

Macquarie Sumo Application

For use with the Macquarie Sumo PDS dated 21 May 2011.



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 (i.e. for underwriting purposes).

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* (Cth), 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.

Filling in this application

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

1 Please read this before answering the question

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

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.

Have you obtained a quote showing cover being applied for under each policy and premium? This quote forms part of the application.

No

 Please obtain a quote and attach it to this application.

Yes

 Attach the quote to this application.

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 Macquarie Sumo 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, or where the premium for this application exceeds certain thresholds, as set out in the Macquarie Life Adviser Guide.

Adviser code	<input type="text"/>	Adviser name	<input type="text"/>
Dealer code	<input type="text"/>	Dealer name	<input type="text"/>
		Adviser signature	<input type="text"/>

Medical requirements to be organised by adviser?

No

Yes

Preassessment reference number (if applicable)

When you have finished

Please submit this signed application immediately to Macquarie Life. Please ensure the quote is attached.

Form A: Non-superannuation ownership

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** 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

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

 @

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.

No Go to next question

Yes Provide details below

The total of percentages must be 100%

Name	<input type="text"/>		
Relationship	<input type="text"/>	Gender	<input type="text"/>
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="text"/>	Gender	<input type="text"/>
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="text"/>	Gender	<input type="text"/>
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="text"/>	Gender	<input type="text"/>
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="text"/>	Gender	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Percentage of benefit	<input type="text"/> %

Total benefit (must add up to 100%) %

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 e.g. 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

Direct debit from Macquarie Investment Manager, Investment Accumulator or Investment Consolidator account	<input type="checkbox"/> Account number <input type="text"/>
Direct debit from bank account	<input type="checkbox"/> Please 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	Date
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Signature 2	
<input type="text"/>	
Name	Date
<input type="text"/>	<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"/>	
Expiry date	<input type="text"/> / <input type="text"/>	
Name on card	<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"/> / <input type="text"/> / <input type="text"/>	

20 Declaration of applicant(s)

Information disclosed

- I have received the Macquarie Sumo PDS dated 21 May 2011 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 2 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 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 acknowledge that policies issued under Macquarie Sumo 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.

20 continued

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.

Applicants

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

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

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

Form B: Self managed superannuation fund ownership

Use **Form B** 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.

1 Policy owner details

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

Trustee name(s)

Name of superannuation fund

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 e.g. 1st, 15th

--

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

--

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"/>	<input type="text"/>	<input type="text"/>
Expiry date	Name on card	
<input type="text"/> / <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"/>	

5 Declaration of applicant(s)

Trustee declaration

- I am a trustee, or a director of the trustee, of the fund and I am authorised by the trustee 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 and policy.

Information disclosed

- I have received the Macquarie Sumo PDS dated 21 May 2011 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 2 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 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 and Superannuation Optimiser as set out in the PDS.
- I acknowledge that policies issued under Macquarie Sumo 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.

5 continued

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

Form C: 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 Contact details

Residential address. **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

@

3 What is your highest educational qualification?

Less than year 12

Year 12 or equivalent/IB Diploma

Tertiary degree

Professional

Trade qualified

Occupational and financial details

4 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	\$	%
Last financial year		
Year ending 30/06/20__	\$	%
Year before last		
Year ending 30/06/20__	\$	%

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	\$	%
Last financial year		
Year ending 30/06/20__	\$	%
Year before last		
Year ending 30/06/20__	\$	%

5 What is your current occupation?

6 What is the industry you currently work in?

7 Who is your current employer?

8 How many hours do you work per week?

9 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%)

10 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

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

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

13 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

14 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?

15 Are you applying for Disability Income Insurance?

- No *Go to 30*
Yes *Go to next question*

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

- No *Go to 30*
Yes What type of structure

- Sole trader
Partnership
Contractor
Other Give details below

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

18 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*

19 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

20 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*

21 How many owners or partners does your business have?

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

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

No Go to next question

Yes Provide details below

24 Do you receive or expect to receive net income from other sources (e.g. 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

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

26 Do you work from home?

No Go to next question

Yes Go to 28

27 Business address

Street number and name

Suburb/Town

State

Postcode

28 What percentage of the business income do you personally generate? %

29 Is an income splitting amount paid to your spouse?

No Go to next question

Yes How much?

\$

Existing insurance cover

30 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

Insurer

Sum insured \$

Do you intend to cancel this cover? Yes No

Disability covers only Waiting period Benefit period

Existing insurances

Cover type Life TPD Trauma Disability

Insurer

Sum insured \$

Do you intend to cancel this cover? Yes No

Disability covers only Waiting period Benefit period

Existing insurances

Cover type Life TPD Trauma Disability

Insurer

Sum insured \$

Do you intend to cancel this cover? Yes No

Disability covers only Waiting period Benefit period

31 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

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

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

Insurer

Sum insured \$

Do you intend to cancel this cover? Yes No

Disability covers only Waiting period Benefit period

Further information

32 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
<input type="text"/>	(<input type="text"/>) <input type="text"/>

Residency and travel

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

- No *Go to next question*
Yes **Go to 35**

34 Do you intend to reside in Australia permanently?

- No Provide full details and reasons for this insurance.

- Yes *Go to next question*

35 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

36 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 40**
Yes Provide details of activity, frequency and any qualifications you might hold.

37 Have you listed amateur football in question 36?

- No **Go to 39**
Yes *Go to next question*

38 If you are applying for Disability Income Insurance 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

39 Would you accept an exclusion, if any of the activities you have described in question 36 (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

40 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

41 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

42 Do you consume alcohol?

No *Go to 44*

Yes *Go to next question*

43 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)

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

No *Go to next question*

Yes Provide details below

45 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

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

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

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

No *Go to 50*

Yes *Go to next question*

49 Was the weight change of more than 10kgs in the last 12 months due to dietary factors or healthy lifestyle changes?

No Provide details below

Yes *Go to next question*

Family medical history

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

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

51 Did you answer "Yes" to any item in question 50?

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

52 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 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 slipped disc, sciatica, 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 complaint, e.g. anxiety, depression, stress, insomnia, nervous breakdown, panic attacks, schizophrenia, post-natal depression, eating disorders or suicide attempt?	No <input type="checkbox"/> Yes <input type="checkbox"/>
f. Any endocrine disorder, e.g. diabetes, 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, e.g. 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 (e.g. 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"/>

52 continued

p. Any disease or disorder of the ears or eyes (other than minor defects corrected by spectacles, lenses) e.g. 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 in the last five years undergone or have you been advised to undergo any medical investigations or tests (e.g. genetic test, colonoscopy, ultrasound, blood test or ECG)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
u. 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"/>
v. 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"/>
w. 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 53

x. Have you ever had any complications with pregnancy or childbirth e.g. ectopic pregnancies or miscarriages, and/or undergone IVF?	No <input type="checkbox"/> Yes <input type="checkbox"/>
y. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	No <input type="checkbox"/> Yes <input type="checkbox"/>
z. 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"/>
aa. 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=" / /"/>

3 Item

Name of condition or diagnosis

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

What treatment has been prescribed? (e.g. 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? (e.g. 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

54 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
 ()

55 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
 / /

56 Are you about to undertake, or have undertaken in the last 12 months, a full executive medical health check (other than for this application)?

- No *Go to next question*
- Yes If you answered yes we may contact you to discuss authorising the release of the test results for confidential use in the underwriting process, which may enable you to avoid repeating some or all of the required medical tests.

57 Please read this before answering the question

Macquarie Life may need to request additional information relating to your financial circumstances from the person(s) you name below.

On the express understanding that Macquarie Life may only use this information in connection with your application and in accordance with the Privacy Statement as explained in the PDS, by answering "Yes" to the question, you consent to Macquarie Life:

- contacting the person(s) directly to obtain relevant financial information relevant to my application;
- obtaining original or copies of the relevant financial information;
- sharing that information with our external service providers when appropriate to assess my application;
- retaining that relevant financial information for so long as we reasonably need it.

Do you consent to Macquarie Life Limited seeking relevant financial information in connection with this application from the person(s) named below?

Yes

Name

Company

Address

Phone number
 ()

Name

Company

Address

Phone number
 ()

58 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 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).

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

This document is current as at 21 May 2011 and is issued by Macquarie Life Limited (Macquarie Life) ABN 56 003 963 773 AFSL 237 497 (“we”, “us”, “our” or “Macquarie” as the context requires). Macquarie Life is not an authorised deposit-taking institutions for the purposes of the Banking Act (Cth) 1959, and Macquarie Life’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.

Macquarie Life



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FORWARD thinking

