

AXA's Elevate

Insurance Application form

Issue date 19 September 2011



redefining / insurance

Application form

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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 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.

Important information for applicants

Please read these instructions carefully before starting this application

Before you start

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

The PDS(s) contain 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 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 us 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 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. 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 Australia with the same type of cover for the same or lesser amount of insurance, and

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

you were previously underwritten by us, 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, we 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 contract.

Definitions in this application

'Person to be insured' is the person whose life, health or income is to be insured under this application.

'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. Where applying for the Life Insurance Superannuation Plan or the Income Insurance Superannuation Plan, the Plan owner is N.M. Superannuation Proprietary Limited.

'You' either refers to the Plan owner under the plan or the 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 product(s) you want to apply for.
- 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 Sign the Application form where indicated.
- 5 Send your completed Application form to your financial adviser.

Financial adviser contact details

Application summary

► **Before you complete this application:**

- If you are altering an existing plan, please refer to your Plan Document for terms and conditions of your plan.

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 will be owned by N.M. Superannuation Proprietary Limited, through the Wealth Personal Superannuation and Pension Fund, and premiums will be paid for out of the North account. The person 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 will be paid for 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 through the Super Directions Fund.

If you nominate a Summit, Generations or iAccess Superannuation or Pension Plan, all superannuation plans quoted will be paid for out of your Superannuation/Pension account. The person 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

	Workplace Rewards name/ Title Family name/RACV cardholder name	Workplace Rewards number/ Family number/RACV card number
<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 300px; height: 20px;" type="text"/>	<input style="width: 200px; height: 20px;" type="text"/>

For RACV, please provide 16-digit card number

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
	/ /	
	/ /	
	/ /	

Application summary (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(s) (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).
Please refer to the definition of insurable income, in the Income details section on page 22.

Residential address of Person to be insuredStreet 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 Non-superannuation application sections on pages 30 to 31 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 application sections on pages 33 to 39.

Correspondence details

► Only complete this section if the addressee or correspondence address is different to the Person to be insured

Is the addressee for correspondence different to the Person to be insured? No Yes

Company/Self-managed superannuation fund C/O (eg company title/department)

Title Given name(s)/Trustee name(s) (please print) Family name

Is the address for correspondence different to the residential address of the Person to be insured? No YesStreet number and name

Town/Suburb State Postcode Country

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 2 for details of your Duty of Disclosure.

Daytime phone number ()	Hours you can be contacted
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After hours phone number ()	Hours you can be contacted
---------------------------------	----------------------------

Mobile phone number	Hours you can be contacted
---------------------	----------------------------

Residence and travel details

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 In the next 12 months, do you intend to leave Australia to go and live in another country? No Yes

If yes, please provide details:

Where	Duration

Q3 Do you intend to travel outside Australia or New Zealand for holiday or business purposes? No Yes

If yes, please provide details:

Where	When	Duration

Insurance details

Q4 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

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.

Personal details (continued)

Insurance details (continued)

Q5 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:

Q6 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
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; text-align: center;">/ /</div>

Q7 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
			/ /
			/ /
			/ /

Personal habits

Q8 (a) Have you ever been a smoker or used any sort of tobacco products?

No ► Go to Q9

Yes ► What do you or did you use?

Cigarettes Tobacco pipes Cigars

Nicotine replacement products Other If other, please specify

On average, how many do you or did you smoke or use daily?

If you have stopped, when? month year

(b) Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? No Yes

If yes, please advise the name of the condition and any treatment received:

Condition	Treatment
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

Q9 (a) How many standard drinks containing alcohol do you consume per week on average?

[standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer]

standard glasses per week

(b) Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? No Yes

If yes, please advise your alcohol intake amount at the time, reason you were advised and details of any treatment:

Q10 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:

Your health details

'You' refers to the Person to be insured.

Doctor details

Q11 Please provide the details of the general practitioner/medical centre you would normally consult for medical conditions or advice, including the details of your last consultation.

Name of general practitioner/medical centre

Street number and name

Town/Suburb

State

Postcode

Phone number

 ()

Facsimile

 ()

How long have you been his/her patient? years

Date of last consultation	Reason	Result
/ /		

Personal health history

Q12 (a) What is your: Height Weight

(b) Has your weight varied in the last 12 months? No Yes

If yes, please tick one of the following and provide the amount and the reason: Gain Loss

Amount

Reason

<input type="text"/> kg	<input type="text"/>
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Your health details (continued)

'You' refers to the Person to be insured.

Personal health history (continued)

Q13 At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

- (a) No Yes **Back or neck disorder** including slipped disc, sciatica or whiplash
- (b) No Yes **Disorder or injury of the joints** including arthritis or gout (eg a disorder or injury of the ankle, elbow, hip, knee, wrist or shoulder)
- (c) No Yes Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis)
- (d) No Yes **Nervous disorder or mental illness** (eg depression, anxiety, stress, insomnia, post-natal depression or post traumatic stress disorder)
- (e) No Yes **Chronic fatigue or chronic pain syndrome**
- (f) No Yes Fibromyalgia, fibrositis or myalgia
- (g) No Yes Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury
- (h) No Yes Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy
- (i) No Yes Epilepsy, fit or blackout, migraine or recurrent headaches
- (j) No Yes Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face
- (k) No Yes **High blood pressure or raised cholesterol** (including being advised to take medication or have your levels monitored)
- (l) No Yes Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain
- (m) No Yes Disorder of the blood including anaemia or haemophilia
- (n) No Yes **Asthma**
- (o) No Yes Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder
- (p) No Yes Disorder of the thyroid
- (q) No Yes Diabetes, sugar in the urine or raised blood sugar levels
- (r) No Yes Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones
- (s) No Yes Disorder of the digestive system, gall bladder, stomach, bowel or liver including hepatitis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, hernia or irritable bowel syndrome
- (t) No Yes Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision)
- (u) No Yes Disorder of the ears or speech including hearing loss or tinnitus
- (v) No Yes Disorder of the skin including psoriasis, eczema or dermatitis
- (w) No Yes Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or skin cancer or any malignant condition
- (x) No Yes **Cyst, skin lesion, growth, lump** (including breast lump), **mole or freckle** that has bled, become painful, changed colour or increased in size
- (y) No Yes Any sexually transmitted infection or disease

If you answered 'YES' to any of the items in Q13, please provide details in the table below, **EXCEPT** for any condition in bold text above for which you should complete the relevant section of Q22 instead. If you answered 'NO' to all items, go to Q14.

Item No. eg (f)	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 %
	/ /				%
	/ /				%
	/ /				%
	/ /				%
	/ /				%
	/ /				%

Your health details (continued)

Q14 At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

Males only

(a) No Yes Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or undescended testicle?

Females only

(b) No Yes Are you currently pregnant? If yes, please advise expected delivery date

(c) No Yes Have you ever had any complications with pregnancy or childbirth? If yes, please provide details below, including whether resolved after delivery.

(d) No Yes Have you ever had an abnormal breast ultrasound, mammogram or investigation?

(e) No Yes Have you ever had an abnormal cervical pap smear or biopsy of the cervix or uterus?

If you answered 'YES' to any of the items in Q14, please provide details in the table below.

Item No. eg (b)	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 %
	/ /				%
	/ /				%
	/ /				%
	/ /				%

Q15 Other than what you have already told us in this application, have you in the last **five years** (not including colds or flu):

(a) No Yes Attended any other medical appointment (eg counselling), or had any other test (eg x-ray, blood) with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists?

(b) No Yes Used or are you currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition?

(c) No Yes Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than three consecutive days?

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

Item No. eg (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 %
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%

Your health details (continued)

'You' refers to the Person to be insured.

Personal health history (continued)

Q16 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 yes, please provide full details.

Q17 Other than what you have already told us in this application:

(a) Have you ever been admitted to hospital for any reason? No Yes

(b) Are you experiencing any symptoms or complaints for which you have not consulted a doctor? No Yes

(c) 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 Q17 (a), (b) or (c) above please provide details:

Q18 (a) Have you or any of your current or previous sexual partners tested positive for 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

(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 (eg 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).

(If you answered 'Yes' to any part of Q18 we will send you a confidential questionnaire to complete).

Family history

Q19 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, sisters and brothers).

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)

Sports and pastimes details

Q20 Have you in the last 12 months, do you currently, or do you intend to take part in any of the following activities?

- (a) No Yes **Aviation (other than a fare paying passenger on a licensed public service)**
- (b) No Yes **Motor racing (including car, bike and boat)**
- (c) No Yes **Underwater diving**
- (d) No Yes **Football**
- (e) No Yes **Motor bike riding, including trail bike riding and commuting (please specify below)**
- (f) No Yes **Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports)**

If you answered 'YES' to items (d), (e) or (f), please provide details of each activity in the table below. For any activity in bold text above please complete the relevant section of Q21. If you answered 'NO' to all items above, go to Q22.

Item No. eg (f)	Activity/sport and 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

Q21 Detailed sports and pastimes questionnaires

► Only complete the relevant sections of this question if you answered 'Yes' to Q20 (a), (b) or (c) above.

(a) Aviation questionnaire

- 1 Do you hold a Department of Transport licence to fly aircraft? No Yes
 If yes, please state type of licence and period held:
- 2 Do you intend to change the scope of your present licence? No Yes If yes, please provide details:
- 3 Have you ever had an accident or been charged with violating civil aviation regulations? No Yes
 If yes, please provide details:
- 4 Do you always use recognised Department of Transport airfields? No If no, please provide details below: Yes
- 5 Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft, aerobatics):
- 6 Please provide details of the number of hours flown:
 - (i) in total as a pilot
 - (ii) in the last 12 months
 - (iii) expected each year in the future
- 7 Do you intend to engage in any form of aviation other than the above? (eg ballooning, paragliding) No Yes
 If yes, please provide details:

Sports and pastimes details (continued)

Q21 Detailed sports and pastimes questionnaires (continued) ►

(b) Motor racing questionnaire

1 What type(s) of motor sports activities do you participate in (eg circuit racing, drag racing, formula racing, karting, rallies, speedway, stock car racing, time trials)?

2 What type(s) of motor vehicles do you drive or crew? Please state the make, model, year of manufacture, engine size, category, group and class details:

3 Please state the nature of your participation:

Recreational Competitive Sponsored Amateur Professional

4 Number of events you participate in: Last 12 months Next 12 months (expected)

5 Where have you, or do you intend to compete or race? Please provide the name of all organised events:

6 What maximum speeds do you reach?

7 Please provide details of your licences/certifications and memberships attained:

Licence/certification or membership details	When attained/joined
	/ /
	/ /

8 Have you ever had your licence restricted or suspended for any reason? No Yes If yes, please provide details:

(c) Underwater diving questionnaire

1 What type of diving activities do you participate in (eg snorkelling, scuba diving, free diving)?

2 What diving certification do you hold?

3 Average depth you dive to metres

4 Maximum depth you dive to metres

5 Number of times you dive per year

6 Professional Amateur

7 Do your diving activities include pothole, cave or sink hole diving, wreck exploration or any other hazardous diving?

No Yes If yes, please provide details, including how often:

8 Do you ever dive alone? No Yes If yes, please provide details, including where and how often:

9 Have you ever had a diving accident or sickness? No Yes If yes, please provide details:

Health questionnaires

Q22 Detailed health questionnaires

► Only complete the relevant health questionnaires, if you answered 'Yes' to any items in bold text in Q13.

(a) Back or neck disorder questionnaire

- 1 Neck disorder Back disorder – please clarify which area is/was painful (eg upper, lower, middle, neck):
- 2 What was the cause of the disorder (eg accident, arthritis, osteoporosis)?
- 3 (a) When did you **first** experience symptoms?
 (b) When did you **last** have any symptoms?
 Please describe symptoms fully, including details of any radiation of pain down either the legs or arms:
- (c) On average, how long does each episode last?
- 4 Have you had any recurrence of this disorder? No Yes
 If yes, when and how often? (please include the number of recurrences, the causes and how long they lasted):
- 5 How long, if at all, have you been symptom free?
- 6 How many times have you been absent from work or unable to perform your normal daily activities?
- 7 Are you currently able to do your work or perform your normal activities without any restriction, stress or discomfort?
 No Yes If no, please provide details:
- 8 (a) Are you currently receiving treatment? No Yes
 (b) What is or was the nature of the treatment? Please include details of any medication, physical therapy or surgery:
- 9 Have you had any investigations such as an x-ray, CT Scan or MRI? No Yes If yes, what were the results?
- 10 Please provide names and addresses of all doctors and health care professionals consulted in relation to your back or neck disorder and approximate dates of consultations:

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(b) Disorder or injury of the joints questionnaire

1 What is the name of your disorder or injury?

2 Please state which joints are or were affected, including whether left or right:

3 Please describe symptoms fully:

4 When did you **first** experience symptoms of this disorder or injury?

5 When did you **last** experience symptoms of this disorder or injury?

6 What was the cause of the disorder or injury?

7 Have you had any treatment for your disorder or injury? No Yes
If yes, please provide details (eg medication, surgery, plates or screws inserted/removed, arthroscopy, physiotherapy, injection):

8 Are you currently receiving treatment or is any treatment expected in the future? No Yes If yes, please provide details:

9 Have you had any recurrence of this disorder? No Yes If yes, when and under what circumstances?

10 Please provide names and addresses of all doctors and health care professionals consulted in relation to your joint disorder or injury and the approximate dates of consultations:

11 Have you ever taken time off work or been unable to perform your normal daily activities because of this disorder or injury?
 No Yes If yes, please provide details:

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(c) Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire

1 Have you ever suffered from, had treatment for or been diagnosed with any of the following? Please tick.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Inability to sleep |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fears or phobias | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Obsessive compulsive disorder |
| <input type="checkbox"/> Other – please specify: | | | |

2 What was the cause of your symptoms?

3 Please describe your symptoms fully:

4 (a) What was the date of the **first** symptoms?

(b) What was the date of the **last** symptoms?

5 Did you have more than one episode of symptoms? No Yes

If yes, please provide full details, including number of recurrences:

6 Please provide details of the treatment you have received for this condition (eg treatment with tranquillisers or other drugs, counselling, psychotherapy or surgery):

7 Have you ceased treatment? No Yes

If no, and treatment is ongoing, please provide details (eg dosage and type of medication, counselling):

If yes, please provide a date and whether or not this was at the direction of your doctor:

8 Have you ever been an inpatient at a hospital or clinic? No Yes

If yes, please provide details including number of times, dates and hospital/clinic name:

9 Have you ever thought about, or tried to deliberately harm yourself or take your own life?

- No Yes I would like to provide my answer confidentially (we will contact you to discuss)

If yes, please provide details:

Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire continued on next page ►

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(c) Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire (continued)

10 Have you ever taken time off work or been unable to perform your normal daily activities because of your symptoms?

No Yes If yes, please provide details, including dates:

11 Are you currently able to do your work or perform your normal daily activities without any restriction, stress or discomfort?

No If no, please provide details: Yes

12 (a) Name of doctor or health professional **last** consulted for this disorder and the date of the **last** consultation:

(b) Please provide names and addresses of any other doctors or health care professionals consulted for this condition, including approximate dates of consultations:

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(d) High blood pressure or raised cholesterol questionnaire

- 1 Please indicate which of the following have been raised/high: Blood pressure Cholesterol Both
- 2 (a) When did you first find that your readings/levels were raised or were you advised to have your reading/levels monitored or noted?

- (b) What was your reading/level at the time noted in 2(a)?

Blood pressure / Cholesterol

- 3 (a) What was the last blood pressure/cholesterol reading, and when was this taken?

Blood pressure / Date

Cholesterol reading Date

- (b) Is the reading above consistent with others when checked? No Yes

If no, what is a typical reading?

- 4 How often are you required to see your doctor for reviews/check-ups?

Monthly Quarterly Twice yearly Annually Other - details:

- 5 When is your next check-up due?

- 6 Are you currently taking any medication for your blood pressure/cholesterol levels?

- No - go to question 8
 Yes, please provide the name of any medication you take and the daily dosage

Condition	Medication	Daily dosage
Blood pressure		
Cholesterol		

- 7 Has your treatment type or dosage changed within the last 12 months?

- No - go to question 9 Yes, please provide the details below and continue to question 9

When was it changed?	What was changed?	Why was it changed?

- 8 Have you ever been prescribed medication for blood pressure/cholesterol? No Yes

If no, how has the condition been managed?

If yes, when and why have you ceased taking this medication?

- 9 Have you undergone or been referred for any other investigations (eg resting or exercise ECG, 24hr holter monitor, urinalysis, echocardiogram)?

- No Yes If yes, please provide details:

- 10 Has any underlying cause been found for your raised blood pressure/cholesterol? No Yes

If yes, please provide details:

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(e) Asthma questionnaire

- 1 When was your asthma diagnosed?
- 2 When did you **first** have symptoms?
- 3 When did you **last** have symptoms?
- 4 Approximately how many times per year do you or did you get symptoms?
- 5 Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma (eg dust, sawdust, pollen, grass)?
 No Yes If yes, please provide details:
- 6 In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma?
 No Yes If yes, please provide details including the number of times and days:
- 7 Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (eg aerosol spray, tablets or injections, amounts and number of times per day):
- 8 Have you ever been treated for your asthma with steroids (eg Prednisone)? No Yes
 If yes, please provide details, including dates:
- 9 Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma? No Yes
 If yes, please provide details:
- 10 In the last three years, have you had or been advised to have a chest X-Ray or respiratory function test? No Yes
 If yes, please provide dates and results:
- 11 Have you ever had any complications or other conditions related to your asthma (eg cardiac or respiratory arrest, heart disease, chest deformities)?
 No Yes If yes, please provide details:
- 12 (a) Please provide details of the doctor who you consult for your asthma:
- (b) When did you **last** consult this doctor for asthma?

Health questionnaires (continued)

Q22 Detailed health questionnaires (continued) ►

(f) Cyst, skin lesion, growth, lump, mole or freckle questionnaire

1 Please indicate the condition(s) you have had, or received treatment for, the number, the site and the date diagnosed:

Condition	Number	Site	Date diagnosed
Basal cell carcinoma (BCC)			/ /
Hyperkeratosis or solar keratosis			/ /
Melanoma			/ /
Mole or naevi			/ /
Sebaceous (fatty) cyst			/ /
Squamous cell carcinoma (SCC)			/ /
Other, please specify:			/ /

2 For each cyst, mole, growth, lump or skin lesion disclosed above, please advise if removed.

If removed, please provide date and method (ie by surgery, freezing or otherwise):

If not removed, please provide reason why it was not removed:

3 Were any special tests, investigations or treatment required? No Yes If yes, please provide details:

4 Please advise the results of any laboratory testing: Malignant Benign Do not know

5 Do you have, or are able to obtain a copy of the laboratory testing results? No Yes

If yes, please attach a copy of these results.

6 Have you been or are you required to attend any further treatment or follow-up since the original cyst, mole or skin lesion was removed?

No Yes If yes, please provide details of date(s) and what was advised:

7 Did you consult a doctor other than your usual doctor as disclosed in Q11? No Yes If yes, please provide full details:

Occupation details

If you have not applied for plans listed in the box to the right

► Go to page 25

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance.

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

Q23 Please give details of your current and previous occupation or jobs over the last five years. If you have a second occupation, please give details in Q32 below.

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

Q24 In the last five years have you ceased or do you intend to cease working for reasons other than holidays (eg unemployment or end of contract)?
 No Yes If yes, please provide details:

Q25 How many hours per week do you spend working in your main occupation? hours

Q26 How many weeks per year do you spend working in your main occupation? weeks per year

Q27 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%

Q28 (a) What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

(b) When did you qualify/graduate?

(c) Please give details of any other qualifications you hold:

Q29 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:

Q30 Do you intend to change your occupation or employment status? No Yes If yes, please provide details below:

Q31 Have you or any business with which you have been associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?

No Yes If yes, (a) when (b) date of discharge

Q32 Do you have any other occupations or jobs? No Yes If yes, please provide details below including specific duties:

Q33 Number of hours per week worked and annual income derived from your other occupations or jobs.

hours
 \$

Income details

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance.

What is Insurable income?

This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work.

It does not include investment or interest income.

Q34 Insurable income

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

- ▶ If you are self-employed, in a partnership or an employee of your own company (or contractor), please complete the 'For self-employed' section below
- ▶ If you are an employee, please complete the 'For employees' section on page 23

For self-employed

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

(a) Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available. **Do not include any amounts paid to you that are paid from past profits, capital or loans.**

Year ending	Gross income for entire business	Less all expenses incurred in earning that income	Equals net business income before tax	Your share of net business income	Wages/salary/super/drawings/director's fees paid to you	Your total income
30 / 06 /	\$	\$	\$	\$	\$	\$
30 / 06 /	\$	\$	\$	\$	\$	\$

(b) If you have applied for income insurance, did you include superannuation guarantee contributions in the calculation of the Monthly Benefit?
 No Yes If yes, how much? \$ (Maximum is 9 per cent of Insurable income. This amount will be allocated to a complying Superannuation Fund in the event of a claim.)

(c) What percentage of the business do you own? % If not 100 per cent owner, please provide percentage ownership and roles/duties of the other owners. Please include details of any income splitting arrangements.

(d) How many people do you employ?

(e) What proportion of total business income is from your personal exertion? %

(f) Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)?

No Yes If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax
	\$
	\$
	\$
	\$

(g) If you were to become disabled, would any of your income (eg investment income and trail/renewal commission) continue?

No Yes If yes, please provide the following details:

(i) What type and amount of income would continue if you were not working?

(ii) Is there an agreement in place (written or otherwise) in relation to this entitlement and when it may cease?

No Yes If yes, please provide further details:

(h) Has your business had a net operating loss over either of the last two financial years? No Yes

If yes, please provide copies of your full company accounts for the last two financial years, including any associated entities.

(i) So far this financial year, is your business trading profitably? No - please provide details in the space below Yes

Income details (continued)

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance.

What is Insurable income?

This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work.

It does not include investment or interest income.

Q34 Insurable income (continued)

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

- ▶ If you are self-employed, in a partnership or an employee of your own company (or contractor), please complete the 'For self-employed' section on page 22
- ▶ If you are an employee, please complete the 'For employees' section below

For employees

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

(j) Please indicate your current employment status:

- Permanent full time
- Permanent part time
- Casual or non-permanent
- Not currently employed
- Other, please specify:

(k) Please give details of your total remuneration package from all sources currently and for the last two financial years.

Please include any additional benefits (eg pre-tax superannuation guarantee contributions, regular bonuses and commissions, fringe benefits):

Current remuneration	Last financial year	Previous financial year	
\$	30 / 06 /	\$	30 / 06 /
			\$

(l) If you have applied for Income Insurance, did you include superannuation guarantee contributions in the calculation of the Monthly Benefit?

No Yes If yes, how much? \$ (Maximum is 9 per cent of gross income. This amount will be allocated to a complying Superannuation Fund in the event of a claim.)

(m) Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)?

No Yes If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax
	\$
	\$
	\$
	\$

(n) If you were to become disabled, would any of your income (including investment income) continue?

No Yes If yes, please answer (i) and (ii):

(i) What is the income amount that would continue, for how long, and the source (eg salary, sick pay, company profits, investments, rental)?

(ii) Is there an agreement in place (written or otherwise) that determines when this entitlement will cease?

No Yes If yes, please provide details:

Business expenses details

If you have not applied for plans listed in the box above

► Go to page 25

Q35 Business structure

Company Partnership Trust Sole proprietor

Date the business was purchased/started / /

Q36 Business details

Business name

Business street number and name

Town/Suburb

State

Postcode

Q37 Employees

Number of income producing employees:

Full time

Part time

Number of non-income producing employees:

Full time

Part time

Q38 If a partnership/company, number of partners/directors

Q39 Percentage of business income derived from your personal exertion

 %

Q40 If you were to become totally disabled, what would be the reduction in business income?

 %

Please provide a brief explanation of what would happen to the business if you were to become disabled:

Q41 Monthly expenses of the business over the last 12 months

Monthly expenses

(i) Rent or mortgage interest payments

(ii) Electricity, gas, water, heating

(iii) General insurance premiums

(iv) Cleaning

(v) Telephone

(vi) Leasing of equipment or motor vehicles

(vii) Property rates and taxes

(viii) Dues to professional bodies

(ix) Accountant's fees

(x) Salaries and associated costs (eg superannuation contributions) for employees who do not generate revenue

(xi) Other fixed expenses (please provide details below)*

(xii) **Total** monthly expenses (Total of (i) to (xi) above)

(xiii) Percentage of expenses in (xii) above that you are responsible for

 %

* Details of other expenses

For qualified registered medical practitioners or dentists classified as MP or AA only.

Q42 Net Locum Cost†

† Net Locum Cost is the estimated cost of engaging a locum to replace you while you are totally disabled and unable to work due to sickness or injury, less any income this person generates. Only complete this question if you estimate locum expense will exceed income generated by the locum.

Authorities and application forms for completion

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					
27	Medical authorities	✓	✓	✓	✓	✓
27	Financial authority	✓ ³	✓ ³	✓ ³	✓ ³	✓ ³
29	Payment authorities	✓	✓	2	2	
	Non-superannuation application					
30	Nomination of beneficiaries	✓				✓
32	Non-superannuation insurance application and signatures	✓				✓
	Superannuation application					
33	Nomination of dependants		✓	1	1	
37	Tax file number		✓	1	1	
39	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.

3 Financial authorities are only required if your accountant or financial adviser is required to release financial information to AXA.

This page has been left blank intentionally.

Medical and financial authorities

To be completed by the Person to be insured for all applications.

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

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

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. 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

Non-superannuation application

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.

Do you wish to make a nomination? No Yes

If yes, please nominate the beneficiaries to receive the payment of benefits 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" value=" "/>
Address					
<input type="text"/>					
Phone number		Relationship of the nominated person to the Plan owner		% of death benefit*	
<input type="text" value="()"/>		<input type="text"/>		<input type="text" value=" %"/>	
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" value=" "/>
Address					
<input type="text"/>					
Phone number		Relationship of the nominated person to the Plan owner		% of death benefit*	
<input type="text" value="()"/>		<input type="text"/>		<input type="text" value=" %"/>	
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" value=" "/>
Address					
<input type="text"/>					
Phone number		Relationship of the nominated person to the Plan owner		% of death benefit*	
<input type="text" value="()"/>		<input type="text"/>		<input type="text" value=" %"/>	
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" value=" "/>
Address					
<input type="text"/>					
Phone number		Relationship of the nominated person to the Plan owner		% of death benefit*	
<input type="text" value="()"/>		<input type="text"/>		<input type="text" value=" %"/>	
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" value=" "/>
Address					
<input type="text"/>					
Phone number		Relationship of the nominated person to the Plan owner		% of death benefit*	
<input type="text" value="()"/>		<input type="text"/>		<input type="text" value=" %"/>	
Total percentage					100 %

Non-superannuation application

Nomination of beneficiaries

(continued)

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.	
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Plan owner declaration

Plan owner family name

Given name(s)

I/We

the Plan owner(s), nominate the person(s) named above 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

Non-superannuation application

Non-superannuation insurance application and signatures

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.	
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Declarations and consent

Plan number **This Application form is dated 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 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, and
- **read the Declarations and consent** of the Product Disclosure Statement and understand the terms outlined.

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 of birth	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 of birth	Date signed
<input type="text"/>	X	/ /	/ /

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

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

Company seal	Print full name of company/self-managed superannuation 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"/>		

- 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.
- For SMSFs, if there are more than two trustees, please provide their full name(s) and signature(s) in the space below.

Superannuation application

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.

What nomination do you wish to make?

To make a binding nomination complete the binding nomination section below including witness declarations.

To make a non-binding nomination complete the non-binding nomination section on page 35.

Please note: you can change your nomination at any time by notifying the Trustee of the Super Directions Fund in the approved form.

Binding nomination (Trustee must pay specific people you have selected, provided that your nomination is valid)

Direct the Trustee to pay my death benefit exactly as follows (ie no Trustee discretion)

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" value=" "/>
Address					
<input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner			% of death benefit*
	<input type="text" value="()"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR† <input type="checkbox"/> Child			<input type="text" value=" %"/>
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" value=" "/>
Address					
<input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner			% of death benefit*
	<input type="text" value="()"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR† <input type="checkbox"/> Child			<input type="text" value=" %"/>
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" value=" "/>
Address					
<input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner			% of death benefit*
	<input type="text" value="()"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR† <input type="checkbox"/> Child			<input type="text" value=" %"/>
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" value=" "/>
Address					
<input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner			% of death benefit*
	<input type="text" value="()"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR† <input type="checkbox"/> Child			<input type="text" value=" %"/>
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" value=" "/>
Address					
<input type="text"/>					
	Phone number	Relationship of the nominated person to the Plan owner			% of death benefit*
	<input type="text" value="()"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR† <input type="checkbox"/> Child			<input type="text" value=" %"/>
					Total percentage
					<input type="text" value="100 %"/>

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

* Percentages must be whole numbers † Interdependency Relationship

This Application form is dated 19 September 2011

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

Superannuation application

Nomination of dependants

(For Super Directions Fund members only)

(continued)

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

Declaration, acknowledgment and signature**Member declaration**

Do not sign this declaration unless in the presence of both witnesses.

I have read the information in the 'binding nominations' section of the Product Disclosure Statement and understand that:

- in the event of my death, the Trustee will pay the death benefit in accordance with this nomination
- unless I revoke or amend it before it expires, this nomination will cease to be valid in three years time
- this nomination revokes any previous nomination that I may have made
- I declare that at the date of this application I have answered all questions accurately
- I am aware that if I do not make a valid binding nomination, the Trustee has the right to select the person or persons to whom to pay the benefit in the event of my death. I ask that the Trustee consider the preferred dependant(s) mentioned above when making a selection
- I acknowledge that my binding nomination is not valid unless completed to the satisfaction of the Trustee and received at the Customer Service Centre.

Signature of member

Date signed

X	
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/	/
---	---

Please complete the Witness declarations section below ►**Witness declarations – must be completed if making a binding nomination****Note:** Each witness must be an independent person and cannot be a nominated beneficiary.

I declare that:

I am over 18 years of age and am not a person nominated above, and that this nomination was signed by the member in my presence.

Witness 1 – full name

Signature

Date signed

	X	/	/
--	---	---	---

I am over 18 years of age and am not a person nominated above, and that this nomination was signed by the member in my presence.

Witness 2 – full name

Signature

Date signed

	X	/	/
--	---	---	---

OR

This Application form is dated 19 September 2011

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

Superannuation application

Nomination of dependants

(For Super Directions Fund members only)

(continued)

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.

Non-binding nomination (The Trustee of the Super Directions Fund will consider your preference but is not bound by this nomination. Witnesses are not required for a non-binding nomination.)

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

Signature of member **X** Date signed / /

This Application form is dated 19 September 2011

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

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Superannuation application

Tax file number (TFN)

- **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.

TFN – only for the Life Insurance Superannuation Plan and/or Income Insurance Superannuation Plan

Family name

Given name(s)

Date of birth

Telephone number

Tax file number (TFN)

 / / () **Your TFN 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:

- 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 (above) and agree to provide my TFN (tick one only) No Yes

Signature

Date

 X / /

This Application form is dated 19 September 2011

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

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Superannuation insurance application and signatures

Declarations and consent

Plan number

This Application form is dated 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(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, and
- **read the Declarations and consent** of the Product Disclosure Statement and understand the terms outlined.

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

This Application form is dated 19 September 2011

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

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 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 check-list

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 that 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)

To be completed by the Adviser for all applications.

Principal servicing adviser details

Account/Adviser name Account/Adviser number

Home phone number Mobile phone number Fax number

() ()

Email address

New Plan Commission splits

Note: Standard commission splits are not available for Rewards (Workplace/Family/Memberships/Business Rewards) applications

New Plan Commission

Account/Adviser name	Account/Adviser number	% split*	State
		%	
		%	
		%	
Total		100%	

* Percentage must be whole numbers

Renewal Business Commission splits

Renewal Business Commission

Account/Adviser name	Account/Adviser number	% split*	State
		%	
		%	
		%	
Total		100%	

* Percentage must be whole numbers

Plan number

Service centre only

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

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



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