# APPLICATION FOR REINSTATEMENT

Part of the Suncorp Group

**Issued** 18 December 2015

## Your duty of disclosure

**To be read by the policy owner and person to be insured before completing this questionnaire.**

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

Your duty of disclosure continues to apply until the contract is entered into. It also applies when you extend, vary or reinstate a contract of life insurance.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows, or in the ordinary course of their business, ought to know; or
- as to which compliance with your duty is waived by the insurer.

### Non-disclosure

If you fail to comply with your duty of disclosure and we would not have entered into the contract if the failure had not occurred, we may avoid the contract within 3 years of entering into it.

If your non-disclosure is fraudulent, we may avoid the contract at any time.

We may elect not to avoid your contract but to vary it by:

(i) reducing the sum insured in accordance with a formula that takes into account the premium that would have been payable if you had complied with your duty of disclosure; or

(ii) placing us in the position in which we would have been in if you had complied with your duty of disclosure.

The options to vary the contract are available to us while cover under the contract remains in force.

Where your contract provides death cover, we may only apply i) above and must do so within 3 years of you entering into the contract with us.

If the contract is for insurance of the life of another person, any failure by him or her to tell us a matter that he or she knows, or could reasonably be expected to know, is relevant to our decision whether to enter into the contract and, if so, on what terms, may be treated as a failure by you to comply with your duty of disclosure.

## Policy owner details

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Please specify

Surname

Given name(s)

Postal address

State Postcode

Phone Home ( ) Work ( ) Mobile

The policy owner of:

Policy number issued on the life of

Type of policy hereby make application for the reinstatement of this policy which has been cancelled.

If we need to get more information from you, may one of our underwriters phone or e-mail you? (this can save time and ensure that the underwriter fully understands your circumstances).

Yes ☐ No ☐ If 'yes', please indicate your preferred phone number and/or e-mail address as well as a convenient time to call:

At home ☐ At work ☐ Days Convenient times From: To:

Insured's phone number Insured's email address

Every now and then, we and any related companies that use the Asteron Life brand might let you know about news, special offers, products and services that you might be interested in. We will engage in marketing unless you tell us otherwise. You can contact us on 1800 221 727 to update your marketing preferences at any time.

**Note: Completion of this form does not mean that the policy will be automatically reinstated. Further medical evidence may be required before reinstatement is considered.**

# Statement by person to be insured

Please provide full details to all questions whether you feel it relevant or not. You have a legal duty to provide full information and failure to comply may affect a future claim.

**Note: A parent holding a policy on the life of a child under the age of sixteen may answer the questions in the statement.**

Name of person to be insured

Surname Date of birth / /

Given name(s)

1. Since the date of your original application have you consulted, been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist, or any other health care professional, been in a hospital, had an operation or had any tests (including genetic tests), e.g. x-ray, ECG, mammogram, pap smear etc? This does not include common colds, flus or regular age-related health checks where the results were all normal. Yes ☐ No ☐

2. i. Since the date of your application to this company have you had any change in health or suffered from any sickness or injury? Yes ☐ No ☐
   If yes, please provide details

ii. Do you have any physical impairment, disability, medical condition or other departure from good health? Yes ☐ No ☐
   If yes, please provide details

iii. Are you taking prescribed medication on a regular basis (other than the contraceptive pill)? Yes ☐ No ☐

3. Do you intend to seek or have you been advised to have any medical examination, advice, treatment, tests or an operation in the future? Yes ☐ No ☐

   If you answered 'Yes' to any of Q1, Q2 or Q3, please provide details in the table below:

| Qn. no. | Sickness, injury or tests | Test results | Date commenced | Time off work | Degree of recovery (%) | Date of last symptoms | Treatment received | Full name and address of doctor or hospital |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

4. Please answer the following:

   N.B. If you do not have a regular doctor, answer the following questions with reference to your most recent medical consultation.

   a. Name of your regular doctor/medical centre

   Address

   State Postcode

   Phone ( ) Fax ( )

   b. How long have you been a patient of this doctor? Date of last consultation / /

   Reason for consultation

Outcome

c. If you have been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address

State Postcode

Please provide date, reason and outcome of last consultation(s)

5. Have you ever smoked tobacco or any other substance at any time in the last 12 months?

Yes ☐ No ☐ If 'yes', type (e.g. cigarettes)? Daily Quantity?

How many years? (if beyond 12 months)

Date ceased? If applicable / / Other

6. Do you currently participate in or do you have any intention of participating in any organised sport or hazardous activity including but not limited to: football, boxing, wrestling, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, bungy jumping, professional sports, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (e.g. Qantas or any other organised sport or hazardous activity)?

Yes ☐ No ☐ If 'yes' please provide full details.

7. a. What is your present occupation?

b. Describe usual role and duties

8. What is your annual salary or current earned income or other remuneration before tax but net of business expenses? (Income Protection and Business Expenses only) $

9. In the next 12 months do you intend to take extended leave, or to travel, work or live overseas for any period of time? Yes ☐ No ☐

If 'yes', please advise: Date leaving / / Date returning / /

Countries to be visited

Reason for trip

10. (Please only complete if Child Cover is included within your policy.) Since the date of your original application, has the insured child(ren) had any illness, injury or medical disorder (including but not limited to heart, lung, blood, digestive, urinary or cancer related illness as well as neurological / developmental disorders or other illness, injury or medical disorder) which has required ongoing treatment, advice or surgical procedure? Yes ☐ No ☐

If 'yes', please provide details in the following table.

| Child | Condition, dates, treatment, results | Full name and address of doctor or hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

11. Has an application for an insurance policy or cover on your life been submitted to any other company since the date of your original application to this company? (E.g., this may include an application for an insurance policy by you, or an application for cover under a group policy on your behalf). Yes ☐ No ☐

i. If 'yes', please advise type and amount of cover, and name of company.

ii. Has this cover been accepted? Yes ☐ No ☐

If 'yes', please advise if accepted at standard rates, accepted at an increased rate of premium or with amended terms.

If 'no', please advise why the cover has not yet been accepted, including if deferred or declined.

# Declaration

I/We agree that:

l. The original application form for this policy, as varied by this application and the Statement overleaf, shall form the basis of the contract with Suncorp Life & Superannuation Limited for reinstatement of this policy.

m. If this policy is reinstated, reinstatement will be based on the truth of the answers made in the Statement overleaf.

n. Suncorp Life & Superannuation Limited will not pay:

   i. for suicide within 13 calendar months from the date of reinstatement; or

   ii. critical conditions/trauma benefits; within 3 calendar months from the date of reinstatement.

   - for cancer if first diagnosed,
   - for heart attack, out of hospital cardiac arrest or stroke if first occurred, or
   - for heart surgery events if the disease or condition which the surgery is directed at is first diagnosed,

   Please refer to your policy document for further details.

I/We declare that the statements made in this statement are true and complete and agree that they shall form part of the application for insurance and shall be relied upon by Suncorp Life & Superannuation Limited in deciding whether to issue a policy including the premiums and terms to offer.

To the extent that if the answers are not in my/our own handwriting they have been checked by me/us and I/we certify that they are correct to the best of my/our knowledge.

I/We have read and acknowledge the Duty of Disclosure to Suncorp Life & Superannuation Limited and understand that this duty continues to apply until the insurance applied for has been accepted by Suncorp Life & Superannuation Limited. I/we also acknowledge that the Duty of Disclosure will also apply if I/we extend, vary or reinstate a contract of insurance.

Any statements I/we have made on or with an application to another insurer and which I/we have presented to Suncorp Life & Superannuation Limited are intended by me/us as declarations and representations to Suncorp Life & Superannuation Limited and I/we acknowledge that Suncorp Life & Superannuation Limited will use them in assessing this insurance application.

Before or at the time I/we provided any personal information, I/we have read and understood the current Suncorp Life & Superannuation Limited (SLSL) and Suncorp Portfolio Services Limited (Trustee) Privacy Statement in the current Asteron Life Complete PDS and Policy Document (Asteron Life Complete PDS), which is also available at asteronlife.com.au/privacy.

I/We consent to SLSL and, if I am/we are applying for membership of the Fund, the Trustee collecting, using and disclosing my/our personal information (including sensitive information), in accordance with the Privacy Statement. This includes disclosing my/our personal information to my/our financial adviser to clarify the decision in the event the application cannot be accepted (if relevant).

I/We understand that the insurance application for reinstatement where applied for will not become effective until my/our application is accepted by the insurer in writing.

Signature of the person to be insured

✗

Date d d / m m / y y y y

Signature of policy owner (if different from person to be insured

✗

Date d d / m m / y y y y

If you have any queries about completing this form please contact Asteron Life Customer Service on 1800 221 727.

The completed form may be faxed to 1300 766 833 or emailed to life_customerservice@asteronlife.com.au

# Medical history authorisation by the Person to be Insured (Must be completed)

To Doctor

I authorise any doctor, hospital, clinic and other medical or related facility, or any other person who has attended me, to provide Suncorp Life & Superannuation Limited with any information with respect to any sickness, injury, consultation, tests (including genetic test(s)), prescriptions or treatment and copies of all hospital records.

I authorise Medicare Australia to release to Suncorp Life & Superannuation Limited, at their request, a copy of my medical history records.

I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Name of person(s) to be insured

OR Children to be insured

Maiden name (if applicable)

Signature

✗

Date d d / m m / y y y y

Signature of person to be insured or their guardian (if under 18).

# Direct Debit Request

**Personal details**

Surname | Given name(s)

Surname | Given name(s)

Postal Address

State | Postcode

Telephone: Home ( ) | Work ( ) | Mobile

**Payment details**

| Policy number |
|---|
| |
| |
| |

N.B. any outstanding premiums will be debited from the account or credit card supplied

## Part A Direct debit (bank, building society, credit union)

**Details of account to be debited:**

This form is to authorise Suncorp Life & Superannuation Limited (user ID 367806) to debit premiums from your account with a financial institution.

Name of account holder

Name of financial institution

Name of account to be debited

BSB number ☐☐☐-☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Frequency: ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

I/We acknowledge that this direct debit arrangement is governed by the terms of the Direct Debit Request Service Agreement attached and the terms and conditions of my Suncorp Life & Superannuation Limited (Asteron Life) policy.

Account holder's signature

✗

Date d d / m m / y y y y

Account holder's signature

✗

Date d d / m m / y y y y

## Part B Credit card (only Mastercard and Visa available)

I authorise Suncorp Life & Superannuation Limited to charge my: (tick one) ☐ Visa ☐ Mastercard

Frequency: ☐ Monthly ☐ Quarterly ☐ Half-Yearly ☐ Yearly

Card holder's name

Card number ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Expiry date

Card holder's signature ✗ Date d d / m m / y y y y

# Direct Debit Request Service Agreement

This Direct Debit Request (DDR) Service Agreement is only applicable if you choose to authorise Suncorp Life & Superannuation Limited (SLSL) to debit premiums in relation to your policy from your nominated financial institution account. This agreement must be read when providing direct debit details to SLSL.

This DDR Service Agreement is issued by SLSL (ABN 87 073 979 530). You should direct all enquiries about your direct debit to our customer service team on 02 8275 3999 or if outside Sydney on 1800 221 727.

## 1. Our commitment to you

a. We will give you at least 14 days' notice in writing before changing the terms of the debiting arrangements, unless you agree to an earlier change.

b. We'll keep information relating to your nominated financial institution account confidential, except where required for the purposes of conducting direct debits with your financial institution.

c. Where the debiting date is not a business day, we'll draw from your nominated financial institution account on the next business day.

## 2. Your commitment to us

It is your responsibility to:

- ensure your nominated financial institution account can accept direct debits.
- ensure there are sufficient funds available in the nominated financial institution account to meet each instalment.
- advise us if the nominated account is transferred or closed, or the account details change.
- ensure that all account holders on the nominated financial institution account agree to the debiting arrangement.

## 3. Your rights

a. Subject to the terms and conditions of your insurance policy, you may alter the debiting arrangements. Such advice should be received by us at least 7 working days before the debiting date for any of the following:

- altering the Direct Debit Request (DDR).
- deferring a drawing.
- suspending the DDR.
- cancelling the debiting arrangement completely.

  If you do any of these things, you must make alternative arrangements to pay outstanding amounts and, if applicable, future amounts. Alternatively you may request a stop or cancellation by contacting your financial institution. If you take this course of action you may incur a fee from your financial institution.

b. Where you consider that a debit has been initiated incorrectly, you should contact us on 02 8275 3999 or if outside Sydney on 1800 221 727. In the unlikely event of a complaint not being resolved satisfactorily, you can address the complaint to: The Manager, Life Customer Service, GPO Box 68, Sydney NSW 2001.

## 4. Other information

a. We reserve the right to ask that instructions from a customer, to stop or in any way alter the debiting arrangement are in a written, verbal
or electronic form.

b. The terms and conditions of your SLSL policy govern your instalments. The policy allows us to cancel it after writing to you if debits are dishonoured by your financial institution and your premium is overdue by 30 days or more.

c. We may vary the amount subject to the terms and conditions of your policy to be deducted from the account or the frequency of future debits by giving at least 14 days notice to you, in writing. All future amounts payable by you under the policy will be debited to the bank account shown in the DDR unless you tell us you wish to cancel the arrangement.

d. Financial institution fees (including dishonour charges) may also apply to this debiting arrangement.

This page has been left blank intentionally.

LR813 03/08/09
AS00331 18/12/2015 A