

Life Insurance Plan

# Mortgage Protection: Insurance application form

This application form is effective 19 September 2011



**redefining / insurance**

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Please send the completed application form with a copy of the premium quote to our Customer Service Centre:

AXA Australia  
Customer Service Centre  
PO Box 14330  
MELBOURNE VIC 8001

This application form is available to mortgage protection clients for life cover for sums insured up to \$400,000 (across all plans held with us).

For sums insured above \$400,000, or for total and permanent disability, trauma, income insurance or business expenses or for a superannuation plan, please use the standard insurance application form.

## Who is eligible?

To qualify for Mortgage Protection cover under the Life Insurance Plan you, the person insured, must be aged between 25 to 50 years old and must have:

- a new property mortgage
- an existing property mortgage that has been in force for less than five years, or
- a property mortgage which has been re-financed within the last five years.

The maximum allowable cover is the lesser of:

- \$400,000, or
- the outstanding mortgage amount.

Where cover is required for two mortgagees, the combined maximum allowable cover is the lesser of:

- \$400,000, or
- the outstanding mortgage amount.

An application is required for each mortgagee.

# Important information for applicants

Please read these instructions carefully before starting this application

## Before you start

**This application is for Mortgage Protection under the Life Insurance Plan – ordinary life cover only.**

Before you sign this application form, you should be aware that your adviser or The National Mutual Life Association of Australasia Limited is obliged to have provided you with the Product Disclosure Statement (PDS) and other information relevant to special offers and/or member discounts for the product you are applying for.

The (PDS) contains important information to help you understand the product and to decide whether it is appropriate to your needs.

## We rely on what you tell us

Before we decide to issue a plan, we need to know exactly what the risk is that we are to insure and how likely you would be to make a claim.

## Your duty of disclosure

Before you enter into a contract of life insurance with us, 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, or
- 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 the failure (or misrepresentation) had not occurred, we may avoid the contract within three years of the commencement date. If your non-disclosure (or misrepresentation) is fraudulent, we may avoid the contract at any time.

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 matters to the insurer.

If we allow you to replace an existing contract of insurance\* held with AXA with the same type of cover for the same or lesser amount of insurance, and you were previously underwritten by the insurer, then you are not required to disclose **any further** information relating to any matter that occurred after the commencement of the existing contract.

In entering into the replacement contract of insurance, the insurer will rely on the **information that you previously provided** in relation to the existing contract of insurance. For that reason, the insurer's right in relation to a breach to your duty of disclosure (or misrepresentation made) in relation to the existing policy will be applied to the replacement policy.

## Definitions in this application

**'Person to be insured'** is the person whose life, health or income is to be insured under this application. Most of the questions in this application are about the Person to be insured.

**'Adviser'** refers to the financial adviser who is guiding you to complete this application.

**'Plan owner'** refers to the person who owns the plan. In many cases, the Plan owner is the same person as the Person to be insured. However, a Plan owner can apply to take out insurance on a different person.

**'You'** either refers to the Plan owner under the plan or the proposed Person to be insured, where indicated.

**'We'/'Us'** refers to the underwriter, The National Mutual Life Association of Australasia Limited, trading as AXA Australia. The only exception to this is where you sign declarations, in which case, 'I/We' refers to the proposed Plan owner or the Person to be insured, as indicated.

## How to apply

- 1 Please read the PDS for the Life Insurance Plan.
- 2 Ask your financial adviser to assist you with the details in this application form.
- 3 Use a black pen to complete this application form.
- 4 Provide proof of your loan from your lending institution. This must include details of the outstanding amount of the loan, the commencement date, loan duration and reason for the loan.
- 5 Sign the application form where indicated
- 6 Send your completed application form to your financial adviser:

## Financial adviser contact details

\* All Life Insurance (including Life Insurance Superannuation), Trauma Insurance and Total and Permanent Disability Insurance Plans.

# Application summary

This application form is effective 19 September 2011.

► Before you complete this application:

- If you are applying for a new plan, please read the current Product Disclosure Statement for the Life Insurance Plan.
- If you are altering an existing plan, please refer to your Plan Document for terms and conditions of your plan instead.

Please use a black pen to fill in this application.

## Application details

Date this application signed

Plan/Application number

Plan owner type (tick one)  Individual  Business application

Are you applying for insurance through  Summit  Generations  iAccess

If through Summit, Generations or iAccess please provide your existing client reference number ►

**If you nominate a Summit, Generations or iAccess IDPS account, the plan quoted for will be paid for out of your IDPS cash account. To nominate a Summit, Generations or iAccess IDPS account, you must be authorised to transact on that account.**

Application type (tick one)  AXA Workplace Rewards and/or Family  AXA RACV Rewards

Title	Workplace Rewards name/ Family name/RACV card name	Workplace Rewards number/ Family number/RACV card number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Business rewards  
ABN (for employer/key person/business partner/trustee)

Campaign  New plan  Increase sum insured

Conversion/replace existing plan OR  Continuation option ► Existing Plan number

Add cover  Re-submitted application  Other (provide details in Adviser notes)

Is this plan fee to be waived?  No  Yes ► to which Plan number?

Full name of Plan owner of linked plan

Is there a concurrent application form being submitted?  No  Yes ► to which application?  Business partner(s)  Spouse  Children's Trauma  
 Another AXA product (eg Summit, Generations)  
 Another AXA application on the Person to be insured

Please provide details below:

Name of insured on concurrent application	Date of birth	Plan number/Product name
	/ /	
	/ /	
	/ /	

## Product

Please tick this box confirming you have attached the applicable insurance quote.

### Person to be insured

Is the person to be insured also the:  Plan owner  Payer of insurance premium

Title  Family name (please print)  Given name(s)  Previous name (if applicable)

Gender  Male  Female Marital status  Date of birth  /  /  Country of birth

Occupation title and the industry that the Person to be insured works in

Insurable income in last 12 months \$  (Personal exertion income after expenses but before income tax)

### Residential address of Person to be insured

Street number and name  Town/Suburb  State  Postcode  Country

Home phone number  ( ) Business phone number  ( ) Mobile phone number

Email address

The Person to be insured will need to complete the Life Insurance Plan Application and Signatures section on page 14.

### Address for correspondence

► Only complete this section if different to the residential address of Person to be insured above

Street number and name  Town/Suburb  State  Postcode  Country

### Plan owner(s)

► Only complete this section if Plan owner is different to the Person to be insured

Plan owner is payer of insurance premium (only if not being paid by Person to be insured)

Title	Family name	Given name(s)	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

The Plan owner(s) will need to complete the Signatures section on page 14.

## Product

### Life Insurance Plan

Sum insured

Life Insurance Plan

\$

Premium structure:  Stepped  Level – to age  Level premiums will alter to stepped premiums from age 70. The plan expires at age 99 but if you wish for it to expire earlier, complete the required age in the box.  
 Blended – Blended premiums will alter to stepped premiums from age 60.

The Total instalment and total yearly premiums fields **MUST** be completed for all applications.

### Total instalment and yearly premiums

Including Yearly Plan Fee (if applicable)

Total yearly premium

\$

Total instalment premium

\$

A deposit premium is required. The deposit premium can be paid by cheque\* or credit card. If we do not receive the deposit premium for monthly or fortnightly payment frequencies, we will deduct a deposit of one month's premium from your bank account or credit card on commencement of the policy. For quarterly, half yearly or yearly credit card deductions, the deposit premium may be deducted provided the credit card authority submitted with the application authorises this deduction.

### Payment method

If the Life Insurance Plan is held via Summit, Generations or iAccess, payment will be deducted from your cash account.

If the Life Insurance Plan is not held via Summit, Generations or iAccess, select one payment method and frequency:

Direct payment by cheque\* or credit card (only available for yearly payments)

OR

Direct debit from bank account or credit card:

Fortnightly – initial full month's deposit required

Monthly

Quarterly

Half yearly

Yearly

(Optional) Choose a date for bank account lodgment from 1st to 28th only

Please remember to complete a payment authority for your financial institution on page 13.

\* Cheques should be made payable to AXA Australia.

# Personal details

**Warning: you have a duty to disclose all information relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect information may affect your entitlement to benefits.**

'You' refers to the Person to be insured (unless otherwise indicated).

## Contact details for Person to be insured

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

**Important: Please see page 3 for details of your Duty of Disclosure.**

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

## Insurance details

**Q1** (a) 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:

(b) In the last five years have you, or do you intend in the next 12 months, to claim unemployment benefits?

No  Yes If yes, please provide details:

Benefit type	Date
	/ /

(c) 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 details

**Q2** Have you in the last 12 months, do you currently or do you intend to engage in any hazardous pursuit or pastime? (eg aviation other than as a fare paying passenger, underwater diving, motor racing, motor bike, trail bike riding, rock climbing, hang gliding etc.)  No  Yes

**If you answered Yes to the item above, please provide details in the table below.**

Activity or sport	Location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?	Competitive/ non-competitive
				<input type="checkbox"/> Amateur <input type="checkbox"/> Professional	<input type="checkbox"/> Competitive <input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur <input type="checkbox"/> Professional	<input type="checkbox"/> Competitive <input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur <input type="checkbox"/> Professional	<input type="checkbox"/> Competitive <input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur <input type="checkbox"/> Professional	<input type="checkbox"/> Competitive <input type="checkbox"/> Non-competitive

## Your health details

- Q3** (a) Do you smoke or have you smoked in the last 12 months?  No  Yes
- (b) How many standard drinks containing alcohol do you consume per week on average?  standard glasses per week  
 [standard drink = 1 nip spirits, 100ml wine, 10oz/285ml beer]
- (c) Have you or have you ever used recreational drugs or drugs not prescribed by a doctor?  No  Yes

If you answered Yes to any of the items above, please provide details in the table below.


- Q4** (a) What is your: Height  Weight
- (b) During the last five years (other than for colds, flu or the contraceptive pill), have you attended a doctor, medical centre or other health care professional (eg naturopath, herbalist, etc) for any symptoms, sickness, injury, operation, inherited disorder or blood test?  No  Yes
- (c) During the last five years have you used or are currently using any prescribed or unprescribed, medication, (other than for colds, flu or the contraceptive pill) for any symptoms, sickness, injury or medical condition?  No  Yes
- (d) Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery?  No  Yes

If you answered Yes to any of the items above, please provide details in the table below.

Item No. eg 4(b)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery %
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%

- Q5** 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 other 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 you answered Yes to the item above, 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)

- Q6** (a) 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
- (b) 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?  No  Yes

Note – 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).

'You' refers to the Plan owner (ie The person who has the authority to decide how the benefit is dispersed).

### Nominate beneficiaries

You can choose who and how your death benefit is paid in the event of the death of the Person to be insured.

Do you wish to make a nomination?  No  Yes

Please nominate the beneficiaries to receive the payment of benefits in the table below.

<b>1</b>	Title	First name	Family name	Gender	Date of birth
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input style="width: 40px; text-align: center; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black; font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> / /
	Address <input style="width: 100%; height: 20px;" type="text"/>				
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> ( )	<input style="width: 100%; height: 20px;" type="text"/>		<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> %	
<b>2</b>	Title	First name	Family name	Gender	Date of birth
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input style="width: 40px; text-align: center; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black; font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> / /
	Address <input style="width: 100%; height: 20px;" type="text"/>				
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> ( )	<input style="width: 100%; height: 20px;" type="text"/>		<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> %	
<b>3</b>	Title	First name	Family name	Gender	Date of birth
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input style="width: 40px; text-align: center; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black; font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> / /
	Address <input style="width: 100%; height: 20px;" type="text"/>				
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> ( )	<input style="width: 100%; height: 20px;" type="text"/>		<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> %	
<b>4</b>	Title	First name	Family name	Gender	Date of birth
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input style="width: 40px; text-align: center; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black; font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> / /
	Address <input style="width: 100%; height: 20px;" type="text"/>				
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> ( )	<input style="width: 100%; height: 20px;" type="text"/>		<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> %	
<b>5</b>	Title	First name	Family name	Gender	Date of birth
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input style="width: 40px; text-align: center; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black; font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> / /
	Address <input style="width: 100%; height: 20px;" type="text"/>				
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> ( )	<input style="width: 100%; height: 20px;" type="text"/>		<input style="font-size: small; font-weight: bold; color: gray; vertical-align: middle;" type="text"/> %	
				<b>Total percentage</b>	<input style="width: 60px; height: 20px; border: 1px solid black; font-weight: bold; color: black; vertical-align: middle; text-align: center;"/> 100 %

**Plan owner declaration**

Plan owner name(s)

I/We , the Plan owner(s), nominate the person(s) named below to receive any proceeds that may become payable under this plan, as a result of the death of the Person to be insured.

I understand that:

- payment of benefits will be made on the basis of the latest nomination received in writing by AXA Australia
- if there is no nomination, or the nomination has been revoked, benefits will be paid to the Plan owner (or their estate)
- nominated beneficiaries should seek advice from their taxation adviser regarding the potential taxation implication of any benefit received
- if a nominated beneficiary predeceases the person insured, then that nominated beneficiary's benefit will be paid to the Plan owner (or their estate)
- the Plan owner may vary the nomination at any time by completing a Nomination of Beneficiary form and forwarding it to AXA Australia.

Signature of Plan owner

Date signed

## Medical and financial authorities

### Medical authorities

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

#### Authority to release medical information to AXA

I,  Family name,  Given name(s),  Date of birth ( / / ) 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  X Date signed  ( / / )

#### 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.

I,  Family name,  Given name(s),  Date of birth ( / / ) 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  X Date signed  ( / / )

### Financial authority

► Only complete this section if you want your accountant or financial adviser to release information to AXA.

#### Authority to release financial information to AXA

I,  Family name,  Given name(s),  Date of birth ( / / ) authorise my accountant/financial adviser to release to the insurer (NMLA trading as AXA and its group of companies), all information that the insurer requests for the purpose of assessing my application for insurance. 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  X Date signed  ( / / )

Accountant/financial adviser name  Accountant/financial adviser contact number  ( )

Accountant/financial adviser address

This page has been left blank intentionally.

## Payment authorities

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

### Payment method

If the insurance is held via North, Summit, Generations or iAccess, payment will be deducted from your cash account.

If the insurance is not held via North, Summit, Generations or iAccess, 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 or 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

Credit card type:  MasterCard  Visa

Credit card number

-     -     -          Expiry date

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)

Company ABN (Australian Business Number)

#### Account holder signature(s)

Signature - account holder 1

Date signed

Signature - account holder 2 (if applicable)

Date signed

X  / /  X  / /

# Insurance application and signatures

Declarations and consents

To be completed by the person to be insured and by the Plan owners.

Plan number

This application form is effective from 19 September 2011.

► Before you sign this application form, you should:

- be aware that your financial adviser is obliged to have provided you with the Product Disclosure Statement and other information relevant to special offers and/or member discounts for the product you are applying for
- **read the Product Disclosure Statement** because it contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- **read the Declaration and consent** of the Product Disclosure Statement and understand the terms outlined.

The most up-to-date PDS please check with your financial adviser, visit our website [axa.com.au](http://axa.com.au) or call AXA Customer Services on 132 987.

## Signature of Person to be insured

If the Person to be insured is the same person as the Plan owner ► go to 'Signature of Plan owners'.

Print full name of Plan owner	Signature	Date of birth	Date signed
<input type="text"/>	X	<input type="text"/>	<input type="text"/>

## Signature of Plan owners

Print full name of Plan owner	Signature	Date of birth	Date signed
<input type="text"/>	X	<input type="text"/>	<input type="text"/>
<input type="text"/>	X	<input type="text"/>	<input type="text"/>

# Financial adviser and commission details

## Underwriting and financial requirements

Have you spoken to our Underwriting Department for pre-assessment advice?  No  Yes

If yes, who did you speak to, what did you discuss and on what date did this occur?

Has the Person to be insured completed and signed all the relevant authorities, including medical authorities and/or financial authority?

No  Yes

Have you arranged or do you intend to arrange for any mandatory medical examinations or pathology tests to be completed?

No  Yes ► If you have advised the Person to be insured to have these tests specify name of  doctor, paramedical facility or pathology laboratory who will arrange for the test:

## Adviser checklist

If changes have been made to the application, has the Person to be insured initialled all changes?  No  Yes  Not applicable

Has supporting financial evidence been included with this application?  No  Yes

If this application is for agreed value income insurance, will the client be providing substantiating financial evidence in support of the monthly benefit proposed?  No  Yes

Note: if you have ticked 'No' above, financial evidence will be required in the event of a claim and the client will receive written notification from us after the policy has commenced.

Has a quote been provided with this application?  No  Yes

Is there any other documentation attached to this proposal?

No  Yes ► Please tick

Financial Questionnaire

Other ► Specify

Has this application been faxed prior to sending?  No  Yes ► Specify fax number ( )

(Addressee)

Has the Person to be insured read the duty of disclosure?  No  Yes

Do you have a preferred or alternative contact method?  No  Yes ► Please provide details in adviser notes below.

Have you explained to the client the possible implications on the contract of any non-disclosure?  No  Yes

Are there any other circumstances or facts, such as the client's background, not fully covered by answers provided herein which you feel may assist our assessment of this application?  No  Yes ► Specify (refer to Adviser notes if extra space required)

## Adviser notes

# Financial adviser and commission details (continued)

## Principal servicing adviser details

Account/Adviser name  Account/Adviser number  Phone number (  )

Mobile/Fax number  Email address

## New Plan Commission splits (Note: standard commission splits are not available for Rewards (Workplace/Family/Membership/Business Rewards) applications)

### New Plan Commission

Account/Adviser name	Account/Adviser number	% split*	State
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<b>Total</b>		<b>100%</b>	

\* Percentage must be whole numbers

## Renewal Business Commission splits

### Renewal Business Commission

Account/Adviser name	Account/Adviser number	% split*	State
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<input type="text"/>	<input type="text"/>	%	<input type="text"/>
<b>Total</b>		<b>100%</b>	

\* Percentage must be whole numbers

# AXA administration

Plan number

## Service centre only

Deposit paid	Date	Amount	Receipt number	Account/By
	/ /	\$		
	/ /	\$		
	<b>Total</b>	\$		

**Previous business**     No     Yes – Give details

Plan number			
Person insured			
Benefit symbol			
Code acceptance			
Assessment			
Special conditions			
Amount of risk			
Reinsurance			
Status and commencement date			

Plan number			
Person insured			
Benefit symbol			
Code acceptance			
Assessment			
Special conditions			
Amount of risk			
Reinsurance			
Status and commencement date			

Plan number			
Person insured			
Benefit symbol			
Code acceptance			
Assessment			
Special conditions			
Amount of risk			
Reinsurance			
Status and commencement date			

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The National Mutual Life Association of Australasia Limited  
ABN 72 004 020 437 AFS Licence No. 234649  
Registered Office: 750 Collins Street Docklands Victoria 3008



**redefining / insurance**