Resolution Life

Application for Reinstatement

Information sheet

When to use this form

Use this form to apply to reinstate your lapsed Firstcare-Lifetime Protection plan.

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**.
- 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.

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– 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.

! Genetic test approach

You only need to tell us about any genetic testing you've had or have consented to have if the total combined sum insured with all life insurers for the insurance being applied for is over:

• $500,000 life cover

• $500,000 total and permanent disability cover (TPD)

• $200,000 trauma / critical illness cover, or

• $4,000 a month income protection cover, salary continuance cover or business expenses cover.

You can choose to tell us about a genetic test that you have had where the result was favourable. However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

Note: Resolution Life complies with the Moratorium on Genetic Tests. A copy of the moratorium is available in the Life Insurance Code of Practice **cali.org.au/life-code**.

Your privacy

Personal information

We may collect personal information directly from you or from your financial adviser.

We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it.

We may also collect and use any of your personal information, including sensitive information, collected and held by the Resolution Life Group if you authorise us to do so.

We may also use this information for related purposes—for example, enhancing customer service, product options and providing you with ongoing information about opportunities that may be useful for your financial needs through direct marketing. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the Resolution Life Group, or by your financial adviser. Please contact us if you do not want your personal information used for direct marketing purposes.

We usually disclose information of this kind to:

– other members of the Resolution Life Group
– your financial adviser or broker (if any)
– the owner of the plan (if applicable)

- external service suppliers who may be located in Australia or overseas, who supply administrative, financial or other services to assist the Resolution Life Group in providing Resolution Life Financial Services. A list of countries where these providers are likely to be located can be accessed via our Privacy Policy
- the Australian Transaction Reports and Analysis Centre (AUSTRAC) where required by our anti-money laundering compliance plan
- the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost super
- anyone you have authorised or if required by law.

Sensitive information

If sensitive information, such as health information, is collected in relation to this financial product, then additional restrictions apply. Resolution Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, Resolution Life, to assess your application for new or additional insurance. Resolution Life may also use this information for directly related purposes — for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims.

Resolution Life may disclose this type of health information to:

- your financial adviser or broker (if any)
- the Trustee or other members of the Resolution Life Group
- the owner of the plan (if applicable)
- Resolution Life's reinsurers
- 'doctors'
- any person Resolution Life considers necessary to help either assess claims or resolve complaints.
- anyone you have authorised or if required by law.

If you are an 'insured person', aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

If you are an 'insured person', Resolution Life and/or their health screening provider may also speak to a third party for the sole purpose of arranging a health screening appointment. This third party may include a spouse, family member, personal assistant, financial adviser or other relevant party.

Under the current Resolution Life Privacy Policy, you may access personal information about you held by the Resolution Life Group. The Resolution Life Privacy Policy sets out the Resolution Life Group's policies on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy, and information about how Resolution Life deals with such complaints. The Resolution Life Privacy Policy can be obtained online at **resolutionlife.com.au** or by calling our Customer Service Centre on 133 731.

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

904262_RL 11/23

Resolution Life

Application for Reinstatement

Use this form to apply to reinstate your lapsed Firstcare- Lifetime Protection plan.
Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

Completion instructions

- ☐ For owners of adult plans > Complete sections **1**, **2**, and **6**
- ☐ For owners of child plans > Complete sections **1**, **2**, **5** and **6**
- ☐ For insured persons > Complete section **3**
  - > If you are the second insured person, complete section 4.

1. Telephone underwriting

We may need to contact you between 8.00am to 7.00pm regarding the details of your application:

Daytime number	Hours you can be contacted	After hours number	Hours you can be contacted

Mobile number	Hours you can be contacted	Email address

2. Plan details – to be completed by plan owner(s)

Plan number(s)

Please state why the plan lapsed.

If more than two owners, please use an additional **application for reinstatement** form.

Plan owner 1

Type of owner

☐ Self managed super fund ☐ Company ☐ Individual

Trustee name

Super fund name

OR

Company name

OR

Title	Surname	Given name(s)

Date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female

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2. Plan details – to be completed by plan owner(s) (continued)

Plan owner 2

Type of owner

☒ Individual

Title | Surname | Given name(s)

Date of birth (D D M M Y Y Y Y) | Gender ☐ Male ☐ F emale

Residential address

Suburb | State | Postcode

Business number | Home number | Mobile number

If more than two insured persons please use an additional **application for reinstatement** form.

First insured person

Title | Surname | Given name(s)

Second insured person

Title | Surname | Given name(s)

3. Insured person 1

To be completed by the first insured person, or the owner of a child's plan which has Suspension of premium benefit.

Existing insurance details

Other than this/these applications, are you applying for, or do you have in force, any personal insurance with Resolution Life or any other insurer? If 'Yes', please provide details of all existing in force policies with Resolution Life or other insurers, and/or any policies you are applying for (including other insurers). ☐ No ☐ Yes

Do not include values of cover from this application.

Name of insurer	Life cover	Total & Permanent Disablement cover or Permanent incapacity cover	Trauma cover	Monthly disability (income) cover	Disability type	Is this cover to be cancelled?(iv)
Resolution Life Australasia Limited	$	$	$	$	☐ TSC(i) ☐ IP(ii) ☐ BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		
	$	$	$	$	☐ TSC(i) ☐ IP(ii) ☐ BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		
	$	$	$	$	☐ TSC(i) ☐ IP(ii) ☐ BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		

(i) Temporary salary continuance cover/Temporary incapacity cover.

(ii) Income protection cover.

(iii) Business overheads insurance cover.

(iv) **Note:** Your insurance application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do this means your insurance claim on your Resolution Life plan may be invalid. If this insurance application is to replace existing insurance cover, the Resolution Life insurance plan to be replaced will cease and a new insurance plan will start.

3. Insured person 1 (continued)

Travel details

a. Do you have any intention of travelling outside Australia or New Zealand within the next 12 months? ☐ No ☐ Yes
(If 'Yes', give details)

Health information

a. What is your state of health?

b. Within the **last month**:

i. Have you travelled overseas? ☐ No ☐ Yes

ii. Have you had contact with someone who has recently returned from overseas? ☐ No ☐ Yes

iii. Have you been exposed to someone who suffered and was later diagnosed with COVID-19? ☐ No ☐ Yes

c. If 'Yes' to any of the items in b, please provide details below:

i. When did you or the other person return from overseas or when were you exposed?
D D M M Y Y Y Y

ii. Have you completed the required 14 days of self-quarantine/isolation? ☐ No ☐ Yes

iii. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? (If 'Yes' give details) ☐ No ☐ Yes

d. i. Have you been tested for COVID-19? ☐ No ☐ Yes

ii. If you've been tested, what was the result?

☐ Negative

☐ Positive

iii. If you tested 'positive' did you have a following COVID-19 test result which was negative? ☐ No ☐ Yes

iv. If you tested 'positive' were you hospitalised? (If 'Yes' give details) ☐ No ☐ Yes

Period in hospital	Hospital name and address	Treatment received	Did you spend time in intensive care?
/ / to / /			☐ No ☐ Yes If 'Yes', number days ____ days

e. If you had symptoms or tested 'positive' to COVID-19, have you fully recovered with no continuing or residual symptoms or complications? (If 'No' give details) ☐ No ☐ Yes

f. Do you have AIDS or any AIDS-related disorders or have you had a positive blood test for the HIV antibody? ☐ No ☐ Yes

g. During the **last 5 years**:

i. Have you consulted, been examined, or received advice or any preventative or prophylactic treatment (eg a mastectomy) from any medical practitioner, psychologist, physiotherapist, chiropractor, or other health professional; or had any medical or surveillance tests or investigations (eg ultrasound, colonoscopies, blood tests, ECG, X-ray, mammogram, etc)? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. If 'Yes', please give full particulars below of each instance. ☐ No ☐ Yes

If additional space is required, attach a separate sheet of paper.

Condition/Name	Date first started	Date of last symptoms	No. of occurrences	Time off work	Details/ Symptoms	Complications/ Ongoing effects
1.	/ /	/ /				
2.	/ /	/ /				

Name and address of doctor or hospital

1.
2.

3. Insured person 1 (continued)

Health information (continued)

ii. Have you been in a hospital, clinic or nursing home? (if 'Yes', give details) ☐ No ☐ Yes

iii. Have you been advised to have an operation? (If 'Yes', give details) ☐ No ☐ Yes

iv. Have you been refused a life, disablement, trauma/critical illness, sickness and accident plan or Superannuation cover or accepted with an increased premium or been offered insurance on terms other than those for which you applied? (If 'Yes', give details) ☐ No ☐ Yes

h. Have you smoked tobacco or any other substance, used e-cigarettes, nicotine patches or nicotine replacement products within the last 12 months? ☐ No ☐ Yes

If 'Yes', please advise which of the following apply and quantity consumed.

☐ Cigarettes Quantity per: ☐ day ☐ week ☐ month

☐ Tobacco pipes Quantity per: ☐ day ☐ week ☐ month

☐ Cigars Quantity per: ☐ day ☐ week ☐ month

☐ Nicotine replacement products ☐ E-cigarettes ☐ Other, please specify:

If you have indicated above that you use nicotine replacement products, e-cigarettes or any other substance, please answer questions i and ii below.

i. How often are or were these nicotine patches, e-cigarettes or other nicotine products used, replaced or refilled?

ii. What strength are or were they? ☐ mgs

i. Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted—go to next question.

☐ Yes — please cross all that apply and provide the details further below:

- ☐ Breast and/or ovarian cancer
- ☐ Lynch syndrome, familial polyposis or bowel/colon cancer
- ☐ Diabetes
- ☐ Heart attack
- ☐ Haemochromatosis
- ☐ Multiple sclerosis
- ☐ Motor neurone disease
- ☐ Alzheimer's disease or any other type of dementia
- ☐ Any hereditary disorder or condition that runs in families
- ☐ Prostate cancer
- ☐ Polycystic kidney disease, renal cell cancer or kidney cancer
- ☐ Stroke
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Any other cancer or any other heart condition

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

3. Insured person 1 (continued)

Occupation, activities, residence and income details (this section must be completed for all applicants)

a. Current occupation

b. Type of industry

c. What is the average amount of time you work? hours per week weeks per year

d. Does your occupation involve manual labour? (If 'Yes', give details) ☐ No ☐ Yes

e. Have you any intention of changing your occupation or taking extended leave of absence in the future? (If 'Yes', give details) ☐ No ☐ Yes

f. In the **last 3 years** have you taken part, or in the future do you intend to take part, in any hazardous activity or any organised sport? Examples of such activities are flying (other than as a fare-paying passenger), motor sports, trail or quad bike riding, diving, abseiling, rock climbing and football. (If 'Yes', give details) ☐ No ☐ Yes

Activity type	Amateur/professional	Hours/events per year

Please provide any other information that may help us understand your involvement in the above activities.

g. Do you have any definite plans to travel or reside overseas, or are you currently residing overseas? (If 'Yes', give details including dates, countries to be visited, length of stay, reason.) ☐ No ☐ Yes

Financial – Complete this section where the sum insured is $500,000 or greater, or for Income Protection Insurance.

a. What has been your net income for the last two years (ie gross income or revenue, less business expenses)?

Year ending 30/06/20 $ Year ending 30/06/20 $

b. Has your business traded profitably for the last two years? ☐ No ☐ Yes

Note: Further financial evidence to support this application may be required.

Agreement and declaration

– I declare that the answers to all the questions and the written information provided in this application and any separate statements are true, correct and complete, whether or not they are in my own handwriting, and that I have kept back nothing which might cause the insurer to decide that the insured person is a greater risk to insure.

– I acknowledge that I have received and read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the information sheet. I understand that my Duty to Take Reasonable Care Not to Make a Misrepresentation continues even after this application has been completed, until Resolution Life notifies me in writing that it has accepted my application for reinstatement. I understand that, if I fail to comply with this duty, the reinstatement may be cancelled or the cover may be altered.

– I authorise any insurer (including companies related to Resolution Life), to disclose to Resolution Life, and for Resolution Life to collect, any information they have on my health, medical history, pastimes, work history, or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it. I understand that, under Government Privacy legislation, I may access a copy of these reports from Resolution Life. I have been advised by Resolution Life of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.

– Resolution Life is authorised to divulge to their reinsurers any information that Resolution Life has acquired with regard to me.

Name

Signature of insured person (or owner if a child's plan)

✗

Date D D M M Y Y Y Y

4. Insured person 2

To be completed by the first insured person, or the owner of a child's plan which has Suspension of premium benefit.

Existing insurance details

Other than this/these applications, are you applying for, or do you have in force, any personal insurance with Resolution Life or any other insurer? If 'Yes', please provide details of all existing in force policies with Resolution Life or other insurers, and/or any policies you are applying for (including other insurers). ☐ No ☐ Yes

! Do not include values of cover from this application.

Name of insurer	Life cover	Total & Permanent Disablement cover or Permanent incapacity cover	Trauma cover	Monthly disability (income) cover	Disability type	Is this cover to be cancelled?(iv)
Resolution Life Australasia Limited	$	$	$	$	☐ ☐ ☐ TSC(i) IP(ii) BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		
	$	$	$	$	☐ ☐ ☐ TSC(i) IP(ii) BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		
	$	$	$	$	☐ ☐ ☐ TSC(i) IP(ii) BOI(iii)	☐ If 'Yes' give policy no:
Amount to cancel	$	$	$	$		

(i) Temporary salary continuance cover/Temporary incapacity cover.
(ii) Income protection cover.
(iii) Business overheads insurance cover.
(iv) **Note:** Your insurance application will be considered on the understanding that if you intend to cancel any existing cover, that you will do so on acceptance of this application. Failure to do this means your insurance claim on your Resolution Life plan may be invalid. If this insurance application is to replace existing insurance cover, the Resolution Life insurance plan to be replaced will cease and a new insurance plan will start.

Travel details

a. Do you have any intention of travelling outside Australia or New Zealand within the next 12 months? ☐ No ☐ Yes
(If 'Yes', give details)

Health information

a. What is your state of health?

b. Within the **last month**:
i. Have you travelled overseas? ☐ No ☐ Yes
ii. Have you had contact with someone who has recently returned from overseas? ☐ No ☐ Yes
iii. Have you been exposed to someone who suffered and was later diagnosed with COVID-19? ☐ No ☐ Yes

c. If 'Yes' to any of the items in b, please provide details below:
i. When did you or the other person return from overseas or when were you exposed?
D D M M Y Y Y Y
ii. Have you completed the required 14 days of self-quarantine/isolation? ☐ No ☐ Yes
iii. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? (If 'Yes' give details) ☐ No ☐ Yes

4. Insured person 2 (continued)

Health information (continued)

d. i. Have you been tested for COVID-19? ☐ No ☐ Yes

ii. If you've been tested, what was the result?

☐ Negative

☐ Positive

iii. If you tested 'positive' did you have a following COVID-19 test result which was negative? ☐ No ☐ Yes

iv. If you tested 'positive' were you hospitalised? (If 'Yes' give details) ☐ No ☐ Yes

Period in hospital	Hospital name and address	Treatment received	Did you spend time in intensive care?
/ / to / /			☐ No ☐ Yes If 'Yes', number days ☐ days

e. If you had symptoms or tested 'positive' to COVID-19, have you fully recovered with no continuing or residual symptoms or complications? (If 'No' give details) ☐ No ☐ Yes

f. Do you have AIDS or any AIDS-related disorders or have you had a positive blood test for the HIV antibody? ☐ No ☐ Yes

g. During the **last 5 years**:

i. Have you consulted, been examined, or received advice or any preventative or prophylactic treatment (eg a mastectomy) from any medical practitioner, psychologist, physiotherapist, chiropractor, or other health professional; or had any medical or surveillance tests or investigations (eg ultrasound, colonoscopies, blood tests, ECG, X-ray, mammogram, etc)? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. If 'Yes', please give full particulars below of each instance. ☐ No ☐ Yes

! If additional space is required, attach a separate sheet of paper.

Condition/Name	Date first started	Date of last symptoms	No. of occurrences	Time off work	Details/Symptoms	Complications/ Ongoing effects
1.	/ /	/ /				
2.	/ /	/ /				

Name and address of doctor or hospital

1.
2.

ii. Have you been in a hospital, clinic or nursing home? (if 'Yes', give details) ☐ No ☐ Yes

iii. Have you been advised to have an operation? (If 'Yes', give details) ☐ No ☐ Yes

iv. Have you been refused a life, disablement, trauma/critical illness, sickness and accident plan or Superannuation cover or accepted with an increased premium or been offered insurance on terms other than those for which you applied? (If 'Yes', give details) ☐ No ☐ Yes

4. Insured person 2 (continued)

Health information (continued)

h. Have you smoked tobacco or any other substance, used e-cigarettes, nicotine patches or nicotine replacement products within the last 12 months? ☐ No ☐ Yes

If 'Yes', please advise which of the following apply and quantity consumed.

☐ Cigarettes Quantity per: ☐ day ☐ week ☐ month

☐ Tobacco pipes Quantity per: ☐ day ☐ week ☐ month

☐ Cigars Quantity per: ☐ day ☐ week ☐ month

☐ Nicotine replacement products ☐ E-cigarettes ☐ Other, please specify:

If you have indicated above that you use nicotine replacement products, e-cigarettes or any other substance, please answer questions i and ii below.

i. How often are or were these nicotine patches, e-cigarettes or other nicotine products used, replaced or refilled?

ii. What strength are or were they? ☐ mgs

i. Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted — go to next question.

☐ Yes — please cross all that apply and provide the details further below:

- ☐ Breast and/or ovarian cancer
- ☐ Lynch syndrome, familial polyposis or bowel/colon cancer
- ☐ Diabetes
- ☐ Heart attack
- ☐ Haemochromatosis
- ☐ Multiple sclerosis
- ☐ Motor neurone disease
- ☐ Alzheimer's disease or any other type of dementia
- ☐ Any hereditary disorder or condition that runs in families
- ☐ Prostate cancer
- ☐ Polycystic kidney disease, renal cell cancer or kidney cancer
- ☐ Stroke
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Any other cancer or any other heart condition

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

4. Insured person 2 (continued)

Occupation, activities, residence and income details (this section must be completed for all applicants)

a. Current occupation

b. Type of industry

c. What is the average amount of time you work? hours per week weeks per year

d. Does your occupation involve manual labour? (If 'Yes', give details) ☐ No ☐ Yes

e. Have you any intention of changing your occupation or taking extended leave of absence in the future? (If 'Yes', give details) ☐ No ☐ Yes

f. In the **last 3 years** have you taken part, or in the future do you intend to take part, in any hazardous activity or any organised sport? Examples of such activities are flying (other than as a fare-paying passenger), motor sports, trail or quad bike riding, diving, abseiling, rock climbing and football. (If 'Yes', give details) ☐ No ☐ Yes

Activity type	Amateur/professional	Hours/events per year

Please provide any other information that may help us understand your involvement in the above activities.

g. Do you have any definite plans to travel or reside overseas, or are you currently residing overseas? (If 'Yes', give details including dates, countries to be visited, length of stay, reason.) ☐ No ☐ Yes

Financial – Complete this section where the sum insured is $500,000 or greater, or for Income Protection Insurance.

a. What has been your net income for the last two years (ie gross income or revenue, less business expenses)?

Year ending 30/06/20 $ Year ending 30/06/20 $

b. Has your business traded profitably for the last two years? ☐ No ☐ Yes

Note: Further financial evidence to support this application may be required.

Agreement and declaration

– I declare that the answers to all the questions and the written information provided in this application and any separate statements are true, correct and complete, whether or not they are in my own handwriting, and that I have kept back nothing which might cause the insurer to decide that the insured person is a greater risk to insure.

– I acknowledge that I have received and read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the information sheet. I understand that my Duty to Take Reasonable Care Not to Make a Misrepresentation continues even after this application has been completed, until Resolution Life notifies me in writing that it has accepted my application for reinstatement. I understand that, if I fail to comply with this duty, the reinstatement may be cancelled or the cover may be altered.

– I authorise any insurer (including companies related to Resolution Life), to disclose to Resolution Life, and for Resolution Life to collect, any information they have on my health, medical history, pastimes, work history, or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it. I understand that, under Government Privacy legislation, I may access a copy of these reports from Resolution Life. I have been advised by Resolution Life of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.

– Resolution Life is authorised to divulge to their reinsurers any information that Resolution Life has acquired with regard to me.

Name

Signature of insured person (or owner if a child's plan)

✗

Date D D M M Y Y Y Y

5. Statement of health (child)

Personal statement relating to the health of the insured child for a child's plan.

Important: Please refer to the **genetic test approach** in the **information sheet** when answering these questions.

a. What is the present state of the child's health?

b. Has the child had any illness or met with any accident since the above plan was effected? (If 'Yes', state the **date**, **nature**, **duration** of illness or injury **treatment** received and name and address of the attending doctor.) ☐ No ☐ Yes

c. Has there been any other change in circumstances since the plan was effected which may affect the risk? (If 'Yes', please give details) ☐ No ☐ Yes

Agreement and declaration (owner of the child's plan)

– I declare that the answers to all the questions and the written information provided in this application and any separate statements are true, correct and complete, whether or not they are in my own handwriting, and that I have kept back nothing which might cause the insurer to decide that the insured person is a greater risk to insure.

– I acknowledge that I have received and read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the Information sheet. I understand that my Duty to Take Reasonable Care Not to Make a Misrepresentation continues even after this application has been completed, until Resolution Life notifies me in writing that it has accepted my application for reinstatement. I understand that, if I fail to comply with this duty, the reinstatement may be cancelled or the cover may be altered.

– I authorise any insurer (including companies related to Resolution Life), to disclose to Resolution Life, and for Resolution Life to collect, any information they have on my health, medical history, pastimes, work history, or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it. I understand that, under Government Privacy legislation, I may access a copy of these reports from Resolution Life. I have been advised by Resolution Life of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.

– Resolution Life is authorised to divulge to their reinsurers any information that Resolution Life has acquired with regard to me.

Name

Signature of the owner of the child's plan

✗

Date

D D M M Y Y Y Y

6. Agreement and declaration

To be completed by the plan owner(s)

I apply for reinstatement of my plan and declare and acknowledge the following:

- The answers to all the questions and the written information provided in this application and any separate statements are true, correct and complete, whether or not they are in my own handwriting, and I have kept back nothing which might cause the insurer to decide that the insured person is a greater risk to insure.
- I have received and read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' from the Information sheet. I understand that my Duty to Take Reasonable Care Not to Make a Misrepresentation continues even after I have completed this application, and right up until Resolution Life notifies me in writing that it has accepted my application for reinstatement. I understand that, if I fail to comply with this duty, the reinstatement may be cancelled or the cover may be altered.
- Resolution Life may, in considering my application for reinsurance, apply conditions to the plan including restarting or resuming any waiting periods that Resolution Life considers necessary in its discretion.
- I understand in the event this application for reinstatement is accepted and underwritten by Resolution Life, the billing details previously provided and used to pay for the cover will be used for a deduction of premiums under the reinstated policy. I understand that the premium amount deducted will be to cover from the reinstatement date to the next billing date. The exception to this is for superannuation plans that commenced prior to 1 July 2014 or for Firstcare Lifetime plans containing Income Protection and/or Business Overheads Insurance. In these situations, as I will be covered from the date of lapse, the premiums debited will be from the lapse date to the next billing date after reinstatement.

Name

Plan owner 1 signature

✗

Date

D D M M Y Y Y Y

Name

Plan owner 2 signature

✗

Date

D D M M Y Y Y Y

Where to send this form

Mail or email this completed form to:

Resolution Life Customer Service
GPO Box 5441
Sydney NSW 2001

askus@resolutionlife.com.au

Any questions?
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