

Exercising a Trauma Reinstatement and/or Life Buy Back

Policy owner details		
If the plan is owned by a company, trust or SI section at the end of this form. Where there a with company (if applicable) in the notes sect	are multiple policy owners, please include th	
Title Surname	Given name(s)	Date of birth
Residential address	Suburb	State Postcode
Preferred contact number	Email address	
Exercising option		
Please refer to your plan document for the term	ms and conditions of the option you are	exercising
\square I am exercising the Trauma Reinstatement Option	on	
☐ I am exercising the Life Cover Buy-Back		
Plan number		Sum insured being applied for
		\$
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
		D D M M Y Y Y
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 p	premium frequency and must be between 1st	t and 28th)
Credit card type: ☐ Mastercard ☐ Visa	, ,	,
Credit card number	Expiry date	
Name on card	Cardholder's signature	Date signed
	×	D D M M Y Y Y Y

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			
Name of bank/financial institution	Account name		
Signature account holder 1	Signature account holder 2 (if applicable)		
Signature account holder 1	Signature account holder 2 (if applicable)		
×	*		
Date signed D D M M Y Y Y Y	Date signed		
Agreement and declaration			
 I have read the plan document for my original plan and the Pro and understand and agree to the following: The premium payable for the new plan will be based on the insured person applicable at the time the new plan is applied. Any revised terms such as exclusions and loadings that applied wording for the new plan has been updated and is different to claim, I will be assessed under the exclusion wording that be. Increases to the sum insured under the Automatic inflation at the new plan. I have read the 'Direct Debit Request Service Agreement' in account as set out in this application (if applicable). A claim will not be payable under the reinstated trauma cover in 	premium rates, plan terms and conditions and age of the d for. ied to the original plan will apply to the new plan. If the exclusion of the exclusion wording in the original plan, in the event of a nefits me most. Ind the Future insurability benefit will not be available on the PDS and authorise Resolution Life to debit my nominated		
Full name of policy owner 1	Full name of policy owner 2		
and position with company (if applicable) Signature of policy owner 1 / trustee 1 / director 1	and position with company (if applicable) Signature of policy owner 2 / trustee 2 / director 2 (if applicable)		
×	×		
Date D D M M Y Y Y Y	Date D D M M Y Y Y Y		
sign and enter into a contract of life insurance on beha-	tion must be signed by all trustees or person(s) authorised to alf of all trustee(s) in accordance with the trust deed and rules directors, a director and company secretary, or the sole		

Notes	

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
- Call us on 133 731

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