



BT Protection Plans Future Insurability Benefit and Business Cover Benefit Form

GPO Box 5467, Sydney NSW 2001, Australia
Phone 1300 553 764, life.insurance@btfinancialgroup.com

Any Future Insurability Benefit or Business Cover Benefit increase that may be provided is subject to the terms and conditions of your policy.

Please note that you must apply for increases under the Future Insurability Benefit or Business Cover Benefit within 30 days of the personal event or within 30 days of the review date immediately following the business event, periodic increase or income protection event.

Only one increase will be accepted under this benefit in any 12 month period.

To apply to increase the sum insured under your policy using the Future Insurability Benefit or Business Cover Benefit, please:

1. Complete the 'Details of Future Insurability Benefit or Business Cover Benefit increase' (below) and tick a box to indicate the appropriate 'event applied for';
2. On pages 2-6 of this form, find the section which applies to the event you have selected and follow the instructions;
3. Attach the required information;
4. Complete, date and sign the 'Declaration' at the end of this form; and
5. Send this completed form and the required attachments to your adviser, fax it to (02) 9274 5239 or mail it to us at the following address:

BT Protection Plans

GPO Box 5467

Sydney NSW 2001

It's important to be truthful in your dealings with us because we rely on the information that you provide to us in confirming your increased cover. If any information provided to us changes before we confirm your increased cover, you must tell us.

YOUR DUTY OF DISCLOSURE

You have a duty, under the Insurance Contracts Act 1984, to tell us every matter that you know, or could reasonably be expected to know, is relevant to the decision whether to insure you and, if so, on what terms.

Every person to be insured under your Policy has the same duty of disclosure. If they fail to comply with their duty, their failure to disclose any relevant matter may be treated as a failure by you to comply with your duty of disclosure.

The duty does not require disclosure of any matter:

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

Genetic testing

You do not need to tell us about any genetic test you have previously had, or intend to have unless we specifically ask you. You are obliged to inform us of any diagnosis of a medical condition, even if the diagnosis resulted directly or indirectly from a genetic test. You may volunteer results of genetics tests where the outcome is favourable.

Non-disclosure

If you fail to comply with your duty and the Policy would not have been entered into if the failure had not occurred:

- the Policy may be varied to reduce the sum insured or to reflect the terms that would have applied if you had complied with your duty; or
- the Policy may be treated as never having existed if your non-disclosure was fraudulent or, if it is within 3 years of entering into the Policy, the insurer would not have been prepared to enter into the contract of life insurance on any terms.

DETAILS OF FUTURE INSURABILITY BENEFIT OR BUSINESS COVER BENEFIT INCREASE

Policy Number

Portfolio Number

Name of Insured Person

1. Please tick one Future Insurability/Business Cover Event that applies in the last column.

Event	Applicable under Future Insurability benefit	Applicable under Business Cover Benefit	EVENT APPLIED FOR
Marriage or a de facto spouse	x		<input type="checkbox"/>
Birth or adoption	x		<input type="checkbox"/>
Post-graduate degree	x		<input type="checkbox"/>
Change in tax dependency status*	x		<input type="checkbox"/>
Becoming a carer	x		<input type="checkbox"/>
Secondary school	x		<input type="checkbox"/>
Divorce	x		<input type="checkbox"/>
Death of a spouse	x		<input type="checkbox"/>
Mortgage	x		<input type="checkbox"/>
Salary increase	x		<input type="checkbox"/>
The value of the key person in your business increases	x	x	<input type="checkbox"/>
The net value of the Insured Person's financial interest in the business increases	x	x	<input type="checkbox"/>
The value of the Insured Person's loan increases	x	x	<input type="checkbox"/>
Periodic increase	x		<input type="checkbox"/>

*This event is restricted to Death Benefit increases for any policies held through superannuation and will only apply once for an Insured Person under all policies.

DETAILS OF FUTURE INSURABILITY BENEFIT OR BUSINESS COVER BENEFIT INCREASE

2. Please tick the benefit(s) to which you are applying for an increase under the Future Insurability Benefit or the Business Cover Benefit.

Death Benefit	<input type="checkbox"/>
TPD Benefit	<input type="checkbox"/>
Living Benefit	<input type="checkbox"/>
Income Protection Monthly Benefit	<input type="checkbox"/>

PERSONAL EVENTS

SECTION 1 – MARRIAGE OR A DE FACTO SPOUSE

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. Attach:

- For marriage, a copy of the marriage certificate; or
- For first anniversary of a de facto spouse, a statutory declaration from each spouse plus supporting notices issued by local council, government agency or financial institution.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 2 – BIRTH OR ADOPTION

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. Attach:

- For birth, a copy of the birth certificate; or
- For adoption, a copy of the adoption certificate.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 3 – POST-GRADUATE DEGREE

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A certified copy of an academic transcript or a testamur issued by the accredited university confirming the Insured Person has completed a post-graduate degree.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 4 – CHANGE IN TAX DEPENDENCY STATUS

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A statutory declaration that the Insured Person no longer has any tax dependants, and that this change in circumstance occurred within the previous 30 days.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 5 – BECOMING A CARER

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A statutory declaration from the aged or disabled person being cared for (dependant), or the dependant's legal representative, or certification from the Guardianship Board, detailing:
- that the Insured Person is the primary carer for the dependant; and
 - that the Insured Person is financially responsible for and/or is physically providing support to the dependant with communication, mobility, or self-care.
- In addition, a signed and dated letter from the dependant's doctor verifying that the care:
- has been provided for a period of at least 6 months (for more than 20 hours per week) and was previously not required; and
 - is still necessary for medical reasons and likely to be required for more than 20 hours per week.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 6 – SECONDARY SCHOOL

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A copy of the letter of enrolment or admission from the secondary school; and
- A copy of either the birth certificate or adoption order naming the Insured Person as the parent.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 7 – DIVORCE

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A copy of the certificate of divorce, or divorce order, issued by the Family Court.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 8 – DEATH OF A SPOUSE

A. Indicate the amount by which you wish to increase the sum insured:

B. Attach:

- A copy of the death certificate of the spouse; and
- Either:
- a copy of the marriage certificate of the Insured Person and their spouse; or
 - for a de facto spouse, a statutory declaration attesting the existence of the relationship on a permanent and bona fide domestic basis, which has lasted for at least 12 months.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 9 – MORTGAGE

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. Attach:

- Written confirmation from your mortgage provider(s) of either:
- If a new mortgage, the amount borrowed and effective date of the mortgage; or
 - If an increase to an existing mortgage, the original amount borrowed, the increase in the amount borrowed and the effective date of the increase.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 10 – SALARY INCREASE

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. Attach:

- Written confirmation from the employer of the annual salary package of the Insured Person before and after the increase.

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 11 – PERIODIC INCREASE

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. The Policy Owner has not exercised the Future Insurability Benefit for any reason and the sum insured has not had an increase in the last three years (excluding CPI and loyalty benefit increase).

Agree

C. Ensure you have signed and dated the Declaration at the end of this form.

BUSINESS EVENTS/BUSINESS COVER EVENTS

SECTION 12 – VALUE OF THE KEY PERSON IN YOUR BUSINESS INCREASES

A. Indicate the amount by which you wish to increase the sum insured:

\$

B. Answer the following questions:

i) What makes the Insured Person so crucial to the operation of the business?

ii) What was the total value of the gross remuneration package of the Insured Person (including the Insured Person's share of any distributed net profit) in each of the last 3 years?

Year ending	Amount
30/6/	\$
30/6/	\$
30/6/	\$

iii) What proportion of the company's net profit can be fairly attributable to the Insured Person?

\$

iv) What loss would the company be expected to suffer in the event of the Insured Person's death and how has that amount been calculated?

v) What/Who was the source of the information provided in this application and how is that source qualified to provide the financial information?

C. Ensure you have signed and dated the Declaration at the end of this form.

SECTION 13 – THE NET VALUE OF THE INSURED PERSON’S FINANCIAL INTEREST IN THE BUSINESS INCREASES**A. Indicate the amount by which you wish to increase the sum insured:****B. Answer the following questions:**

i) What percentage of the partnership/shares/units are owned/held by the Insured Person?

ii) Give details for the last three years of:

Year ending	30/6/	30/6/	30/6/
Business turnover			
Gross profit			
Before tax net profit/loss			
Total assets			
Total liabilities			

iii) What was the net value of the business and the Insured Person’s share of the net value of the business in each of the last three years?

Year ending	Net value of business	Insured Person’s share of net value
30/6/	\$	\$/%
30/6/	\$	\$/%
30/6/	\$	\$/%

iv) What/Who was the source of the information provided in this application and how is that source qualified to provide the financial information?

C. Ensure you have signed and dated the Declaration at the end of this form.**SECTION 14 – THE VALUE OF THE INSURED PERSON’S LOAN INCREASES****A. Indicate the amount by which you wish to increase the sum insured:****B. Answer the following questions:**

i) How much was the original loan?

ii) How much did the loan for the Insured Person increase by?

iii) Have you ensured that you have attached evidence of increase?

Yes No **C. Ensure you have signed and dated the Declaration at the end of this form.****SECTION 15 – PERIODIC INCREASE****A. Indicate the amount by which you wish to increase the sum insured:****B. The Policy Owner has not exercised the Future Insurability Benefit for any reason and the sum insured has not had an increase in the last three years (excluding CPI and loyalty benefit increase).** Agree**C. Ensure you have signed and dated the Declaration at the end of this form.**

INCOME PROTECTION EVENTS

SECTION 16 – SALARY INCREASE

A. Indicate the amount by which you wish to increase the insured monthly disability benefit:

\$

You may apply to increase the insured monthly disability benefit by up to 15%, subject to the terms and conditions of your policy. For example, this increased amount must not exceed 75% of the Insured Person's monthly earnings and must not be more than the maximum benefit limit available under Income Protection Plus.

B. Attach:

Written confirmation from the employer of the annual salary package of the Insured Person before and after the increase.

Note: The salary package does not include irregular payments such as bonuses or commissions that may not continue to be made in the future.

C. Complete the income details required below.

D. Ensure you have signed and dated the Declaration at the end of this form.

PART A – TO BE COMPLETED BY 'EMPLOYEES' ONLY.

i) Please detail income earned before tax, over the last two financial years.

Description	Year ending	/ /	Year ending	/ /
Salary/Wage	\$		\$	
Employer Superannuation Contributions	\$		\$	
Salary Sacrifice	\$		\$	
Commission	\$		\$	
Bonuses	\$		\$	
Other (please specify):	\$		\$	
ANNUAL INCOME	\$		\$	

ii) If the variance between the 2 years income is greater than 20%, please provide detail as to the reason:

iii) How long (in days) are you likely to continue to receive an income due to sick leave pay?

days

PART B – TO BE COMPLETED BY 'SELF-EMPLOYED' ONLY. YOU ARE 'SELF-EMPLOYED' IF YOU ARE A SOLE TRADER, A PARTNER IN A BUSINESS OR A BUSINESS OWNER, INCLUDING IF YOU ARE AN EMPLOYEE OF YOUR OWN COMPANY OR TRUST.

ii) What percentage of the business do you own?

%

ii) What percentage of the business does your spouse own?

%

ii) How many people do you employ other than yourself and your spouse?

Full-time Part-time

ii) Please detail income after business expenses but before tax over the last two financial years for the business in which you are involved.

	Year ending	/ /	Year ending	/ /
a) Total business income	\$		\$	
b) Less total expenses	\$		\$	
c) Equals income before tax	\$		\$	
d) % Ownership	\$		\$	
Multiply (c) x (d)	\$		\$	
Add back any personal salary/wages, motor vehicle for personal use, director's fee, personal superannuation	\$		\$	
ANNUAL INCOME	\$		\$	

v) Are you currently generating a monthly net income of at least the same rate as shown for the most recent year in the table above?

Yes No

If No please provide details:

Reason for change?

Current monthly income after business expenses but before tax?

\$

vi) In the event of your total disability, will your business continue to operate?

Yes No

If Yes please give an estimate of the income after expenses but before tax you would be entitled to receive and the source of that income:

Income after six months of total disability	\$ <input type="text"/>
Income after twelve months of total disability	\$ <input type="text"/>
Source of income	<input type="text"/>

PART C – TO BE COMPLETED BY ALL INSURED PERSONS WHOSE MONTHLY BENEFIT WILL BE GREATER THAN \$20,000 AFTER THE INCREASE.

Do you have a net investment income greater than \$250,000 per year and/or net assets exceeding \$5 million (excluding the family home and superannuation)?

Yes No

If Yes please provide details below:

i) What is the source of this income?

ii) Please indicate the amount of investment income you receive and the frequency of this income (e.g. per annum, one off).

iii) How long is this income expected to continue?

DECLARATION

POLICY OWNER

I/We declare and agree that:

- I/we have read and understood this completed application and declare that the statements made and the information contained therein is true and correct as at the date I/we signed this application.
- I/we have read the section titled 'Protection of your privacy' in the BT Protection Plans Product Disclosure Statement and Policy Document (PDS) and I/we agree to the various uses and disclosures of my/our personal information as set out in that section.
- this application and any related documents (including the PDS) shall form the basis of any contract issued.
- I/we have read and understood the section titled 'Your Duty of Disclosure'. I/We declare that I/we have complied with the duty of disclosure and I/we have not withheld any information known to me/us that may influence an assessment or acceptance of my/our insurance(s).
- I/we understand that failure to comply with my/our duty of disclosure could result in avoidance or cancellation of my/our policy, or any claim not being paid in accordance with my/our expectations.
- the insurance I/we have applied for will not become effective until it is confirmed by the Insurer in writing.
- no claim is currently payable under this Policy or any other policy issued by the Insurer in respect of the Insured Person.

Name of Policy Owner 1/Director/Secretary

Signature

Date

Name of Policy Owner 2/Director/Secretary

Signature

Date

- Please mark with a cross (✗) this box if you do not wish for the Consumer Price Index (CPI) increase to be applied to any of the Insured Person under this policy at the next policy anniversary. Please note that the Insurer will automatically index the amount of your increased benefits each year on your review date in line with increases in the CPI. If you wish to decline any future CPI increases, you may advise us in writing within 30 days of the review date.

INSURED PERSON

I, the Insured Person or legal representative of the Insured Person, declare and agree that:

- I have read and understood this completed form and declare that the statements made and the information completed therein is true and correct as at the date I signed this form.
- I have read and understood the section titled 'Protection of your privacy' in the PDS and I agree to the various uses and disclosures of my personal information as set out in that section.
- this form will constitute part of my insurance(s) and the basis of the contract with the Insurer.
- I have read and understood the section titled 'Your Duty of Disclosure'. I declare that I have complied with the duty of disclosure and I have not withheld any information known to me that may influence an assessment or acceptance of my insurance(s).
- failure to disclose any material fact known to me may invalidate my insurance(s).

Name of Insured Person/legal representative of Insured Person

Signature

Date