

Exercising a Trauma Reinstatement Option and/or Life Buy-back Option

Information sheet

When to use this form

Use this form if exercising a trauma reinstatement option and/or life buy-back option for AMP Elevate insurance.

What you need to tell us

When you apply for insurance

When you apply for insurance, the insurer conducts a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The Duty to Take Reasonable Care Not to Make a Misrepresentation

! Read this if you are applying for insurance as the policy owner, if you will be an insured person under a policy owned by someone else, or if you will be an insured person under a superannuation plan.

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

We may later investigate the answers given in your application, including at the time of a claim.

Where a **policy** owned by one person covers the life of another person, it's important that the other person does not make a misrepresentation when providing information to the insurer. If the other person does make a misrepresentation, then it may be treated as a failure by the owner of the **policy** in their Duty to Take Reasonable Care Not to Make a Misrepresentation. Therefore, you must take reasonable care not to make a misrepresentation when giving us information whether you're the owner of the **policy** or an **insured person** under it.

If you do not meet your legal duty

If you do not meet your Duty to Take Reasonable Care Not to Make a Misrepresentation, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

If there is a failure to comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position it would have been in if the duty had been met. Therefore, if the person who answers our questions does not take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- we may **treat the contract (or your cover) as if it never existed** – the insurer can only do this within three years of your cover starting.
- we may **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told us everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.

- we may **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was;
- what the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will let you know our reasons and the information we rely on and give you an opportunity to provide an explanation.

If we decide to exercise one of these remedies, we will advise you of our decision and the process to have this reviewed or make a complaint if you disagree with our decision.

Guidance for answering our questions

When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question that we ask you.
- Do not assume that we will contact your doctor for any medical information.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it or check with us.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact us immediately.

Please keep this information sheet for your records— don't return it with your completed form(s).



This document is issued by Equity Trustees Superannuation Limited (ETSL) ABN 50 055 641 757, AFSL No. 229757 as trustee of the National Mutual Retirement Fund (NMRF) ABN 76 746 741 299 and AMP Life Limited ABN 84 079 300 379 (AMP Life). AMP Life has proudly served customers in Australia since 1849. AMP Limited ABN 49 079 354 519 has sold AMP Life to the Resolution Life Group whilst retaining a minority economic interest. AMP Limited has no day-to-day involvement in the management of AMP Life whose products and services are not affiliated with or guaranteed by AMP Limited. 'AMP', 'AMP Life' and any other AMP trademarks are used by AMP Life under licence from AMP Limited.

Exercising a Trauma Reinstatement Option and/or Life Buy-back Option

Use this form if exercising a trauma reinstatement option and/or life buy-back option for AMP Elevate insurance.

Please print in CAPITAL LETTERS and place a cross in any applicable boxes.

Plan details

Plan owner type (cross one) Individual Business application SMSF (**Note:** Cover owned by an SMSF can only be held under a Life Insurance SMSF Plan or Income Insurance SMSF plan).

Are you applying for insurance through? North Summit Generations iAccess

– For superannuation plans ^S If applying through North, Summit, Generations or iAccess Super or Pension please provide your existing account number

If you nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan, all superannuation plans quoted will be owned by N.M. Superannuation Proprietary Limited as trustee of the Wealth Personal Superannuation and Pension Fund, and paid from your Superannuation/Pension account. The person insured must be the member of the nominated account.

If you do not nominate a North, Summit, Generations or iAccess Superannuation or Pension Plan then all superannuation plans will be owned by Equity Trustees Superannuation Limited as trustee of the National Mutual Retirement Fund.

– For non-superannuation or SMSF plans ^{NS} ^{SMSF} If applying through North, Summit, Generations or iAccess Investment please provide your existing account number

If you nominate a North, Summit, Generations or iAccess Investment account, all non-superannuation or SMSF plans quoted will be paid from your Investment account. To nominate an Investment account, you must be authorised to transact on that account.

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

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

For RACV, please provide 16-digit card number

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

Campaign New plan

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

Full name of plan owner of linked plan

Are you related (mother, father, sister, brother, child or spouse), in a de facto or same sex relationship or in a business relationship with the financial adviser of this plan? No Yes

If yes, refer to page 18 for details on how this will impact commission.

Is there a concurrent application form being submitted? No Yes

If yes, to which application? Business partner(s) Spouse Children's Trauma
 Another AMP Life product
 Another AMP Life application on the person to be insured

Plan details (continued)

Please provide details below:

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

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

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

Gender Male Female Marital status Date of birth Country of birth

Residential address of person to be insuredAddress

Suburb State Postcode Country

Home phone number Business phone number Mobile phone number

Email address

If applying for a non-superannuation or SMSF plan, please complete the Non-superannuation or SMSF application sections on pages 4–9.
If applying for the Life Insurance Superannuation Plan, please complete the Superannuation application sections on pages 10–16.

Plan owner(s)

To be completed only 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.

! 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) ¹	Date of birth	Plan name
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Only provide an Australian business number (ABN) if the plan owner is to be a company or a trustee:

Company ABN

The plan owner(s) will need to complete the Non-superannuation or SMSF application section on pages 4–9.

¹ The names of all trustees should be listed.

Plan owner(s) (continued)**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 super fund

C/O (eg company title/department)

Title

Given name(s)/Trustee name(s)

Family name

Is the address for correspondence different to the residential address of the person to be insured? No Yes

Address

Suburb

State

Postcode

Country

Home phone number

Business phone number

Mobile phone number

Email address

For your financial adviser to complete

Please cross this box confirming you have attached the AMP Elevate Insurance quote (to be submitted with the application form). If only the client quote has been provided we will use the default commission structure of upfront, unless otherwise indicated in the application.

Exercising options**Exercising a life buy-back option**

(Please refer to your plan document for terms and conditions under this option)

Previous plan number

Previous life buy-back option (cross one): Life buy-back – TPD Life buy-back – Trauma

Previous TPD/Trauma sum insured \$

Sum insured being applied for \$

This sum insured amount cannot exceed the amount paid at claim on the previous plan. If this amount does exceed the amount paid at claim on the previous plan, health evidence will be required.

Exercising a trauma reinstatement option

(Please refer to your plan document for terms and conditions under this option)

Previous plan number

Previous trauma sum insured \$

Sum insured being applied for \$

This sum insured amount cannot exceed the amount paid at claim on the previous plan. If this amount does exceed the amount paid at claim on the previous plan, health evidence will be required.



Resolution Life

Non-superannuation or SMSF application

Non-superannuation payment authorities SMSF

! Before you complete this page, please read the 'Paying your premiums' section in the general terms and conditions 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** on the next page)
- 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.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross 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 133 731.

Non-superannuation payment authorities (continued) **NS** **SMSF**

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.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross 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, Australian business number (ABN)

Account holder signature(s)

Signature—account holder 1

Date signed

Signature—account holder 2 (if applicable)

Date signed

Nomination of beneficiaries NS

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

! Only complete this page if you have applied for the Life Insurance Plan. Do not complete if you are applying for the Life Insurance SMSF 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"/> / <input type="text"/> / <input type="text"/>
	Address <input type="text"/>				
	Phone number	Relationship of the nominated person to the plan owner		% of death benefit ¹	
	<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 ¹	
	<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 ¹	
	<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 ¹	
	<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 ¹	
	<input type="text"/>	<input type="text"/>		<input type="text"/> %	
	Total percentage				<input type="text"/> 100%

1. Percentages must be whole numbers.

Nomination of beneficiaries (continued) NS

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 AMP Life
 - 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 AMP Life.

Signature of the plan owner

Date signed

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Non-superannuation or SMSF insurance application and signatures (Declarations and consent) **NS** **SMSF**

Plan number

This application form is dated 1 October 2021.

! Before you sign this application form, you should:

- be aware that your adviser or AMP Life 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 and understand the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **product disclosure statement**, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy. I understand that if the questions are not answered truthfully, accurately and completely the insurance I have applied for may be avoided (treated as if it never existed) or altered and if I have made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted, and
- read the Declarations and consent section (including the 'Privacy – collection, use and disclosure of sensitive information') in the **product disclosure statement** and understand the terms outlined.

Signature of person to be insured **NS** **SMSF**

If the person to be insured is the same person as the plan owner, go to 'Signature of plan owner(s) – only for individuals'.

Print full name of person to be insured

Date of birth

Signature

Date signed

Signature of plan owner(s) – only for individuals (including individual trustees of an SMSF) **NS** **SMSF**

Print full name of SMSF or Trust (if applicable)

For Plan owner(s) (must be aged 16 years or over)

Print full name of plan owner/Trustee

Date of birth

Signature

Date signed

Plan owner/Trustee (delete one)

Print full name of plan owner/Trustee

Date of birth

Signature

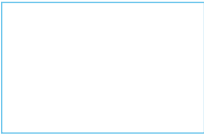
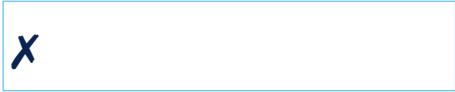
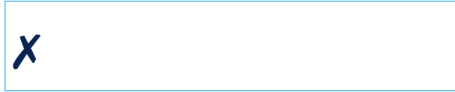
Date signed

Plan owner/Trustee (delete one)

- For SMSFs, if there are more than two trustees required as signatories, please provide their full name(s) and signature(s) at the bottom of this page.

Non-superannuation or SMSF insurance application and signatures (Declarations and consent) **NS SMSF** (continued)

Signatures of plan owners – only for companies (including company trustees of an SMSF) **NS SMSF**

Company seal 	Print full name of company <input type="text"/>		
	Signature 1 	Signature 2 	Date signed <input type="text" value="/ /"/>
	Director/Sole Director and Secretary (delete one)	Director/Secretary (delete one)	
	Print full name of person(s) signing for and on behalf of the above company <input type="text"/>		

To be signed by:

- For any company, either two directors of the company or a director and company secretary, or
- For a proprietary company, one signature as 'sole director and secretary' where the company has only one director who is also the sole company secretary.

Note: If the company constitution mandates the use of a company seal then it must be provided along with the relevant signatures outlined above.



Superannuation application S

Superannuation payment authorities S

! Before you complete this page, please read the 'Paying your premiums' section in the general terms and conditions 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** on the next page)
- Receive payment due notices (only available for quarterly, half-yearly and yearly payments)
- Partial rollover from a complying super fund (please complete and return the **Enduring rollover authority** form – eligibility criteria applies)

Option 1: Direct debit by credit card

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

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross 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 133 731.

Superannuation payment authorities (continued) 5

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.

If a deposit premium is not supplied, we will automatically deduct the premium on acceptance and completion of this application.

Frequency of ongoing premium deductions (cross 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, Australian business number (ABN)

Account holder signature(s)

Signature—account holder 1

Signature—account holder 2 (if applicable)

Date signed

Date signed

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

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. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.

Nomination of dependants (For National Mutual Retirement Fund (NMRF) members only) s

! 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 adviser.

What nomination do you wish to make?

To make a binding nomination complete the 'Binding death benefit nomination' section below including witness declarations.

To make a non-binding nomination complete the 'Non-binding death benefit nomination' section on page 14.

Please note: You can change your nomination at any time by notifying the Trustee of the NMRF in the approved form.

Binding death benefit 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"/> / <input type="text"/> / <input type="text"/>
Address <input type="text"/>					
	Phone number	Relationship of the nominated person to the person insured			% of death benefit ¹
	<input type="text"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR ² <input type="checkbox"/> Child			<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 person insured			% of death benefit ¹
	<input type="text"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR ² <input type="checkbox"/> Child			<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 person insured			% of death benefit ¹
	<input type="text"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR ² <input type="checkbox"/> Child			<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 person insured			% of death benefit ¹
	<input type="text"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR ² <input type="checkbox"/> Child			<input type="text"/> %

1 Percentages must be whole numbers.

2 Interdependency Relationship.

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

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. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.

Nomination of dependants (For National Mutual Retirement Fund (NMRF) members only) (continued) 5

Binding death benefit nomination (continued)

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 person insured			% of death benefit ¹
<input type="text"/>	<input type="checkbox"/> Financial dependant <input type="checkbox"/> Spouse <input type="checkbox"/> IR ² <input type="checkbox"/> Child			<input type="text"/> %
				Total percentage
or <input type="checkbox"/> My Legal Personal Representative (eg the executor of your will)				100%

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 before the death of the member.

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

 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 18 years of age or over, 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

I am 18 years of age or over, 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

1 Percentages must be whole numbers.

2 Interdependency Relationship.

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

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. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.

Nomination of dependants (For National Mutual Retirement Fund (NMRF) members only) (continued) [s](#)

Non-binding death benefit nomination

(The Trustee of the NMRF 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 person insured Financial dependant Spouse IR² Child % of death benefit¹ %

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

Address

Phone number Relationship of the nominated person to the person insured Financial dependant Spouse IR² Child % of death benefit¹ %

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

Address

Phone number Relationship of the nominated person to the person insured Financial dependant Spouse IR² Child % of death benefit¹ %

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

Address

Phone number Relationship of the nominated person to the person insured Financial dependant Spouse IR² Child % of death benefit¹ %

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

Address

Phone number Relationship of the nominated person to the person insured Financial dependant Spouse IR² Child % of death benefit¹ %

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

Total percentage **100%**

Print full name of member


Date of birth

Signature of member

Date signed


1 Percentages must be whole numbers. 2 Interdependency Relationship.

Tax file number (TFN)

 Only complete this page if you are applying for superannuation cover with the Life Insurance Superannuation Plan that is not being paid for from a North, Summit, Generations or iAccess account.

Plan number

Note: The plan owner is the Trustee of NMRF.

 This section must be completed by the person to be insured applying for the Life Insurance Superannuation Plan. Applications cannot be accepted without a TFN.

TFN – only for the Life Insurance Superannuation Plan

Title Family name Given name(s)

Date of birth Telephone number TFN

Your TFN is confidential. Before you provide your TFN 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 (cross one only) No Yes

Signature

Date

Superannuation insurance application and signatures (Declarations and consent) S

Plan number

! Before you sign this application form, you should:

- be aware that your financial adviser or AMP Life 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 and understand the section entitled ‘The Duty to Take Reasonable Care Not to Make a Misrepresentation’ in the **product disclosure statement**, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy. I understand that if the questions are not answered truthfully, accurately and completely the insurance I have applied for may be avoided (treated as if it never existed) or altered and if I have made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted, and
- read the Declarations and consent section (including the ‘Privacy – collection, use and disclosure of sensitive information’) in the **product disclosure statement** and understand the terms outlined.

Superannuation membership

Are you applying for insurance through? North Summit Generations iAccess

Please provide your existing North, Summit, Generations or iAccess account number

Are you applying for insurance through superannuation that is not attached to North, Summit, Generations or iAccess? This will be through the NMRF. No Yes

If yes, please complete questions 1 to 3 (below)

1. Current employment status

- Employee, go to question 2
- Self employed (sole trader, partnership)
- Employed by own company, go to question 3

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

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

If yes, please complete employer details below and question 4.

Company name

Company address

4. Please confirm that your employer has agreed to pay for premium increases due to indexation. No Yes

To be completed by the person to be insured

Title Print full name of person to be insured

Date of birth

Signature

Date signed

Adviser reference only

Any commission style or dial down commission can be selected in the AMP Elevate Insurance quote (to be submitted with the application form).



This document is issued by Equity Trustees Superannuation Limited (ETSL) ABN 50 055 641 757, AFSL No. 229757 as trustee of the National Mutual Retirement Fund (NMRF) ABN 76 746 741 299 and AMP Life Limited ABN 84 079 300 379 (AMP Life). AMP Life has proudly served customers in Australia since 1849. AMP Limited ABN 49 079 354 519 has sold AMP Life to the Resolution Life Group whilst retaining a minority economic interest. AMP Limited has no day-to-day involvement in the management of AMP Life whose products and services are not affiliated with or guaranteed by AMP Limited. ‘AMP’, ‘AMP Life’ and any other AMP trademarks are used by AMP Life under licence from AMP Limited.

Financial adviser and commission details

Underwriting and financial requirements

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

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

If you were provided with a request ID or service request ID number, please provide this number.

Has the person to be insured completed and signed all the relevant authorities, including medical authorities and/or financial authority? No Yes

Have you arranged or do you intend to arrange for any mandatory medical examinations or pathology tests to be completed? No Yes

If you have advised the person to be insured to have these tests specify name of doctor, paramedical facility or pathology laboratory who will arrange for the test:

Adviser checklist

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

Has a quote been provided with this application? No Yes

Is there any other documentation attached to this proposal? No Yes

If yes, please cross: Children's Trauma Option personal statement Financial questionnaire

Other, please specify

Has this application been faxed prior to sending? No Yes

If yes, specify fax number (Addressee)

Have the client and the person to be insured read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation'? No Yes

Do you have a preferred or alternative contact method? No Yes

If yes, please provide details in Adviser notes below.

Have you explained to the client the possible implications on the contract of not complying with 'The Duty to Take Reasonable Care Not to Make a Misrepresentation'? 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

If yes, specify (refer to Adviser notes if extra space required)

Adviser notes

Principal servicing adviser details

Account/Adviser name Account/Adviser number

Business phone number Mobile phone number Fax number

Email address

Please note: If the plan owner or person insured on this application is related (mother, father, sister, brother, child or spouse), in a de facto or same sex relationship or in a business relationship with the adviser listed above, flat commission will be paid on the accepted cover.

New plan commission splits

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

Account/Adviser name	Account/Adviser number	% split ¹	State
Total		100%	

Renewal business commission splits

Account/Adviser name	Account/Adviser number	% split ¹	State
Total		100%	

¹ Percentage must be whole numbers.



AMP Life administration

Plan number

Service centre only

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

Previous business

No Yes If 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			

