

This form is to be used where you are transferring cover to one of AXA's Elevate insurance plans from another insurance provider. Please note business expense insurance is not transferable.

To be completed by the Person to be insured in all cases.

Takeover terms

If we allow you to replace an existing contract of insurance with the same type of cover for the same or lesser amount of insurance with AXA, then mandatory medical and financial evidence will be waived. You will be required to complete a short form personal statement (enclosed in this application form). However, AXA may still request medical or financial evidence on a discretionary basis. Your financial adviser will be able to tell you if you are eligible to request cover under these terms.

Please note that all exclusion and premium loading types on your existing contract of insurance will be applicable to your insurance with AXA. The wording of the exclusions for your insurance with AXA may differ from the wording of your existing contract of insurance. When you receive the wording of the exclusions from AXA, you should read them carefully before accepting the insurance terms with AXA.

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, 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.

Your duty of disclosure continues until the contract of life insurance has been accepted by the insurer and confirmation is issued in writing.

Insurance type	Life	Total and permanent disability	Trauma	Income
Maximum transfer age (next birthday)	60	60	60	55
Max sum insured available	\$3 million	\$2 million	\$1 million	\$10,000
Loadings, restrictions or exclusions	The transferring plan must be accepted at standard rates. Any existing exclusions on the transferring plan will apply to the new plan.			
Underwriting	<ul style="list-style-type: none"> ▪ For life, TPD and trauma insurance the transferring plan must have been fully underwritten within the last five years by the preceding insurer, and not have been accepted under modified or limited underwriting requirements or on takeover terms. ▪ For income insurance the transferring plan must have been fully underwritten within the last three years by the preceding insurer, and not have been accepted under modified or limited underwriting requirements or on takeover terms. ▪ The occupation rating of the new AXA plan will be the rating AXA applies to the client's occupation. The occupation rating applied will determine the benefit period, waiting period and options available. ▪ Mandatory medical and financial evidence will be waived, however discretionary underwriting still applies. The underwriter may still request medical and financial evidence on a discretionary basis. 			
Takeover requirements	<ul style="list-style-type: none"> ▪ Fully completed takeover form ▪ Original plan document (for a platform plan where this is not available, please provide confirmation from the transferring insurer/fund outlining the underwriting terms, when cover commenced and the current benefits and amounts) ▪ Original plan schedule, and ▪ Most recent renewal notice. 			

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 Income Insurance Superannuation Plan is

N.M. Superannuation Proprietary Limited ABN 31 008 428 322 AFS Licence No 234654,

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

Any reference throughout this application form to North, refers to North as part of the Wealth Personal Superannuation and Pension Fund.

Any reference to the Superannuation or Pension plans of Summit, Generations or iAccess refers to Summit, Generations or iAccess as part of the Wealth Personal Superannuation and Pension Fund.

Application details

Date this application signed / /

Plan/Application number

Plan owner type (tick one) Individual Business application

Are you applying for insurance through North

If through North please provide your existing North account number ►

If you nominate North, all superannuation plans quoted for will be owned by N.M. Superannuation Proprietary Limited, through the Wealth Personal Superannuation and Pension Fund, and premiums will be paid out of the North account. The person to be insured must be the member of the nominated account. If you also apply for any non-superannuation plans, these will be owned by the individual, unless you nominate an IDPS account below.

The above will apply unless otherwise specified in the adviser notes.

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, all non-superannuation plans quoted for will be paid out of your IDPS account. To nominate an IDPS account, you must be authorised to transact on that account. If you also apply for any superannuation plans, without nominating an existing North Superannuation account, these will be owned by N.M. Superannuation Proprietary Limited through the Super Directions Fund.

If you nominate a Summit, Generations or iAccess Superannuation or Pension Plan, all superannuation plans quoted for will be paid out of your Superannuation/Pension account. The person to be insured must be the member of the nominated account. If you also apply for any non-superannuation plans, these will be owned by the individual.

The above will apply unless otherwise specified in the adviser notes.

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" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>

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

- Campaign
- New plan
- 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
	/ /	
	/ /	
	/ /	

Insurance takeover application form (continued)

Person to be insured

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

Title	Given name(s) (please print)	Family name	Previous name (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Gender	Marital status	Date of birth	Country of birth
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>

State	Postcode	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home phone number	Business phone number	Mobile phone number
() <input type="text"/>	() <input type="text"/>	() <input type="text"/>

Email address

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.

Daytime phone number	Hours you can be contacted
() <input type="text"/>	<input type="text"/>

After hours phone number	Hours you can be contacted
() <input type="text"/>	<input type="text"/>

Mobile phone number	Hours you can be contacted
<input type="text"/>	<input type="text"/>

Plan owner(s) to be completed if the Plan owner is a company, an external trustee or an individual other than the life to be insured. Not to be completed if applying for the Life Insurance Superannuation Plan or Income Insurance Superannuation Plan.

► 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/Company/SMSF	Given name(s)/Trustee name(s)*	Date of birth	Plan name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>

* The names of all trustees should be listed.

Only provide an ABN if the Plan owner is to be a company or a trustee:

Company ABN (Australian Business Number)

<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"/>
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The Plan owner(s) will need to complete the Non-superannuation insurance application and signatures section on page 11.

The Person to be insured will need to complete the Non-superannuation insurance application and signatures on page 11 except, if applying for the Life Insurance Superannuation Plan or the Income Insurance Superannuation Plan where the Person to be insured will need to complete the Superannuation insurance application sections on pages 12 to 15.

Details of Person to be insured

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

Q1 Are you an Australian citizen or a permanent resident of Australia? No Yes If no, please provide details including the type of visa you hold.

Q2 Including annual holidays, are you likely to live, travel or work overseas? No Yes If yes, please provide details below.

Where	When	Duration

Q3 (a) 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**, including this one? Note: This includes benefits under superannuation, business or credit insurance or benefits provided by an employer.
 No Yes If yes, please provide details below.

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

Important notes:

If this application for insurance is intended to replace the existing plan(s) listed in the table above:

- 1** When the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim you make to AXA for the insurance applied for and accepted may not be considered.
- 2** Under takeover terms, the insurance cover to be replaced must have been fully underwritten and not have been accepted under modified or limited underwriting requirements or on takeover terms previously.

(b) 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.

(c) Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, unemployment, pension or allowance or court proceedings? No Yes

Company name	Reason	Benefit amount	Date
			/ /
			/ /

Q4 Do you smoke or have you smoked in the last 12 months? No Yes
 If yes, please provide details below.

Cigarettes/Cigars/Tobacco pipes/Nicotine replacement products/Other	How many daily?	Have you stopped? If so, when?

Q5 How many standard drinks containing alcohol do you consume per week on average? (standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer)

Q6 Do you or have you ever used recreational drugs or drugs not prescribed by a doctor? No Yes
 If yes, please give details, including the type of drug and the date(s) used.

Details of Person to be insured (continued)

Q7 Have you in the last 12 months, do you currently, or do you intend to engage in any hazardous pursuit or pastime eg motor racing in any form; underwater diving; rock climbing; sky diving; hang gliding; aviation other than as a fare paying passenger; etc? No Yes

If yes, please provide details below.

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

Q8 What is your: Height Weight

Q9 (a) During the last five years (other than for colds, flu or contraception), have you attended a doctor, medical centre or health professional for any reason? No Yes

If yes, please provide details below.

Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
/ /				%
/ /				%

(b) Other than disclosed above, have you, in the last five years been prescribed, used or has your doctor suggested you should take any medication (other than for colds, flu or contraception)? No Yes

If yes, please provide details below.

(c) Other than what you have already told us in this application:

- (i) Have you ever been admitted to hospital for any reason? No Yes
- (ii) Are you experiencing any symptoms or complaints for which you have not consulted a doctor? No Yes
- (iii) Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery? No Yes
- (iv) Have you ever had, are you currently waiting for a result of, or are you considering having a genetic test? No Yes

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.

If you answered 'Yes' to (i), (ii), (iii) or (iv) above please provide details.

Details of Person to be insured (continued)

(d) 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? No Yes

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).

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)

(e) Have you or do any of your current or previous sexual partners have HIV/AIDS or have any sign of HIV infection? (eg some signs of HIV/AIDS are: unexplained weight loss, swollen glands or persistent diarrhoea) No Yes

(f) In the last five years: Are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? No Yes

HIV risks 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), and 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).

(If you have answered yes to (e) and (f) we will send you a confidential questionnaire for more information.)

Q10 to Q12 are only required where you are applying for Total and Permanent Disability and/or Income Insurance cover.

Q10 Have you, ever suffered from, experienced symptoms of or received medical advice, counselling or treatment for:

- Depression, anxiety, chronic fatigue, stress, nervous or mental disorder? No Yes
- Gout, arthritis, repetitive strain injury or a disorder of the back, neck, joints or muscles? No Yes

If yes, please provide details below.

Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
/ /				%
/ /				%

Q11 (a) Please provide details of your current and previous occupation or jobs over the last five years, including any period unemployed, travelling, studying etc. If you have a second occupation or job please provide details below.

	From	To	Occupation	Employer	Tick which is applicable				
					Employed by own company	Self-employed	Partnership	Employee	Contractor
Current main occupation	/ /	Present			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	/ /	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current second occupation	/ /	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(b) How many hours per week do you spend at your main occupation? hours

(c) How many weeks per year do you spend at your main occupation? weeks

(d) What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

(e) When did you qualify/graduate? / /

Details of Person to be insured (continued)

(f) In your main occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	
Sedentary/Administrative		%
Supervising manual work		%
Light manual		%
Heavy manual		%
Home duties (include details of dependants including ages and any other relevant information)		%
Other (including hazardous duties, eg handling dangerous substances, working at heights)		%
Total duties		100%

(g) Do you ever work from home? No Yes
 If yes, provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients.

(h) Do you intend to change your occupation or employment status? No Yes
 If yes, please provide details below:

Q12 (a) Insurable income last financial year

Income of previous financial year

Note: Insurable income is the income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will cease if you are unable to work. Insurable income does not include investment or interest income. In the event of a claim, we may call for evidence of your income and business expenses. Please ensure the income figures you provide below accurately reflect your financial position for the periods indicated.

If you are applying for agreed value income insurance and not providing justifying financial evidence up-front, the person insured will be required to provide financial evidence at claim stage.

(b) If you became disabled, would all or part of your employment income continue? No Yes
 If yes, please provide details below of the income amount that would continue, for how long and the source (eg salary, sick pay, company profits, investments, rental).

(c) Have you or any business with which you have been associated ever been declared bankrupt or placed in receivership, involuntary liquidation or under administration? No Yes

If yes, please advise when date of discharge

Insurance takeover application form (continued)

Page no.	Forms to be completed	Non-superannuation application (including through a SMSF)	Superannuation application, through Super Directions	Superannuation application, through North	Superannuation or Pension application, through Summit, Generations or iAccess	Non-superannuation application through a Summit, Generations or iAccess investment account
	Authorities					
8	Medical authorities	✓	✓	✓	✓	✓
9	Payment authorities	✓	✓	2	2	
	Non-superannuation application					
10	Nomination of beneficiaries	✓				✓
11	Non-superannuation insurance application and signatures	✓				✓
	Superannuation application					
12	Nomination of dependants		✓	1	1	
13	Tax file number		✓	1	1	
15	Superannuation insurance application and signatures		✓	✓	✓	

- 1 If you are a member or prospective member of North or the Superannuation or Pension Fund of Summit, Generations or iAccess, your tax file number will be completed as part of your membership of the Fund. Your nomination of dependants or any changes to your nomination of dependants for distribution of your death benefits requires the completion of the appropriate death benefit nomination form available under North, Summit, Generations or iAccess as applicable.
- 2 Where a SuperLink plan is applied for, with the intention to link the SuperLink plan to North, Summit, Generations or iAccess payment authorities require completion in relation to the SuperLink plan.

Authorities and application forms for completion

Authority to release medical information to AXA

Person to be insured name

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

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.

Person to be insured name

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

This page has been left blank intentionally.

Nomination of beneficiaries

To be completed if you are applying for a Life Insurance Plan, including plans where the insurance will be paid for out of a Summit, Generations or iAccess investment account.

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

Nominate beneficiaries – only for Life Insurance Plan

► Only complete this page if you have applied for the Life Insurance Plan

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

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

1	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 type="text"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input type="text"/> (<input type="text"/>)	<input type="text"/>		<input type="text"/> %	
2	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 type="text"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input type="text"/> (<input type="text"/>)	<input type="text"/>		<input type="text"/> %	
3	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 type="text"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input type="text"/> (<input type="text"/>)	<input type="text"/>		<input type="text"/> %	
4	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 type="text"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input type="text"/> (<input type="text"/>)	<input type="text"/>		<input type="text"/> %	
5	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 type="text"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner		% of death benefit*	
	<input type="text"/> (<input type="text"/>)	<input type="text"/>		<input type="text"/> %	
Total percentage					<input type="text"/> 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
- 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.

Signature of Plan owner

Date signed

<input type="text"/> X	<input type="text"/> / <input type="text"/> / <input type="text"/>
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Non-superannuation insurance application and signatures

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 or AXA is obliged to have provided you with the Product Disclosure Statement(s) and other information relevant to special offers and/or member discounts for the product(s) 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
- **read the Declarations and consent** of the Product Disclosure Statement and understand the terms outlined, and
- be aware that if you are the Plan owner, by signing you agree to have the premiums for this plan deducted from your cash account.

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 owner – only for individuals'.

Print full name of Person to be insured	Signature	Date signed
<input type="text"/>	X	/ /

Signature of Plan owner – only for individuals

For Plan owners (must be aged 16 years or over)

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

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

Signature of Plan owner – only for companies and trustees (including self-managed superannuation funds)

Company seal	Print full name of company and/or name of Trustee and fund		
<input type="text"/>	<input type="text"/>		
	Signature 1	Signature 2	Date signed
	X	X	/ /
	Print full name of person signing for and on behalf of the above company/self-managed superannuation fund		
	<input type="text"/>	<input type="text"/>	

- Company seal and two directors or director and secretary, or
- Company seal and one signature noted as 'sole director and secretary' where the company has only one director, or
- The signature of a person whose name is clearly written, with the words 'XXX for and on behalf of XYZ Pty Ltd', or
- For SMSFs, if there are more than two trustees, please provide their full name/s and signatures/s in the space below.

Nomination of dependants

(For Super Directions Fund members only)

To be completed only if you are applying for a Life Insurance Superannuation Plan held through Super Directions.

If the person insured is a member of the National Mutual Retirement Fund, binding death nominations are not available. Please contact our Customer Service Centre for the correct form if you wish to make a non binding nomination. If you are applying for membership through North, Summit, Generations or iAccess, your nomination of dependants for distribution of your death benefits requires the completion of the appropriate death benefit nomination form available under North, Summit, Generations or iAccess as applicable. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.

► Before you complete this page:

- you should read the Holding your policy in superannuation section of the Product Disclosure Statement, and
- discuss your needs with your financial adviser.

1 Title First name Family name Gender Male Female Date of birth / /

Address

Phone number () Relationship of the nominated person to the Plan owner Financial dependant Spouse IR† Child % of death benefit* %

2 Title First name Family name Gender Male Female Date of birth / /

Address

Phone number () Relationship of the nominated person to the Plan owner Financial dependant Spouse IR† Child % of death benefit* %

3 Title First name Family name Gender Male Female Date of birth / /

Address

Phone number () Relationship of the nominated person to the Plan owner Financial dependant Spouse IR† Child % of death benefit* %

4 Title First name Family name Gender Male Female Date of birth / /

Address

Phone number () Relationship of the nominated person to the Plan owner Financial dependant Spouse IR† Child % of death benefit* %

5 Title First name Family name Gender Male Female Date of birth / /

Address

Phone number () Relationship of the nominated person to the Plan owner Financial dependant Spouse IR† Child % of death benefit* %

Total percentage **100 %**

or My Legal Personal Representative (eg the executor of your will)

* Percentages must be whole numbers

† Interdependency Relationship

**Nomination of dependants
(continued)**

Binding nomination

I acknowledge that I have read the Additional information section of the Product Disclosure Statement concerning binding nominations and accept the conditions relating to binding nominations.

Non-binding

I acknowledge that I have read the Additional information section of the Product Disclosure Statement concerning non-binding nominations.

No nomination

Signature

Date signed

X

/ /

If you have ticked 'binding nomination', the section below must also be completed.

Witness signatures

I acknowledge that I am over 18, that I am not a nominee on this form and that the above notice was signed and dated by the applicant in my presence.

Witness A

Signature

Name

Date signed

X

/ /

Witness B

Signature

Name

Date signed

X

/ /

This page has been left blank intentionally.

Tax file number

► Only complete this page if you are applying for superannuation cover with the Life Insurance Superannuation Plan and/or Income Insurance Superannuation Plan.

Plan number:

Note: The Plan owner is the Trustee of Super Directions Fund.

This section must be completed by the Person to be insured applying for the Life Insurance Superannuation Plan and/or Income Insurance Superannuation Plan. Applications cannot be accepted without a tax file number.

Tax file number – only for the Life Insurance Superannuation Plan and Income Insurance Superannuation Plan

Given name(s) Family name

Date of birth / / Phone number ()

Your tax file number is confidential. Before you provide your tax file number we are required to tell you the following:

Under the Superannuation Industry (Supervision) Act 1993, your superannuation fund is authorised to collect your TFN, which will only be used for lawful purposes.

These purposes may change in the future as a result of legislative change. The trustee of your superannuation fund may disclose your TFN to another superannuation provider, when your benefits are being transferred, unless you request the trustee of your superannuation fund in writing that your TFN not be disclosed to any other superannuation provider.

It is not an offence not to quote your TFN. However, giving your TFN to your superannuation fund will have the following advantages (which may not otherwise apply):

- Your superannuation fund will be able to accept all types of contributions to your account(s).
- The tax on contributions to your superannuation account(s) will not increase.
- Other than the tax that may ordinarily apply, no additional tax will be deducted when you start drawing down your superannuation benefits.
- It will be easier to trace different superannuation accounts in your name so that you receive all your superannuation benefits when you retire.

I have read the information (below) and agree to provide my tax file number (tick one only) No Yes

Tax file number Signature X Date signed / /

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Superannuation insurance application and signatures

Plan number

This application form is effective from 19 September 2011.

► **Before you complete this Superannuation insurance application and signatures, you should:**

- be aware that your financial adviser is obliged to have provided you with the Product Disclosure Statement(s) and other information relevant to special offers and/or member discounts for the product(s) 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
- **read the Declarations and consent** of the Product Disclosure Statement and understand the terms outlined, and
- be aware that by signing you agree to have the premiums for this plan deducted from your cash account if applicable.

Superannuation membership

Are you applying for insurance through North Summit Generations iAccess

If through North please provide your existing North account number

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

Are you applying for insurance through the Super Directions Fund? No Yes

If yes, please complete questions 1 to 3

Q1 Current employment status

Employee ► Go to Question 2 Self employed (sole trader, partnership) Employed by own company ► Go to Question 3

Q2 Does your employer contribute to an existing superannuation fund on your behalf? No Yes

Q3 Have you selected an employer supported plan (ie your employer pays part or all of your premiums)? No Yes

Company name

Company address

To be completed by the Person to be insured

Print full name of Person to be insured

Signature

Date of birth

Date signed

Financial adviser and commission details

To be completed by the adviser for all applications.

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 the medical authorities? No Yes

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

Children's Trauma Option Personal statement

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

Mailing address for Application form

Please send the completed Application form, with deposit premium to our Customer Service Centre:

AXA Australia
Customer Service Centre
PO Box 14330
MELBOURNE VIC 8001

**Financial adviser
and commission details (continued)**

To be completed by the Adviser for all applications.

Principal servicing adviser

Account name

Account 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 name	Account number	% split*	State
		%	
		%	
		%	

* Percentage must be whole numbers

Total **100%**

Renewal Business Commission splits

Renewal Business Commission

Account name	Account number	% split*	State
		%	
		%	
		%	

* Percentage must be whole numbers

Total **100%**