

Macquarie Life application

Policy Administration



This form can be used when requesting changes to insurance cover for an existing FutureWise, Macquarie Life Active, Macquarie Sumo or Super Protector policy. Please use the New Business Application form if adding a new type of insurance or a new option.

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 your 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).

Filling in this application

Please use black ink and mark boxes like this with an X.

The policy number must be completed at ALL times.

No policy change will be implemented without the signature of the owner unless a client authority has been signed authorising the adviser to effect changes. Product changes (Section I) and policy status changes (Section F) require the signature of the policyholder. If medical questions are completed, the signature of the insured person will be required at all times. This form will only be accepted for any increases if accompanied by a signed quotation.

Complete only the relevant question(s).

A. Personal Details

1 Policy number

2 Provide the effective date of change (if applicable)

3 Details of insured person

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Sex

Male Female

Date of birth

4 Is there a change to your marital status?

No Go to next question

Yes Provide details below

5 Is there a change to your name?

No Go to next question

Yes Provide details below and attach a certified copy of the relevant document showing the change of name eg marriage certificate

6 Are there any changes to your contact details?

No

Yes Provide details below

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

Street number and name

Suburb/Town

State

Postcode

Mailing address (PO Box is acceptable)

Street number and name

Suburb/Town

State

Postcode

Home phone number

Work phone number

Mobile phone number

Fax number

Email address

7 What type of change(s) do you wish to make to your policy?
Mark all that apply and then only complete the relevant sections.
Complete the relevant declarations on page 16.

Mark all that apply

Adviser Details Section B

Beneficiary Details Section C

Non-smoker Premium Rates Section D

Occupation Category Section E

Premium Details Section F

Loadings or Exclusions Details Section G

Apply to increase sum insured/
cover amount or for disability
income insurance: decrease your
waiting period or increase your
benefit period (but not including
benefit period to age 70) Section H

B. Adviser Details

8 I hereby appoint the adviser mentioned below as my new financial adviser.

This change will remove the previously appointed adviser.

Adviser name

Adviser code

Dealer name

Dealer code

Signature of policy owner (Please sign in black ink)

C. Beneficiary Details

9 Complete question 9 if:

- you are the insured person and sole owner of the policy, or complete question 10 if:
- you are a member of the insurance-only division of the Macquarie Superannuation Plan and wish to provide the Trustee with a new nomination.

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
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
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"/> %

10 For members of the insurance-only division of the Macquarie Superannuation Plan only

Name

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

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

Name

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

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

Total benefit (must add up to 100%) %

Signature of FutureWise or Active policy owner **ONLY**. Go to next question if nominating a superannuation beneficiary. (Please sign in black ink)

Name

Relationship

Percentage of benefit* %

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

Name

Relationship
 Spouse Child Interdependant Other Dependant

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

Name

Relationship
 Spouse Child Interdependant Other Dependant

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

Name

Relationship
 Spouse Child Interdependant Other Dependant

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

Name

Relationship
 Spouse Child Interdependant Other Dependant

Sex
 Male Female

Date of birth
 / /

Percentage of benefit %

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

Signature of member (Please sign in black ink)

Declaration date

Witness 1

Name of witness 1

Signature of witness 1 (Please sign in black ink)

This application was signed by the applicant before me and on the date indicated above as the declaration date.

Witness 2

Name of witness 2

Signature of witness 2 (Please sign in black ink)

This application was signed by the applicant before me and on the date indicated above as the declaration date.

D. Non-smoker Premium Rates

Use Section D if you are applying to change from smoker to non-smoker premium rates.

11 Have you smoked in the last 12 months?

No Go to next question

Yes Specify the quantity and type smoked per day

12 Non-smoker's declaration

I declare that I have not smoked tobacco in any form during the past 12 months and have no intention of smoking tobacco at any time in the future.

Signature of life insured (Please sign in black ink)

E. Occupation Category

Use section E to apply to change your occupation category.

13 What occupation category are you applying to change to? Your adviser will be able to tell you this.

14 Give details of the change being made to your education, occupation or income.

Highest educational qualifications

Less than year 12

Year 12 or equivalent/IB Diploma

Tertiary degree

Professional

Trade qualified

Your gross annual income

Your current occupation

How long have you been in your current occupation?

The industry you work in

Your employer

What proportion of time is spent on the following now?

Administration – % of time

Supervision – % of time

Manual – % of time

Travel – % of time

Total duties
(must add up to 100%) %

F. Premium Details

- 15 Which premium structure is required at the next policy anniversary for the following products?

Please only mark the relevant section.

FutureWise – Life

Premium type now required Stepped Level

FutureWise – Trauma

Premium type now required Stepped Level

FutureWise – TPD

Premium type now required Stepped Level

FutureWise – Disability Income

Premium type now required Stepped Level

Active – Death Cover and Health Events cover

Premium type now required Stepped Level

Active – Income Cover

Premium type now required Stepped Level

Super Protector – Life

Premium type now required Stepped Level

Super Protector – TPD

Premium type now required Stepped Level

Super Protector – Disability Income

Premium type now required Stepped Level

- 16 How should future premiums be paid?

Monthly



An additional loading of up to 8% may apply on monthly premiums compared to annual premiums.

Annually

- 17 Would you like to change the regular date on which premiums are deducted from your nominated account?

No 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 20

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

- 19 **Direct debit authority:** 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 on page 18 of this application form.

(All signatories if joint account)

Signature 1

Name

Date

Signature 2

Name

Date

Signature 3

Name

Date

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

No

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"/>	<input type="text"/>	
Credit card authority: 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.		
Signature		
<input type="text"/>		
Name	Date	
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

G. Loadings or Exclusions

21 If requesting a review of loadings, provide details below and attach appropriate information



22 If requesting a review of exclusions, provide details below and attach appropriate information



H. Product Changes

23 Are you applying for an increase to a Super Protector policy?

No Go to next question

Yes Please state the amount by which you want to increase your sum insured or cover amount (do not include the existing amount of cover)

Life \$

TPD \$

Disability Income \$

24 Please read this BEFORE completing Section I.



For any product changes, please attach a quote and complete the following section. For the addition of a new benefit type or new option, please complete a New Business Application form.

For any decreases in benefits, the following section does not need to be completed.

Occupational and financial details

25 What is your highest educational qualification?

Less than year 12

Year 12 or equivalent/IB Diploma

Tertiary degree

Professional

Trade qualified

26 What is your current occupation?

27 What is the industry you currently work in?

28 Who is your current employer?

29 How many hours do you work per week?

30 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%) %

31 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

32 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

33 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?

34 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)

 / /

35 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) for the last three financial years. Also state what percentage of your income is superannuation contributions.

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

For self-employed

State your annual income from personal exertion (after deducting business expenses, but before tax and superannuation contributions). Also state what percentage of your income is superannuation contributions.

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

36 Are there any other occupations you are, or may become involved in?

No Go to next question

Yes Provide details below

37 Are you applying for a change to Disability Income and/or Business Expenses Insurance?

No Go to 56

Yes Go to next question

38 Are you self employed or do you own any part of the business you are working in?

No **Go to 56**

Yes What type of structure

Sole trader

Partnership

Contractor

Other Provide details below

39 How long have you been self employed or owned your own business?

Less than 12 months

More than 12 months

40 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**

41 Has there been a deterioration in the performance (profitability) of your business during this financial year?

No **Go to next question**

Yes Please provide details and reasons

42 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**

43 How many owners or partners does your business have?

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

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

No **Go to next question**

Yes Provide details below

46 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

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

48 Do you work from home?

No **Go to next question**

Yes **Go to 50**

49 Business address

Street number and name

Suburb/Town

State

Postcode

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

 %

51 Is an income splitting amount paid to your spouse?

No **Go to next question**

Yes How much?

 \$

52 Only complete questions 52 to 55 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	\$	<input type="text"/>
Interest payments on business loans	\$	<input type="text"/>
Leasing of office equipment or motor vehicles	\$	<input type="text"/>
Salaries of employees not involved directly in revenue generation	\$	<input type="text"/>
Payroll tax for employees not involved directly in revenue generation	\$	<input type="text"/>
Superannuation contribution for employees not involved directly in revenue generation	\$	<input type="text"/>
Electricity, gas and water	\$	<input type="text"/>
Telephone	\$	<input type="text"/>
Business insurance premiums (excluding this policy)	\$	<input type="text"/>
Locum cover (less earnings generated by locum)	\$	<input type="text"/>
Regular advertising	\$	<input type="text"/>
Fees for professional associations	\$	<input type="text"/>
Printing postage and stationery	\$	<input type="text"/>
Property rates	\$	<input type="text"/>
Bank fees and charges	\$	<input type="text"/>
Cleaning costs	\$	<input type="text"/>
Other expenses	\$	<input type="text"/>
TOTAL EXPENSES	\$	<input type="text"/>

53 Did you indicate an amount for 'Other expenses' in question 52?

No Go to next question

Yes Describe the other expenses

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

%

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

%

Existing insurance cover

56 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			
<input type="checkbox"/> Life	<input type="checkbox"/> TPD	<input type="checkbox"/> Trauma	<input type="checkbox"/> Disability <input type="checkbox"/> Active
Insurer <input type="text"/>			
Sum insured		Start date	
\$ <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
Do you intend to cancel this cover? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Disability covers only:	Waiting period	<input type="text"/>	Benefit period <input type="text"/>

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

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

57 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

58 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

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

No *Go to next question*
 Yes **Go to 61**

60 Do you intend to reside in Australia permanently?

No Provide full details and reasons for this insurance.

Yes *Go to next question*

61 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

62 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 66**
 Yes Provide details of activity, frequency and any qualifications you might hold.

63 Have you listed amateur football in question 62?

No **Go to 66**
 Yes *Go to next question*

64 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

65 Would you accept an exclusion, if any of the activities you have described in question 62 (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

66 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

67 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

68 Do you consume alcohol?

- No *Go to 70*
 Yes *Go to next question*

69 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)

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

- No *Go to next question*
 Yes Provide details below

71 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

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

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

74 Has your weight changed by more than 10kgs in the last 12 months?

- No *Go to 76*
 Yes *Go to next question*

75 Was this change due to healthy lifestyle changes?

- No *Provide details below*

- Yes *Go to next question*

Family medical history

76 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"/>

77 Did you answer “Yes” to any item in question 76?

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

Family member	<input type="text"/>	Age of diagnosis	<input type="text"/>
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Personal medical history

78 Have any of your natural parents or siblings suffered or died from any of the following conditions before the age of 60?

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 apnoea, 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, eg 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"/>
p. Any disease or disorder of the ears or eyes (other than minor defects corrected by spectacles, lenses) eg iritis, glaucoma, optic neuritis, strabismus, blurred or double vision or hearing loss or tinnitus?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
q. Chronic pain syndrome, fibromyalgia, fibrositis, chronic fatigue syndrome or myalgia?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	Yes <input type="checkbox"/>
t. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	Yes <input type="checkbox"/>

v. Have you in the last five years sought treatment from a physiotherapist, chiropractor or massage therapist that you have not already disclosed?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	Yes <input type="checkbox"/>

**The following questions are for female applicants only.
Male applicants go to 79**

y. Have you ever had any complications with pregnancy or childbirth eg ectopic pregnancies or miscarriages, and/or undergone IVF?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
z. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
aa. Have you ever had any symptoms of or sought advice or treatment for any condition of the cervix, ovary, uterus, fallopian tubes, breast or endometrium?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
bb. Are you currently pregnant?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide details below	
	Due date	<input type="text" value=" / /"/>
	Date of expected return to work	<input type="text" value=" / /"/>

79 Did you answer “Yes” to any item in question 78?

No *Go to next question*

Yes If you answered ‘Yes’ to more than 4 items in question 78 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

79 continued

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 questionYes 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 questionYes Provide details below

Have you lost any time from work as a result of this condition?

No Go to next questionYes 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 questionYes 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 questionYes Provide details below

Have you lost any time from work as a result of this condition?

No Go to next questionYes Provide details below

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

80 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
 ()

81 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
 / /

82 Declaration of insured person and policy owner

Information disclosed

- I acknowledge that I have read and understood my duty of disclosure, as set out on page 1 of this application, 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 on page 17 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 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).**

Insured Person to make declaration if sections D, E, G or H of this application form have been completed.

Name and title

Signature (Please sign in black ink)

Date
 / /

Policy Owner

Name and title

Signature (Please sign in black ink)

Date
 / /

Policy Owner

Name and title

Signature (Please sign in black ink)

Date

Policy Owner

Name and title

Signature (Please sign in black ink)

Date

Adviser use only

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

- I am legally entitled to advise on insurance matters.
- The duty of disclosure has been explained to the applicant and, if different, the person to be insured.

Adviser name

Adviser code

Dealer name

Dealer code

Adviser signature

When you have finished

Please submit this signed application immediately to Macquarie Life.

Privacy

Your privacy and that of the insured person, is important to Macquarie Life and the Trustee. This statement explains how personal information can be used or disclosed and provides information about your privacy rights.

By completing the application you and the person to be insured agree to allow Macquarie Life (and, if you are a member of a plan for which MIML is trustee, the Trustee) to use the personal information of you and the person to be insured to:

- assess and process the application for insurance
- communicate with you and your nominated adviser about the application and any cover Macquarie Life supplies to you, monitor, audit, evaluate and otherwise administer your policy, and
- assess, process and investigate any claims.

Other than for the purposes set out in this document, we will not share sensitive, health or financial information. However, we, or other Macquarie companies, may contact you to offer other products or services which may be of interest to you. If you do not wish that to occur please let us know by contacting us.

If you, or the person to be insured, do not supply Macquarie Life and the Trustee with the personal information requested, Macquarie Life may not be able to provide the cover applied for.

Health information

The references in this Privacy Statement to personal information include sensitive information such as medical and health related details of the person to be insured. If required to assess your application, administer your policy or process any claims, Macquarie Life (and, if you are a member of a plan for which MIML is trustee, the Trustee) may seek further information from any medical attendant consulted by the insured person.

Disclosure of personal information

You and the person to be insured also agree that other companies in the Macquarie Group and our external service providers (including for example, reinsurers and mailing houses) may access personal information when appropriate to assess your application, administer your policy or process any claims.

Macquarie Life and the Trustee may also disclose the personal information of you and the person to be insured:

- if acting in good faith, we believe that the law requires or permits us to do so
- if you or the person to be insured consent, or
- to the doctor identified in the application of the person to be insured in the event that any medical tests that we have requested return an abnormal result.

The personal information will also be provided to your adviser in connection with the application for insurance and on-going management of your policy. 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 any medical information received by us in the declaration that forms part of your application, or by writing to us.

Your rights and responsibilities

If you do not supply all of the personal information requested, Macquarie Life may not be able to provide you with the cover for which you apply. You also have a duty of disclosure (explained on page 1 of this application form) under the Insurance Contracts Act.

Under the Privacy Act, you may request access to your personal information held by Macquarie Life (and, if you are a member of a plan for which MIML is trustee, the Trustee).

You can contact us to make such a request or for any other reason relating to the privacy of your personal information. Contact details as shown on page 18 of this application form.






Direct Debit Service Agreement

Where you have elected to have your premium deducted from your account by direct debit, you agree to the terms detailed below.





1. I/we have requested Macquarie Life Limited, ABN 56 003 963 773 AFSL No. 237497, (User ID 145096) to deduct my nominated account with:
 - any amounts that become payable in relation to my policy, or
 - any amount needed to cover contributions to the insurance-only division of the Macquarie Superannuation Plan, through the BECS (Bulk Electronic Clearing System).
2. The financial institution may, in its absolute discretion, at any time by notice in writing to me terminate this request as to future debits.
3. Macquarie Life may, by notifying me within 14 days, vary the timing of future debits.
4. Where the due date does not fall on a business day and I am uncertain whether sufficient cleared funds will be available to meet the direct debit, I will contact my financial institution directly and ensure that sufficient cleared funds are available.
5. I can modify or defer this regular Direct Debit Request at any time by giving Macquarie Life 14 days notice.
6. I can stop or cancel the regular Direct Debit Request at any time by giving Macquarie Life or my financial institution 14 days notice.
7. If at any time I feel that a direct debit against my nominated account is inappropriate or wrong it is my responsibility to notify Macquarie Life or my financial institution as soon as possible.
8. If I believe there has been an error in debiting my account, I will notify Macquarie Life or my financial institution and confirm that notice in writing with Macquarie Life as soon as possible.
9. Direct debiting through BECS is not available on all accounts. I can check my account details against a regular statement or check with my financial institution as to whether I can request a direct debit from my account.
10. It is my responsibility to ensure that there are sufficient cleared funds in my nominated account to honour the Direct Debit Request. I understand that the Direct Debit Request will be automatically cancelled if two debit payments are dishonoured because of insufficient funds. Macquarie Life will give me 14 days notice in writing if they intend to cancel my Direct Debit Request. Macquarie Life will also charge the cost of dishonoured direct debits against my account. Macquarie Life may cancel my cover if the Direct Debit Request is cancelled because of dishonours.
11. It is my responsibility to ensure that the authorisation given to debit the nominated account is identical to the account signing instruction held by the financial institution where the account is held.
12. Macquarie Life may need to pass on details of my direct debit request to their sponsor bank in BECS to assist with the checking of any incorrect or wrongful debits to my nominated account.

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** 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

