



This application form is dated 19 September 2011.

Instructions for the completion of this form

Section A

Is to be completed in all cases by the life to be insured.

Section B

Is to be completed by the life to be insured if applying to reinstate an income insurance plan.

Section C

Is to be completed by the life to be insured and the Plan owner in all cases. Provided six months has not passed since the 'date paid to' the plan may be reinstated subject to completion of sections A, B and C and back payment of one installment premium.

The life to be insured will be reinstated with the insurance product they had previously.

In the event that the life to be insured is applying to reinstate a Life Insurance Superannuation Plan or Income Insurance Superannuation Plan, the life to be insured is applying for reinstatement of membership within the Superannuation Fund, and the Trustee will apply to the insurer for reinstatement of the insurance cover.

Important notice – your duty of disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter you know, or could reasonably be expected to know, that 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 life 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 the insurer knows or, in the ordinary course of business, ought to know
as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure (or make a misrepresentation to us) and we would not have entered into the contract on any terms if you had complied with your duty of disclosure (or made no misrepresentation to us), we may avoid the contract within three years of the commencement date.

An insurer who is entitled to avoid a contract of life insurance may, within three years of the commencement date, elect not to avoid it but to reduce the sum 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 matter to the insurer.

Privacy – use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA. The purpose of collecting your information is to assess your application for insurance.

In assessing your application for insurance, we may need to disclose your personal information to other parties, such as reinsurers, medical and financial professionals, judicial or dispute resolution bodies and other AXA Group companies.

In the future, we may contact you about new products or special offers. If, at any time, you do not want to receive this information you can opt out by telephoning 132 987 and quoting your plan number.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

For our policy on privacy refer to www.axa.com.au or contact AXA Customer Service on 132 987.

Section A

This section is to be completed in all cases by the life to be insured

Plan number(s)

Empty text box for Plan number(s)

Details of life to be insured

Mr Mrs Miss Ms Other - please specify []

Surname (please print)

Given name(s)

Date of birth

Empty text boxes for Surname, Given name(s), and Date of birth

This application form is dated 19 September 2011.

The issuer of all plans except the Life Insurance Superannuation Plan and the Income Insurance Superannuation Plan is The National Mutual Life Association of Australasia Limited ABN 72 004 020 437 AFS Licence No. 234649

The issuer of the Life Insurance Superannuation Plan and the Income Insurance Superannuation Plan is N.M. Superannuation Proprietary Limited ABN 31 008 428 322 AFS Licence No. 234654, Trustee of both the

Super Directions Fund ABN 78 421 957 449 and the Wealth Personal Superannuation and Pension Fund ABN 92 381 911 598

Application for reinstatement (continued)

Contact details

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

Daytime phone number ()	Hours you can be contacted	After hours phone number ()	Hours you can be contacted
Mobile phone number	Hours you can be contacted	Email address	

Other policies and benefits

- 1 Other than this application are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company**? Note: This includes benefits under superannuation, business or credit insurance or benefits provided by an employer.

No Yes If yes, please provide details:

Name of company	Type of cover	Sum insured	Date commenced	To be replaced?
			/ /	<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /	<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /	<input type="checkbox"/> No <input type="checkbox"/> Yes

- 2 Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way?

No Yes If yes, please provide full details including reason, date, company name and type of cover:

--

- 3 Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings?

No Yes If yes, please provide details:

Company/benefit type	Reason	Benefit amount	Date
			/ /
			/ /
			/ /

Sports and pastimes

- 4 Do you engage in or intend to engage in any of the following: aviation (other than as a fare paying passenger), underwater diving, motor sports, mountaineering, power boat racing, hang gliding, boxing, non-competitive motorcycling, trail bike riding, football, martial arts, parachuting or any other hazardous pursuits?

No Yes If yes, please give details:

--

- 5 Do you wish to be covered for the sports and pastimes activities you have disclosed in this application?

No Yes (Note: This is subject to approval by AXA underwriting)

Occupation

- 6 Please give details of your current occupation including your job title, duties and the industry you work in:

Job title	Industry

Duties

--

- 7 How many hours per week do you spend at your principal occupation? Number of hours

- 8 Do you intend to change your occupation? No Yes If yes, please provide details below:

--

Application for reinstatement (continued)

Health

9 What is your: Height: cm/ft Weight: kg/st

10 Do you smoke or have you smoked in the last 12 months? No Yes
 If yes, please provide details including type/substance and how many smoked per day

11 Since your plan commenced have you had any medical examination, advice or treatment, any surgical operation, x-ray, electrocardiograph, blood tests (eg cholesterol, HIV/AIDS, hepatitis, anaemia) or any other test or investigation?
 No Yes If yes, please give details of each instance:

Date	Name and address of doctor/hospital	Details
/ /		
/ /		
/ /		

12 Since your plan commenced have you had any sickness, injury or disorder that you have not mentioned above?
 No Yes If yes, please give details:

Date	Name and address of doctor/hospital	Type of sickness or injury
/ /		
/ /		
/ /		

13 Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery?
 No Yes If yes, please provide name of doctor, date of consultation if known and condition:

Date	Details
/ /	

14 Name of general practitioner/medical centre

Street number and name Town/Suburb State Postcode

Phone number () How long have you been his/her patient? years

15 Have you ever had, are you currently waiting for a result of, or are you considering having a genetic test? Note: You do not have to provide a result if you were or are taking part in a medical research project or trial and haven't been or will not be provided with your individual result.
 No Yes If yes, please provide full details:

16 Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection?
 (For example, some signs are: unexplained weight loss, swollen glands or persistent diarrhoea.)
 No Yes

17 In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?
 HIV risk situations include, but are not limited to: sex with or as a prostitute, sex with an intravenous drug user, contact with someone else's blood (for example, through injection or scratch with a used needle), anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least three years).
 No Yes

(If you answered yes to Question 16 or 17, we will send you a confidential questionnaire to complete.)

18 Have any of your parents, brothers or sisters suffered from heart disease, stroke, high blood pressure, diabetes, breast cancer, bowel cancer, other cancer, polycystic kidney disease, Huntington's Chorea, inherited blood disease, inherited brain disease, kidney failure, muscular dystrophy, or any inherited disease? Note: You are only required to disclose family history information relating to first degree blood related family members – living or deceased (mother, father, brothers and sisters).
 No Yes If yes, please provide details in the table below:

Direct family member (please state their relationship to you but not their name)	Condition/illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)

Section B

These sections are to be completed by the life to be insured for Income Insurance plans only – for other insurance please go to Section C.

Income

1 What was your income from personal exertion in the last year? Use last financial year (June 30) or specify a more recent period upon which your answer is based.

For self-employed

Only complete this question if you are self-employed. This includes sole traders, partners, contractors or if you are an employee in your own company.

	Less	Equals
Gross income from personal exertion	Business expenses incurred in earning that income	Net income before tax
\$	\$	\$

For employees

Only complete this question if you are an employee and do not have any ownership in your employer's business.

Insurable income \$

If not the last financial year (June 30) please specify the period that these figures relate to: / / to / /

Note: The amount of weekly or monthly benefit for which you are eligible depends on the amount of your net income before tax. For income insurance, the maximum benefit insured shall be no greater than 75 per cent of net income before tax (subject to certain maximums and not including cover for any Superannuation Guarantee Contribution). In the event of a claim, AXA may call for evidence of your income and business expenses. Therefore, please ensure the above figures accurately reflect your financial position for the period that you have indicated.

Other claims

2 Are you, upon disablement, entitled to a pension or other benefit from a superannuation plan or your employer?

No Yes If yes, please give details:

3 Would any income benefit be payable for more than two years?

No Yes If yes, what is the income amount that would continue, for how long, and the source (eg salary, sick pay, company profits, investment, rental)?

4 Have you received unemployment benefits in the past two years?

No Yes If yes, please give details:

Reasons for unemployment	Period of unemployment		
	/ /	to	/ /
	/ /	to	/ /

Section C

This section is to be completed in all cases by the life to be insured and the Plan owner

Declaration

To be completed for all insurance plans

I/We apply for reinstatement of insurance cover under the terms the previous insurance contract was provided.

I/We acknowledge that I/we have read the section headed 'Important notice – your duty of disclosure'.

I/We have read and understood the privacy disclosure statement contained in section headed 'Privacy – use and disclosure of personal information'.

I/We consent to my/our personal information being collected and used in accordance with the privacy disclosure statement.

I/We declare that all answers given are complete and true and I/we understand that the Insurer will be relying on the complete accuracy of the answers when assessing my/our application for reinstatement.

Further, I/we acknowledge that AXA has the right to avoid the reinstated plan if I/we have failed to comply with my/our duty of disclosure (or made a misrepresentation to AXA) and the insurer would not have allowed the policy to be reinstated on any terms if the failure (or misrepresentation) had not occurred.

I/We acknowledge that the Life Insurance Plan will not pay a benefit if death is a result of suicide within 13 months of the reinstatement of this plan.

I/We acknowledge that for those conditions that are listed in my trauma plan document under the heading 'Medical conditions (or Trauma events) subject to a qualifying period', the Insurer will not pay a benefit if the medical condition occurs within 90 days of the date the plan is reinstated.

I/We acknowledge that if I/we are applying for insurance provided through the Life Insurance Superannuation Plan or the Income Insurance Superannuation Plan to be reinstated where N.M. Superannuation Proprietary Limited is the Trustee, I/we are re-applying for membership of the fund, ask N.M. Superannuation Proprietary to seek the reinstatement of insurance cover. I/We acknowledge that if this application is accepted any nomination of dependants will be reinstated. Any binding nomination will expire three years from the date of the original nomination.

To be completed for Life Insurance Superannuation Plan and Income Insurance Superannuation Plan

Signature of life to be insured

Date signed

X

/ /

To be completed for all insurance plans except Life Insurance Superannuation Plan and Income Insurance Superannuation

Signature of Plan owner

Date signed

X

/ /

This page has been left blank intentionally.

Medical authorities

► Please complete ALL medical authorities below because some health professionals prefer an original signature.

Authority to release medical information to AXA

Family name Given name(s) Date of birth
I, / / authorise any medical practitioner, doctor, health professional, hospital, clinic or any other insurer to disclose to the insurer (NMLA trading as AXA and its group of companies), or representatives appointed to collect, the full details of my health and medical history. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of Person to be insured Date signed
 X / /

Authority for AXA to release medical information to usual doctor

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

Family name Given name(s) Date of birth
I, / / authorise NMLA trading as AXA to advise
Doctor of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise AXA to provide copies of the relevant health evidence to the doctor noted above.

Signature of Person to be insured Date signed
 X / /

This page has been left blank intentionally.

Payment authorities

To be completed if you are applying for an insurance plan not paid for out of a North, Summit, Generations or iAccess account. Where a SuperLink plan is applied for and intended to link to North, Summit, Generations or iAccess, relevant payment authorities require completion.

► **Before you complete this page**, please read the terms and conditions of this facility in the Product Disclosure Statement.

Payment method

Select method of payment:

- Direct debit by credit card (please complete option 1 below)
- Direct debit by bank account (please complete option 2 below)
- Receive payment due notices (only available for quarterly, half-yearly and yearly payments)

Option 1: Direct debit by credit card

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

Initial premium deposit: No Yes (note: the premium will be deducted on **acceptance** and completion of this application)

Frequency of ongoing premium deductions (tick one): Fortnightly Monthly Quarterly Half yearly Yearly

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

Credit card type: MasterCard Visa

Credit card number

- - - Expiry date -

Name as shown on credit card

Cardholder's signature

Date signed

X / /

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

You will need to complete a new direct debit authority form or provide the new credit card details over the phone. To do this, please contact our Customer Service Centre on 132 987.

Option 2: Direct debit by bank account

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

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

Initial premium deposit: No Yes (Note: The premium will be deducted on **acceptance** and completion of this application)

Frequency of ongoing premium deductions (tick one): Fortnightly Monthly Quarterly Half yearly Yearly

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

BSB number

Account number

-

Bank/financial institution name

Bank/financial institution branch name

Account in name of (name in full)

If company account ABN (Australian Business Number)

Account holder signature(s)

Signature – account holder 1

Date signed

Signature – account holder 2 (if applicable)

Date signed

X / / X / /