

Exercising a Trauma Reinstatement and/or Life Buy Back

Policy owner details

! If the plan is owned by a company, trust or SMSF, please provide the name of the entity and the ABN in the notes section at the end of this form. Where there are multiple policy owners, please include their details, including position with company (if applicable) in the notes section.

Title	Surname	Given name(s)	Date of birth	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Residential address		Suburb	State	Postcode
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Preferred contact number		Email address		
<input type="text"/>		<input type="text"/>		

Exercising option

Please refer to your plan document for the terms and conditions of the option you are exercising

- I am exercising the Trauma Reinstatement Option
- I am exercising the Life Cover Buy-Back

Plan number	Sum insured being applied for
<input type="text"/>	\$ <input type="text"/>

Note: The sum insured cannot exceed the amount paid at claim on the original cover.

Insured person's details

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

Payment authorities

Option 1: Direct debit by credit card

! Direct debit by credit card is not available for plans owned by SMSFs.

Premium frequency: Fortnightly Monthly Quarterly Half-yearly Yearly

Preferred billing date: (This is optional for monthly premium frequency and must be between 1st and 28th)

Credit card type: Mastercard Visa

Credit card number: - - - Expiry date:

Name on card: Cardholder's signature: Date signed:

If your credit card details change (e.g. card number or expiry date) we may be unable to process your payment. To update your credit card details, please call us on 133 731.

Payment authorities (continued)

Option 2: Direct debit by bank account

Premium frequency: Fortnightly Monthly Quarterly Half-yearly Yearly

Preferred billing date: (This is optional for monthly premium frequency and must be between 1st and 28th)

BSB number

Account number

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Name of bank/financial institution

Account name

Signature account holder 1

Signature account holder 2 (if applicable)

Date signed

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Agreement and declaration

I have read the plan document for my original plan and the Product Disclosure Statement (PDS) applicable to the new plan and understand and agree to the following:

- The premium payable for the new plan will be based on the premium rates, plan terms and conditions and age of the insured person applicable at the time the new plan is applied for.
- Any revised terms such as exclusions and loadings that applied to the original plan will apply to the new plan. If the exclusion wording for the new plan has been updated and is different to the exclusion wording in the original plan, in the event of a claim, I will be assessed under the exclusion wording that benefits me most.
- Increases to the sum insured under the Automatic inflation and the Future insurability benefit will not be available on the new plan.
- I have read the 'Direct Debit Request Service Agreement' in the PDS and authorise Resolution Life to debit my nominated account as set out in this application (if applicable).

A claim will not be payable under the reinstated trauma cover in specified circumstances, as set out in the PDS.

Full name of policy owner 1
and position with company (if applicable)

Full name of policy owner 2
and position with company (if applicable)

Signature of policy owner 1 / trustee 1 / director 1

Signature of policy owner 2 / trustee 2 / director 2 (if applicable)

Date

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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! If the policy owner(s):

- is/are the individual trustees of an SMSF: this declaration must be signed by all trustees or person(s) authorised to sign and enter into a contract of life insurance on behalf of all trustee(s) in accordance with the trust deed and rules
- is a company: this declaration must be signed by two directors, a director and company secretary, or the sole director/company secretary.

Where to send this form

Send your completed form to us:



Resolution Life, PO Box 5441, Sydney NSW 2001



insurance@resolutionlife.com.au

Need more information

- The fastest way is to chat with us online at [resolutionlife.com.au](https://www.resolutionlife.com.au)
- Call us on 133 731

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