a FutureWise PDS dated 12 May 2012 or a Macquarie Life Active PDS dated 12 May 2012) and agree to be bound by it.
- I acknowledge that I have read and understood my duty of disclosure, as set out on page 1 of this application and in the PDS, in respect of the above and the declaration of health.
- I understand that my duty of disclosure continues until a written contract of life insurance has been issued by Macquarie Life.
- The person identified on page 26 is my adviser, and is authorised by me to lodge this application and until further notice, otherwise act on my behalf in relation to this insurance.
- I acknowledge that Macquarie Life is entitled to rely on the information in this 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 a non-disclosure, misrepresentation or fraud.
- 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.

Other acknowledgements

- If this policy 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 policies issued under FutureWise or Macquarie Life Active 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.
- I acknowledge that, where I am applying for a Macquarie Life Active policy, the terms and conditions of the policy are available online at www.macquarielife.com.au, or a copy will be sent to me upon my request.

Before you sign and date this application 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(s)

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

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

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

Form B: Self managed superannuation fund ownership

Use **Form B** for FutureWise or Macquarie Life Active where the policy is to be owned by the trustee of a self managed superannuation fund. Please also complete **Form A** if this policy is to be connected to another policy through Flexible Linking or Superannuation Optimiser, or if you are also applying for a Disability Income or Income Cover Extra Benefits policy to be held in non-superannuation ownership.

1 Policy owner details

Provide the following details for the self managed superannuation fund (SMSF)

Trustee name(s)

Name of superannuation fund

Mailing address (PO Box address is acceptable)

If address details are same as page 1, please tick box.
Go to 2

Street number and name

Suburb/Town

State

Postcode

Contact phone number

Australian Business Number (ABN)

2 Would you like to nominate a date of the month different from the cover start date for the ongoing deduction of the premium?

No Premiums will be deducted on the same date of each month/year as the cover start date.
Go to next question

Yes Please provide preferred date of the month. If the nominated date falls on a weekend or public holiday, the premium will be deducted on the next business day.

Preferred date eg 1st, 15th

3 Would you like to pay your premiums by direct debit from an account?

No **Go to 4**

Yes Provide details below

Direct debit from Macquarie Investment Manager, Investment Accumulator or Investment Consolidator account

Account number

Direct debit from bank account – Provide details below

Bank account name

Bank account BSB

Bank account number

By electing to have my/our premium deducted from my/our account by direct debit, I/we agree to the terms outlined in the Direct Debit Service Agreement contained in the Product Disclosure Statement. I understand premiums will be deducted monthly or yearly as indicated on the quote attached to this application.

Signature 1

Name

Date

Signature 2

Name

Date

4 Would you like to pay your premiums by credit card?

No Go to next question

Yes Provide details below

Credit card type	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>
Credit card number	<input type="text"/>	
Expiry date	Name on card	
<input type="text"/>	<input type="text"/>	
<p>I acknowledge that it is my responsibility to notify Macquarie Life of any change in credit card details, including new expiry date. I authorise Macquarie Life to charge any amounts that become payable in relation to my policy to my credit card, the details for which are shown above. I understand premiums will be deducted monthly or yearly as indicated on the quote attached to this application.</p>		
Signature		
<input type="text"/>		
Name	Date	
<input type="text"/>	<input type="text"/>	

5 Declaration of applicant(s)

Trustee declaration

- I am a trustee, or a director of the trustee, of the fund and I am authorised to make this application for cover on the life of the person named in this application.
- I understand that Macquarie Life will not assume any of the superannuation compliance responsibilities associated with the application, policy and benefits.

Information disclosed

- I have received the PDS for the product I am applying for (either a FutureWise PDS dated 12 May 2012 or a Macquarie Life Active PDS dated 12 May 2012) and agree to be bound by it.
- I acknowledge that I have read and understood my duty of disclosure, as set out on page 1 of this application and in the PDS, in respect of the above and the declaration of health.
- I understand that my duty of disclosure continues until a written contract of life insurance has been issued by Macquarie Life.
- The person identified on page 26 is my adviser, and is authorised by me to lodge this application and until further notice, otherwise act on my behalf in relation to this insurance.
- I acknowledge that Macquarie Life is entitled to rely on the information in this 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 a non-disclosure, misrepresentation or fraud.

Other acknowledgements

- 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.
- If this policy 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 policies issued under FutureWise or Macquarie Life Active 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.
- I acknowledge that, where I am applying for a Macquarie Life Active policy, the terms and conditions of the policy are available online at www.macquarielife.com.au, or a copy will be sent to me upon my request.

Before you sign and date this application 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.

Trustee's name	<input type="text"/>
Trustee's position	<input type="text"/>
Trustee's signature (Please sign in black ink)	<input type="text"/>
Date	<input type="text"/>

Trustee's name	<input type="text"/>
Trustee's position	<input type="text"/>
Trustee's signature (Please sign in black ink)	<input type="text"/>
Date	<input type="text"/>

Trustee's name	<input type="text"/>
Trustee's position	<input type="text"/>
Trustee's signature (Please sign in black ink)	<input type="text"/>
Date	<input type="text"/>

Form C: Insurance through the Macquarie Superannuation Plan

Use **Form C** for FutureWise or Macquarie Life Active where you are either:

- applying for membership of the insurance-only division of the Macquarie Superannuation Plan or
- linking the insurance to a new or existing superannuation account within the Macquarie Superannuation Plan including Macquarie Super Manager, Macquarie Super Accumulator, Macquarie Super Consolidator, or Super Options.

Please also complete **Form A** if Flexible Linking or Superannuation Optimiser is to apply, or if you are also applying for a Disability Income or Income Cover Extra Benefits policy to be held in non-superannuation ownership.

Macquarie Investment Management Limited (MIML) is the trustee (Trustee) of the Macquarie Superannuation Plan.

1 Applicant details

The applicant must be the person named as the person to be insured on page 1 of this application.

2 Contact details

- If address details are same as page 1, please tick box.
Go to 3

Residential address (PO Box address is not acceptable)

Street number and name

Suburb/Town

State

Postcode

Mailing address (PO Box address is acceptable)

Street number and name

Suburb/Town

State

Postcode

Home phone number

Work phone number

Mobile phone number

Fax number

Email address

3 Are you linking this insurance to a new or existing Macquarie superannuation account from which premiums will be deducted?

- No I am applying for membership of the insurance-only division of the Macquarie Superannuation Plan. **Go to 5**
- Yes Provide details of the account below. If this is a new account, please also include a completed superannuation application with your application for insurance.

- Macquarie Super Accumulator Macquarie Super Manager
 Macquarie Super Consolidator Macquarie SuperOptions

Account number

4 Are you applying for a Disability Income or Income Cover Extra Benefits policy?

- No **Go to 13 and complete the Declaration**
- Yes

The Extra Benefits policy will be held in non-superannuation ownership with the Insured Person as the policy owner. Please also complete **Form A** to provide separate ownership and premium payment details.

Now go to 13 and complete the Declaration.

5 Please read this before answering the question

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

All contributions that are not employer or spouse will be treated as personal non-concessional contributions, unless you provide us with a valid notice of your intention to claim a tax deduction within certain time frames.

In order to claim a tax deduction for your personal contributions please submit a completed deduction notice in an ATO approved format. Macquarie Life has a standard form that you can use for this purpose which we will send to you each year, or alternatively you may complete the NAT 71121 available from the Australian Taxation Office.

What type of contributions are being made to the Macquarie Superannuation Plan?

Personal Employer Spouse

6 Tax File Number declaration

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

If you do not provide your TFN the Trustee cannot accept contributions made by you or someone on your behalf (other than your employer), while certain concessional contributions and other amounts may be subject to an additional tax at the rate of 31.5%. As a consequence, the Trustee will not accept your application for membership of the insurance-only division of the Macquarie Superannuation Plan until you provide your TFN.

Please provide your Tax File Number below

7 Would you like to nominate one or more beneficiaries?

No **Go to 9**

Yes Provide details below



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"/> Interdependant <input type="checkbox"/> Other Dependant
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Percentage of benefit	<input type="text"/> %

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

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

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

8 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 applicant	<input type="text"/>
Signature of applicant (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"/>
Before me, 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"/>
Before me, on the date indicated above as the Declaration date	<input type="text"/>

9 Would you like to nominate a date of the month different from the cover start date for the ongoing deduction of contributions?

No Contributions will be deducted on the same date of each month/year as the cover start date. **Go to next question**

Yes Please provide preferred date of the month. If the nominated date falls on a weekend or public holiday, the contribution will be deducted on the next business day.

Preferred date eg 1st, 15th

10 Would you like to pay your premiums by direct debit from an account?

No **Go to next question**

Yes Provide details below

Direct debit from Macquarie Investment Manager, Investment Accumulator or Investment Consolidator account

Account number

Direct debit from bank account Provide details below

Bank account name

Bank account BSB

Bank account number

By electing to have my/our contributions deducted from my/our account by direct debit, I/we agree to the terms outlined in the Direct Debit Service Agreement contained in the Product Disclosure Statement. I understand contributions will be deducted monthly or yearly as indicated on the quote attached to this application.

Signature 1

Name

Date

Signature 2

Name

Date

Signature 3

Name

Date

11 Would you like to pay your premiums by credit card?

No **Go to next question**

Yes Provide details below

Credit card type Visa MasterCard

Credit card number

Expiry date Name on card

I acknowledge that it is my responsibility to notify Macquarie Life of any change in credit card details, including new expiry date. I authorise Macquarie Life to charge any amounts that become payable in relation to my policy to my credit card, the details for which are shown above. I understand premiums will be deducted monthly or yearly as indicated on the quote attached to this application.

Signature

Name

Date

12 Would you like a paper version of the annual report to be posted to you?

The annual report for the Macquarie Superannuation Plan will be available at www.macquarie.com.au. If no selection is made, you will not be posted an annual report.

No

Yes

Go to 13

13 Declaration of applicant Information disclosed

- I have received the PDS for the product I am applying for (either a FutureWise PDS dated 12 May 2012 or a Macquarie Life Active PDS dated 12 May 2012) and agree to be bound by it.
- I acknowledge that I have read and understood my duty of disclosure, as set out on page 1 of this application and in the PDS, in respect of the above and the declaration of health.
- I understand that my duty of disclosure continues until a written contract of life insurance has been issued by Macquarie Life.
- The person identified on page 26 is my adviser, and is authorised by me to lodge this application and until further notice, otherwise act on my behalf in relation to this insurance.
- I acknowledge that Macquarie Life is entitled to rely on the information in this 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 a non-disclosure, misrepresentation or fraud.
- 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.

Other acknowledgements

- If this policy 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 and Superannuation Optimiser as set out in the PDS.
- I have read and accept the Anti-Money Laundering Terms and Conditions set out in the PDS.
- I acknowledge that policies issued under FutureWise and Macquarie Life Active 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.
- I acknowledge that, where I am applying for a Macquarie Life Active policy, the terms and conditions of the policy will be available online at www.macquarielife.com.au, or a copy will be sent to me upon my request.
- I declare, where I am applying to become a member of the insurance-only division of the Macquarie Superannuation Plan, that I am eligible to contribute to a superannuation fund, and I agree to advise the Trustee when I am no longer eligible to make contributions to a superannuation fund.

Before you sign and date this application 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.

Name and title

Signature (Please sign in black ink)

Date

Form D: Personal statement – new business

To be completed by the person to be insured.

1 Applicant details

Name of person to be insured (as per passport)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Sex

Male Female

Date of birth

Number of dependants

2 What is your highest educational qualification?

Less than year 12

Professional

Year 12 or equivalent/IB Diploma

Trade qualified

Tertiary degree

Occupational and financial details

3 What is your current occupation?

4 What is the industry you currently work in?

5 Who is your current employer?

6 How many hours do you work per week?

7 What are the principal duties of your occupation and what proportion of time is spent on them?

Administration—% of time

Supervision—% of time

Manual—% of time

Travel—% of time

Total duties
(must add up to 100%) %

8 For manual work, specify the following

Light manual work

% of time

Describe
specific
duties

Location

Heavy manual work

% of time

Describe
specific
duties

Location

Site visits and inspections

% of time

Describe
specific
duties

Location

- 9** Do you work in any of the following situations?
- At heights above 10m
 - In a hazardous environment
 - With hazardous materials
 - Offshore
 - Underground
- No Go to next question
 Yes Provide details below

- 10** Have you been engaged in your present occupation for less than 12 months?
- No Go to next question
 Yes What is your work history for the last 5 years?

- 11** 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?
- No Go to next question
 Yes Provide date discharged (if applicable)
- / /

- 12** Provide the following information about your income

For employees: State your annual earnings before tax from your full time occupation (including superannuation, but excluding bonuses). Also state what percentage of your income is superannuation contributions.

	Annual income <small>(including superannuation)</small>	Superannuation contributions
Current annual earnings	\$	%
Last financial year		
Year ending 30/06	\$	%
Year before last		
Year ending 30/06	\$	%

For self-employed: State your annual earnings before tax from your full time occupation (including superannuation, but excluding bonuses). Also state what percentage of your income is superannuation contributions.

	Annual income <small>(including superannuation)</small>	Superannuation contributions
Current annual earnings	\$	%
Last financial year		
Year ending 30/06	\$	%
Year before last		
Year ending 30/06	\$	%
Two years before last		
Year ending 30/06	\$	%

- 13** Are there any other occupations you are, or may become involved in?

No Go to next question
 Yes Provide details below

- 14** Are you applying for Disability Income and/or Business Expenses insurance?
- No Go to 33
 Yes Go to next question

- 15** Are you self employed or do you own any part of the business you are working in?
- No Go to 33
 Yes What type of structure

- Sole trader
 Partnership
 Contractor

Other Give details below

--

- 16** How long have you been self employed or owned your own business?
- Less than 12 months
 More than 12 months

- 17** Do you own 100% of the business personally?

No Please provide your share of the business, and the names of the other owners, their share, and a description of their role in the business.

Yes Go to next question

- 18** Has there been a deterioration in the performance (profitability) of your business or did it made a loss during this financial year?

No Go to next question

Yes Please provide details and reasons

19 Is your business currently trading or if you operate as a contractor, are you currently working under contract?

No Provide details below

Yes Go to next question

20 How many owners or partners does your business have?

21 How many people do you employ and/or supervise?

22 In the event of your disablement, would your income continue for greater than 90 days?

No Go to next question

Yes Provide details below

23 Do you receive or expect to receive net income from other sources (eg rental income, dividends etc) in excess of \$250,000 per annum or do you have net assets (excluding the family home or superannuation) exceeding \$5m (includes assets that are owned by you, your spouse or any other related entities)?

No Go to next question

Yes Provide details below

24 What is the name of the company, partnership or business?

25 Do you work from home?

No Go to next question

Yes Go to 27

26 Business address

Street number and name

Suburb/Town

State

Postcode

27 What percentage of the business income do you **personally** generate?

 %

28 Is an income splitting amount paid to your spouse?

No Go to next question

Yes How much?

 \$

29 Only complete questions 29 to 32 when applying for Business Expenses Insurance. Estimate below the average monthly expenses you are responsible for—do not include income splitting amount paid to your spouse

Business premises rent/leasing fees

 \$

Interest payments on business loans

 \$

Leasing of office equipment or motor vehicles

 \$

Salaries of employees not involved directly in revenue generation

 \$

Payroll tax for employees not involved directly in revenue generation

 \$

Superannuation contribution for employees not involved directly in revenue generation

 \$

Electricity, gas and water

 \$

Telephone

 \$

Business insurance premiums (excluding this policy)

 \$

Locum cover (less earnings generated by locum)

 \$

Regular advertising

 \$

Fees for professional associations

 \$

Printing postage and stationery

 \$

Property rates

 \$

Bank fees and charges

 \$

Cleaning costs

 \$

Other expenses

 \$

TOTAL EXPENSES

 \$

30 Did you indicate an amount for 'Other expenses' in question 29?

No Go to next question

Yes Describe the other expenses

31 What is your percentage estimate of the business' ongoing trading capacity, in the event of your disability?

 %

32 What percentage of total business expenses are you responsible for?

 %

Existing insurance cover

33 Complete the table below, giving the total for which your life is **currently insured**. Indicate which insurance would be cancelled should this application be approved.

Existing insurances
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$ Start date / /
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

Existing insurances
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$ Start date / /
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

Existing insurances
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$ Start date / /
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

34 Give details of any **other current applications** with Macquarie Life **OR** any other insurer. Indicate which application would be cancelled should this application be approved.

Other current applications
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

Other current applications
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

Other current applications
 Cover type
 Life TPD Trauma Disability Active
 Insurer
 Sum insured \$
 Do you intend to cancel this cover? Yes No
 Disability covers only: Waiting period Benefit period

Further information

35 If we need to get more information from you, what is the most convenient time of day between 9am and 5pm EST, and what phone number can we use to contact you?

Time of day Phone number
 ()

Residency and travel

36 Are you an Australian citizen or permanent resident of Australia?

No *Go to next question*

Yes **Go to 38**

37 Do you intend residing in Australia permanently?

No Provide full details and reasons for this insurance.

Yes *Go to next question*

38 Do you have any intention of living, working or travelling outside of Australia/New Zealand?

No *Go to next question*

Yes Provide full details, include departure date, length and purpose of trip and destinations.

Hazardous activities

39 Please read this before answering the questions on hazardous activities

Hazardous activities include but are not limited to:

- private aviation
- motor sports
- scuba diving
- sailing
- body contact sports such as martial arts or football
- recreations involving heights or underground activities

Do you, or are you likely to, take part in any hazardous activities?

No **Go to 43**

Yes Provide details of activity, frequency and any qualifications you might hold.

40 Have you listed amateur football in question 39?

No **Go to 42**

Yes **Go to next question**

41 If you are applying for Disability Income or Business Expenses Insurance or Income Cover and the type of amateur football activity that you participate in affects the terms of your cover, which of the following do you accept?

90 day exclusion

25% premium loading

42 Would you accept an exclusion, if any of the activities you have described in question 39 (other than amateur football) affect the terms of your cover?

No **Go to next question**

Yes Provide details below of the activities for which you would accept an exclusion

43 Are you a member of the armed forces either full or part time or are you engaged in any reservist activity?

No **Go to next question**

Yes Provide details below

Personal habits

44 Do you currently smoke or have you smoked in the last 12 months?

No **Go to next question**

Yes Specify the quantity and type smoked per day

--

45 Do you consume alcohol?

No **Go to 47**

Yes **Go to next question**

46 What is your current average consumption of alcohol units per week? (1 unit = 1 single pub measure of spirits, small (125ml) glass of wine or 250ml of standard strength beer, lager or cider)

--

47 Have you ever been convicted of driving under the influence?

No **Go to next question**

Yes Provide details below

48 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?

No **Go to next question**

Yes Specify what and when

Height and weight

49 What is your height (centimetres or feet and inches)?

--

50 What is your weight (kilograms or stones and/or pounds)?

--

51 Has your weight changed by more than 10kg in the last 12 months?

No **Go to 53**

Yes **Go to next question**

52 Was this change due to healthy lifestyle changes?

No Provide details below

Yes **Go to next question**

Family medical history

- 53** 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)

a. Ischaemic heart disease and/or cerebrovascular disease (eg heart attack, angina, stroke, TIA, hypertension)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
b. Breast cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>
c. Ovarian cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>
d. Diabetes mellitus	No <input type="checkbox"/>	Yes <input type="checkbox"/>
e. Hypertrophic cardiomyopathy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
f. Colo-rectal cancer (including polyposis of the colon)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
g. Other cancer (eg bowel, prostate)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
h. Alzheimer's disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
i. Parkinson's disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
j. Multiple sclerosis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
k. Huntington's disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
l. Adult polycystic kidney disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
m. Blood disorder	No <input type="checkbox"/>	Yes <input type="checkbox"/>
n. Any other hereditary disorder	No <input type="checkbox"/>	Yes <input type="checkbox"/>

- 54** Did you answer "Yes" to any item in question 53?

No *Go to next question*

Yes *Provide details below.*

If further space is needed, please use photocopies of this page and attach them to your application.

Item <input type="checkbox"/>	Condition <input type="text"/>
Family member <input type="text"/>	Age of diagnosis <input type="text"/>

Item <input type="checkbox"/>	Condition <input type="text"/>
Family member <input type="text"/>	Age of diagnosis <input type="text"/>

Item <input type="checkbox"/>	Condition <input type="text"/>
Family member <input type="text"/>	Age of diagnosis <input type="text"/>

Item <input type="checkbox"/>	Condition <input type="text"/>
Family member <input type="text"/>	Age of diagnosis <input type="text"/>

Personal medical history

- 55** Do you have, or have you ever had, any of the following medical conditions?

a. 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?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
b. Asthma, bronchitis, sleep apnea, any other lung, respiratory or breathing disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
c. 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?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
d. Pain or problems relating to your joints including rheumatoid arthritis, arthritis or gout?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
e. 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?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
f. Any endocrine disorder, eg diabetes mellitus, raised blood sugar levels, sugar in the urine, glandular or thyroid disorders?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
g. Any kidney, urinary, prostate or bladder disorders including blood or protein in the urine, urinary infections or kidney stones?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
h. Any disorder of the digestive system, stomach, bowel, pancreas or liver disorders including hepatitis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, polyps, hernia or irritable bowel syndrome?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
i. Any benign or malignant cancer, tumour, lump (including breast lump), cyst or growth?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
j. 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?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
k. Any other disorder of the skin including psoriasis, eczema or dermatitis?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
l. Epilepsy, fits, convulsions, blackouts, migraines or persistent headache?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
m. 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?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
n. Alzheimer's disease, dementia or any other disorders of the brain and nerves?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
o. Any disorder of the blood including anaemia, haemochromatosis or haemophilia?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

55 continued

p. Any disease or disorder of the eye or ear (other than minor defects corrected by spectacles, lenses) eg iritis, glaucoma, optic neuritis, blurred, double vision or hearing loss or tinnitus? No Yes

q. Chronic pain syndrome, fibromyalgia, fibrositis, chronic fatigue syndrome or myalgia? No Yes

r. Have you ever tested positive for HIV, Hepatitis B or Hepatitis C or any sexually transmitted illness, or are awaiting the results of such a test (other than for this application)? No Yes

s. 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? No Yes

t. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result? No Yes

u. Have you in the last five years undergone or have you been advised to undergo any medical investigations or tests (eg colonoscopy, ultrasound, blood test or ECG)? No Yes

v. Have you in the last five years sought treatment from a physiotherapist, chiropractor or massage therapist that you have not already disclosed? No Yes

w. Have you ever been refused cover, offered cover on special terms, ever claimed or received compensation for injury, sickness, or disability or are there any circumstances not already mentioned that may affect the risk relating to the proposed cover? No Yes

x. Are you currently experiencing any symptoms of illness, undergoing counselling, taking medication, or do you have a physical defect or infirmity not already disclosed? No Yes

The following questions are for female applicants only. Male applicants go to 56

y. Have you ever had any complications with pregnancy or childbirth eg ectopic pregnancies or miscarriages, and/or undergone IVF? No Yes

z. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? No Yes

aa. 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? No Yes

bb. Are you currently pregnant?
 No Yes Provide details below
 Due date / /
 Date of expected return to work / /

56 Did you answer "Yes" to any item in question 55?

No Go to next question

Yes Provide details below

If you answered 'Yes' to more than 4 items in question 55 please use photocopies of the next page and attach them to your application.

1 Item

Name of condition or diagnosis

Date this condition commenced / / Date of last symptoms / /

What treatment has been prescribed? (eg medication, physiotherapy, counselling etc). Provide details including frequency of treatment.

Have you undergone any special tests, x-rays, scans etc for this condition?
 No Go to next question
 Yes Provide details below and include copies of any results or reports if available

Are you still receiving any treatment or regular follow ups?
 No Go to next question
 Yes Provide details below

Have you lost any time from work as a result of this condition?
 No Go to next question
 Yes Provide details below

Provide full details below, including, name, address and telephone numbers of anyone consulted for this condition

2 Item

Name of condition or diagnosis

Date this condition commenced / / Date of last symptoms / /

What treatment has been prescribed?
 (eg medication, physiotherapy, counselling etc). Provide details including frequency of treatment.

Have you undergone any special tests, x-rays, scans etc for this condition?
 No Go to next question
 Yes Provide details below and include copies of any results or reports if available

Are you still receiving any treatment or regular follow ups?
 No Go to next question
 Yes Provide details below

Have you lost any time from work as a result of this condition?
 No Go to next question
 Yes Provide details below

Provide full details below, including name, address and telephone numbers of anyone consulted for this condition

3 Item

Name of condition or diagnosis

Date this condition commenced / / Date of last symptoms / /

What treatment has been prescribed?
 (eg medication, physiotherapy, counselling etc). Provide details including frequency of treatment.

Have you undergone any special tests, x-rays, scans etc for this condition?
 No Go to next question
 Yes Provide details below and include copies of any results or reports if available

Are you still receiving any treatment or regular follow ups?
 No Go to next question
 Yes Provide details below

Have you lost any time from work as a result of this condition?
 No Go to next question
 Yes Provide details below

Provide full details below, including name, address and telephone numbers of anyone consulted for this condition

4 Item

Name of condition or diagnosis

Date this condition commenced / / Date of last symptoms / /

What treatment has been prescribed? (eg medication, physiotherapy, counselling etc). Provide details including frequency of treatment.

Have you undergone any special tests, x-rays, scans etc for this condition?
 No Go to next question
 Yes Provide details below and include copies of any results or reports if available

Are you still receiving any treatment or regular follow ups?
 No Go to next question
 Yes Provide details below

Have you lost any time from work as a result of this condition?
 No Go to next question
 Yes Provide details below

Provide full details below, including name, address and telephone numbers of anyone consulted for this condition

57 Provide the names and telephone numbers of your consulting doctors for the past five years

Current doctor

Initials Surname

Practice name and address

Phone number () Years consulted with this doctor

Previous doctor 1

Initials Surname

Practice name and address

Phone number () Years consulted with this doctor

Previous doctor 2

Initials Surname

Practice name and address

Phone number () Years consulted with this doctor

58 Medical authority

Dear Doctor,

I hereby authorise you or any other physician or surgeon or other person in your employ or associated with you to give Macquarie Life Limited or a service provider authorised to act or on behalf of Macquarie Life any information which they may require and which you have acquired in a professional capacity. A photocopy of this authority should be accepted as my personal authority.

Patient's name

Date of birth / /

Signature

Date / /

59 Are you applying for Child Trauma Insurance or Child Cover?

No **Go to 68**

Yes **Go to next question**

60 Details of the children to be insured

Child 1

Name

Sex

Date of birth

Male Female

Relationship to policy owner

Child 2

Name

Sex

Date of birth

Male Female

Relationship to policy owner

Child 3

Name

Sex

Date of birth

Male Female

Relationship to policy owner

Child 4

Name

Sex

Date of birth

Male Female

Relationship to policy owner

Child 5

Name

Sex

Date of birth

Male Female

Relationship to policy owner

61 Do any of the children to be insured have any existing cover with another company?

No **Go to 64**

Yes **Go to next question**

62 Will this cover be discontinued or replaced?

No **Go to next question**

Yes **Go to 64**

63 Give the following details for each child about the existing cover that will continue

Child

Amount of cover

Date of commencement

\$

Company it is held with

Child

Amount of cover

Date of commencement

\$

Company it is held with

Child

Amount of cover

Date of commencement

\$

Company it is held with

Child

Amount of cover

Date of commencement

\$

Company it is held with

Child

Amount of cover

Date of commencement

\$

Company it is held with

64 Do any of the children to be insured have an immediate biological family member (father, mother, sibling) who suffers from OR has suffered from any of the following:

- cancer
- diabetes
- Huntington's disease, or
- heart disease
- any kidney disorder
- any other genetic/hereditary disease.

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).

No **Go to 66**

Yes **Go to next question**

65 Please provide details about any of the conditions above in respect of the immediate biological family member

Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
Relationship to family member				
<input style="width: 100%;" type="text"/>				
Type of disease which family member suffers				
<input style="width: 100%;" type="text"/>				

Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
Relationship to family member				
<input style="width: 100%;" type="text"/>				
Type of disease which family member suffers				
<input style="width: 100%;" type="text"/>				

Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
Relationship to family member				
<input style="width: 100%;" type="text"/>				
Type of disease which family member suffers				
<input style="width: 100%;" type="text"/>				

Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
Relationship to family member				
<input style="width: 100%;" type="text"/>				
Type of disease which family member suffers				
<input style="width: 100%;" type="text"/>				

Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
Relationship to family member				
<input style="width: 100%;" type="text"/>				
Type of disease which family member suffers				
<input style="width: 100%;" type="text"/>				

66 Have any of the children to be insured ever had or currently have:

66.1 any disorder of the heart or blood vessels?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.2 cancer, cyst, lesion or tumour of any kind?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.3 diabetes or any other endocrine disorder?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.4 severe asthma or any other ongoing lung disease?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.5 epilepsy, fainting attacks or fits of any type?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.6 any blood disorder eg anaemia, haemophilia?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.7 any physical defect or major injury?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.8 any loss of hearing, speech or vision?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.9 any disorder of the kidneys or bladder?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.10 any disorder of the stomach, bowels, liver or pancreas?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.11 any form of incapacity, mental or developmental issue?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66 continued

66.12 any ongoing disorder of the brain or nerves?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.13 undergone or had advice to undergo any surgical procedure?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.14 a reactive blood test to the HIV or Hepatitis B or C virus?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

66.15 ongoing medical treatment for any condition not listed above?

Child 1	Child 2	Child 3	Child 4	Child 5
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

67 Did you answer "Yes" to any question in question 66?

No *Go to next question*

Yes Provide the following details for each 'Yes' answer

- date of diagnosis
- treatment
- treating doctor
- any other information about the disease and/or treatment that you believe is relevant.

If there are more than 2 conditions, please use photocopies of this page and attach them to your application.

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

67 continued

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

Item <input type="checkbox"/>	Diagnosis	<input type="text"/>
Child <input type="checkbox"/>		<input type="text"/>
Date of diagnosis	<input type="text"/>	<input type="text"/>
Treating doctor	<input type="text"/>	
Any other relevant information	<input type="text"/>	

68 Declaration of person to be insured

Information disclosed

- I acknowledge that I have read and understood my duty of disclosure, as set out on page 1 of this application and in the PDS, in respect of the above and the declaration of health.
- I declare that the answers to the preceding questions are true and complete 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 this 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 a non-disclosure, misrepresentation or fraud.
- 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, and if applying for Child Trauma Insurance from any doctor consulted by the child(ren) to be insured, any time before or during the assessment for this application or during the term of any policy issued by Macquarie Life. I authorise the giving of such information during the application process and the term of any policy issued.
- 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. This excludes the release of any reports sourced by Macquarie Life from any outside parties.

(You can instruct us not to supply your adviser with medical information received by us by ticking this box).

Person to be insured

Name and title

Signature (Please sign in black ink)

Date

68 continued

Child Trauma policy owner(s) – only to be completed if applying for Child Trauma

Name and title

Signature (Please sign in black ink)

Date

Child Trauma policy owner(s) – only to be completed if applying for Child Trauma

Name and title

Signature (Please sign in black ink)

Date

Adviser details

Please sign and date the form subject to the following declarations:

- I am legally entitled to advise on insurance matters.
- The applicant has been provided with the relevant PDS.
- The duty of disclosure has been explained to the applicant and, if different, the person to be insured.
- Details of adviser remuneration, including any rebates, are indicated on the quote attached to this application under 'Office use'.
- I understand the Adviser Remuneration type can be selected for a quote and/or rebates applied by clicking on the Adviser Remuneration icon on the Macquarie Life Quick Quote. Changes to instructions on Adviser Remuneration are only valid when provided to Macquarie Life before an application is approved and a policy is issued.
- I understand special conditions or restrictions may apply to adviser remuneration where the person to be insured is within five years of the maximum entry age for the insurance they are applying for as set out in the Macquarie Life Adviser Guide.

Adviser code

Adviser name

Dealer code

Dealer name

Adviser signature

Medical requirements to be organised by adviser?

No

Yes

Preassessment reference number (if applicable)

When you have finished




Please submit this signed application and the quote immediately to Macquarie Life.

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.

Macquarie Life

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

Claims

-  **Freecall** 1800 208 130
-  **Fax** 1800 065 145
-  GPO Box 4443 SYDNEY NSW 2001
-  insuranceclaims@macquarie.com

FORWARD thinking

