RESET

BT Protection Plans Application Form

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

Insurer: Westpac Life Insurance Services Limited ABN 31 003 149 157 AFSL 233728.

Issuer: The Insurer is the issuer of all products, except for Term Life as Superannuation and Income Protection as Superannuation.

The Issuer of Term Life as Superannuation and Income Protection as Superannuation is BT Funds Management Limited ABN 63 002 916 458 AFSL 233724 (BTFM) as trustee of Retirement Wrap ABN 39 827 542 991 (Retirement Wrap)

PLEASE READ BEFORE SIGNING THIS FORM

This Application Form forms part of the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application. Before you complete this Application Form, please read the following sections of the PDS:

- 'Protection of your privacy'; and
- 'Your duty of disclosure'.

SECTION 1 – DETAILS OF COVER (ADVISER TO COMPLETE)

☐ New Policy

☐ Transfer of existing cover with another insurer

☐ Transfer of existing cover with the Insurer

The relevant ownership structure form needs to be completed for all applications. If your client is replacing an existing policy with the Insurer, they also need to complete Form G to request cancellation of the existing cover.

The client must complete Form H (Personal Statement), unless it's a replacement of:

- An existing BT Protection Plans Policy where the Benefit is less than or equal to the existing cover and subject to the client meeting all of the conditions and limits stipulated in the 'Replacing Existing Protection Plans Policies' sub section of the 'Replacements and Alterations' section of the Adviser Guide; or
- A non-BT Protection Plans Policy subject to the client meeting all of the conditions and limits stipulated in the 'Replacing Non Protection Plans Policies' sub section of the 'Replacements and Alterations' section of the Adviser Guide.

Please note that a Product Illustration from LifeCENTRAL+ must be attached

SECTION 2 – OWNERSHIP STRUCTURE OF NEW OR REPLACEMENT POLICY

Please choose the primary ownership structure which applies to this application. Remember to select ALL the options that apply.

Please note that you will need to complete one form for each primary ownership structure (as per the Product Illustration).

Non-Superannuation

> Please complete Form A ☐

Superannuation – Issued to a SMSF

> Please complete Form B ☐

Superannuation – Trustee of Retirement Wrap

> Please complete Form C ☐

Superannuation – Trustee of SuperWrap and Panorama Super

> Please complete Form D ☐

Superannuation – Trustee of Platform Super (for Asgard, LifeFocus, PCP)

> Please complete Form E ☐

Please tick if an Advice Service Fee form and/or a Personal Statement will accompany this application.

Advice Service Fee (if applicable)

> Please complete Form F ☐

Cancellation of Existing Policy for Replacements (if applicable)

> Please complete Form G ☐

Insured Person – Personal Statement

> Please complete Form H ☐

Please note that you will need one Personal Statement per Insured Person.

SECTION 3 – CHECKLIST

Please ensure that you have completed and/or attached the following:

☐ A fully completed Application Form;

☐ A Product Illustration from LifeCENTRAL+; and

☐ A Personal Statement for each Insured Person (if applicable).

FORM A Ownership structure – Non-Superannuation

SECTION 1 – DETAILS OF POLICY OWNER(S)

Policy Owner(s) may be the Insured Person, a trust, business entity or other person; depending on the policy type.

Only complete this section if the Insured Person(s) is not the Policy Owner(s). Otherwise, please go to Section 2.

Income Protection and Income Protection Plus Policies can be owned by a trust or a business entity, in which case, the Insured Person must have direct control of the trust or business entity (eg. the Insured Person is the trustee of the trust, or the partner or director of a business entity).

POLICY OWNER 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (including ACN or ABN)/Name of trust

Date of Birth

☐☐ / ☐☐ / ☐☐☐☐

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

POLICY OWNER 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (including ACN or ABN)/Name of trust

Date of Birth

☐☐ / ☐☐ / ☐☐☐☐

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

If there are more than two Policy Owners, please attach the corresponding information on a separate sheet.

SECTION 2 – ADDRESS FOR NOTICES

All notices for the Policies in this policy group will be sent to this address.

Residential address

Postcode

Country, if not Australia

Postal address *(if different from the residential address)*

Postcode

Country, if not Australia

SECTION 3 – NOMINATION OF BENEFICIARIES FOR TERM LIFE POLICIES

Only complete this section if you wish for the Death Benefit to be paid to someone other than the remaining Policy Owner(s).

Please refer to the PDS for full information on nominating beneficiaries under Term Life.

BENEFICIARY 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname

Date of Birth

☐☐ / ☐☐ / ☐☐☐☐

Gender ☐ M ☐ F

Proportion of Benefit

% A

BENEFICIARY 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname

Date of Birth

☐☐ / ☐☐ / ☐☐☐☐

Gender ☐ M ☐ F

Proportion of Benefit

% B

BENEFICIARY 3

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname

Date of Birth / / Gender ☐ M ☐ F

Proportion of Benefit % C

BENEFICIARY 4

Insured Person's Legal Personal Representative (estate)

Proportion of Benefit % D

Sum of: A + B + C + D must equal **100%**

SECTION 4 – PREMIUM PAYMENT DETAILS

Complete this section for all applications. All Policies in this policy group will have their premiums debited from the same account.

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder 1 signature(s)

X Date / /

Account holder 2 signature(s)

X Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy) /

Cardholder's signature

X Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/ were made fraudulently.

Name

Signature

X Date / /

Name

Signature

✗

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

SECTION 5 – DECLARATION

I/We declare and agree that:

- I/we have received and read the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application;
- I/we have read the completed application and declare that the statements made and 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 PDS and I/we agree to the various uses and disclosures of my/our personal information set out in that section. I/We also agree to make any beneficiary nominated by me/us aware of the matters set out in that section;
- this application, the attached Product Illustration, the accompanying Personal Statement(s) (if applicable), Advice Service Fee form (if applicable) and any related documents (including the PDS) shall form the basis of any contract issued;
- I/we have read and understood the duty of disclosure contained in the PDS. I/We declare that I/we have complied with the duty of disclosure;
- I/we understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my/our Policy, or any claim not being paid in accordance with my/our expectations;
- I/we understand that the duty of disclosure extends beyond my/our completion of this application up until the Insurer accepts this application and issues a Policy;
- I/we understand that for replacement cover that is not being underwritten, the Insurer will rely on the information in all previous applications made to the Insurer (including any increase, addition, variation, or reinstatement) for the existing Policy being replaced in assessing any future claims under the replacement Policy;
- for any increase in cover, the duty of disclosure in the Personal Statement will apply for that increased cover;
- the email address(es) provided in this application may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- details of any Policy(ies) owned by me/us that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

PRIVACY DISCLOSURE

For our customers located in the European Union

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

Please refer to our EU Data Protection Policy on our website at westpac.com.au/privacy/eu-data-protection-policy/ for information about how we manage your personal data under the GDPR.

INDIVIDUAL APPLICATIONS

Policy Owner 1

✗

Date / /

Policy Owner 2

✗

Date / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

COMPANY APPLICATIONS

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of Director / Sole Director

Signature

✗

Date / /

Name of Director / Secretary

Signature

✗

Date / /

SECTION 6 – ADVISER DETAILS (ADVISER TO COMPLETE)

Adviser Name 1

Adviser number 1

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

Adviser Name 2

Adviser number 2

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

FORM B Ownership Structure – Superannuation – Issued to a SMSF

SECTION 1 – DETAILS OF POLICY OWNER(S)

Provide the following details for the SMSF that will be the Policy Owner for these Policies.

SMSF Trustee/s

SMSF Name

Is there Flexible Linking Plus or Income Linking Plus attached to this Policy?..... ☐ **Yes** ☐ **No**

If Yes > please provide details below if the Insured Person is not to be the Policy Owner.

If No > please go to section 2.

POLICY OWNER 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (including ACN or ABN)/Name of trust

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

POLICY OWNER 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (including ACN or ABN)/Name of trust

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

If there are more than two Policy Owners, please attach the corresponding information on a separate sheet.

SECTION 2 – ADDRESS FOR NOTICES

All notices for the Policies in this policy group will be sent to this address.

Residential address

Postcode

Country, if not Australia

Postal address *(if different from the residential address)*

Postcode

Country, if not Australia

SECTION 3 – PREMIUM PAYMENT DETAILS – SUPERANNUATION

*Complete this section for policies held by the **SMSF**. All policies in this policy group will have their premiums debited from the same account details provided below.*

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by direct debit from a SMSF bank account.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder 1 signature(s)

X

Date / /

Account holder 2 signature(s)

X

Date / /

B. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

C. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

SECTION 4 – FLEXIBLE PREMIUM PAYMENT DETAILS

*Complete this section if you have selected **Flexible Linking Plus or Income Linking Plus.***

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder 1 signature(s)

X

Date / /

Account holder 2 signature(s)

X

Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy)

/

Cardholder's signature

X

Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

SECTION 5 – DECLARATION

I/We declare and agree that:

- I/we have received and read the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application;
- I/we have read the completed application and declare that the statements made and 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 PDS and I/we agree to the various uses and disclosures of my/our personal information set out in that section. I/We also agree to make any beneficiary nominated by me/us aware of the matters set out in that section;
- this application, the attached Product Illustration, the accompanying Personal Statement(s) (if applicable), Advice Service Fee form (if applicable) and any related documents (including the PDS) shall form the basis of any contract issued;
- I/we have read and understood the duty of disclosure contained in the PDS. I/We declare that I/we have complied with the duty of disclosure;
- I/we understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my/our Policy, or any claim not being paid in accordance with my/our expectations;
- I/we understand that the duty of disclosure extends beyond my/our completion of this application up until the Insurer accepts this application and issues a Policy;
- I/we understand that for replacement cover that is not being underwritten, the Insurer will rely on the information in all previous applications made to the Insurer (including any increase, addition, variation, or reinstatement) for the existing Policy being replaced in assessing any future claims under the replacement Policy;
- for any increase in cover, the duty of disclosure in the Personal Statement will apply for that increased cover;
- the email address(es) provided in this application may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- details of any Policy(ies) owned by me/us that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

SMSF APPLICATIONS (MUST BE COMPLETED)

Trustee/Director 1

X

Date / /

Trustee/Director 2

X

Date / /

If there are more than two Trustees/Directors, please attach their signatures on a separate sheet.

FLEXIBLE LINKING PLUS OR INCOME LINKING PLUS APPLICATIONS

Please complete individual or company application signatures if Flexible Linking Plus or Income Linking Plus is selected.

INDIVIDUAL APPLICATIONS

Policy Owner 1

X

Date / /

Policy Owner 2

X

Date / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

COMPANY APPLICATIONS

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of Director / Sole Director

Signature

X

Date / /

Name of Director / Secretary

Signature

X

Date / /

SECTION 6 – ADVISER DETAILS (ADVISER TO COMPLETE)

Adviser Name 1

Adviser number 1

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

Adviser Name 2

Adviser number 2

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

PRIVACY DISCLOSURE

For our customers located in the European Union

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

Please refer to our EU Data Protection Policy on our website at westpac.com.au/privacy/eu-data-protection-policy/ for information about how we manage your personal data under the GDPR.

FORM C

Ownership Structure – Superannuation – Trustee of Retirement Wrap

SECTION 1 – DETAILS OF POLICY OWNER(S)

POLICY OWNER

BT Funds Management Limited ABN 63 002 916 458 AFSL 233724 (BTFM).

Is there Flexible Linking Plus or Income Linking Plus attached to this Policy? ..... ☐ **Yes** ☐ **No**

If Yes > please provide details below if the Insured Person is not to be the Policy Owner.

If No > please go to section 2.

POLICY OWNER 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone

( )

Work Phone

( )

Mobile Phone

CIS Number (if known)

Email Address

POLICY OWNER 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone

( )

Work Phone

( )

Mobile Phone

CIS Number (if known)

Email Address

If there are more than two Policy Owners, please attach the corresponding information on a separate sheet.

SECTION 2 – ADDRESS FOR NOTICES

All notices for the Policies in this policy group will be sent to this address.

Residential address

Postcode

Country, if not Australia

Postal address *(if different from the residential address)*

Postcode

Country, if not Australia

SECTION 3 – EMPLOYMENT DETAILS OF INSURED MEMBER

Only complete this section if an employer is to contribute into the Retirement Wrap on behalf of the member.

Employer Name

Employer Contact Phone Number

( )

Employer Mailing Address

Postcode

Country, if not Australia

SECTION 4 – NOMINATION OF BENEFICIARIES FOR TERM LIFE AS SUPERANNUATION POLICIES

Only complete this section if you wish to nominate to whom the Death Benefit is to be paid.

Please refer to the PDS for full information on nominating beneficiaries under Term Life as Superannuation.

BENEFICIARY 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given name(s)

Surname

Date of birth (dd/mm/yyyy) / /

Gender Male ☐ Female ☐

Proportion of Benefit % **A**

BENEFICIARY 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given name(s)

Surname

Date of birth (dd/mm/yyyy) / /

Gender Male ☐ Female ☐

Proportion of Benefit % **B**

BENEFICIARY 3

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given name(s)

Surname

Date of birth (dd/mm/yyyy) / /

Gender Male ☐ Female ☐

Proportion of Benefit % **C**

BENEFICIARY 4

Insured Member's Estate

Proportion of Benefit % **D**

Sum of: **A** + **B** + **C** + **D** must equal **100%**

SECTION 5 – TAX FILE NUMBER (TFN) NOTIFICATION

While you are not required by law to supply the Trustee with your TFN, you will be ineligible to apply for Term Life as Superannuation and/or Income Protection as Superannuation if you have not provided us with your TFN.

When you apply for Term Life as Superannuation and/or Income Protection as Superannuation, you will become a member of the Retirement Wrap (Fund). The Trustee for the Fund is BTFM.

The Trustee is authorised to collect your TFN under the Superannuation Industry (Supervision) Act 1993.

You are under no obligation to provide your TFN. It is not an offence not to provide your TFN. However, in deciding whether to provide your TFN, you should consider the following information:

1. PURPOSES

The Trustee will only use your TFN for lawful purposes, including:

- calculating tax on income and superannuation lump sum payments (your benefits); and
- finding and amalgamating your superannuation benefits.

These purposes may change in the future as a result of legislative change.

The Trustee may disclose your TFN to another superannuation provider when your benefits are being transferred, unless you request in writing to the Trustee that your TFN not be disclosed to any other superannuation provider. The Trustee may also disclose your TFN to the Commissioner of Taxation. The Trustee will not disclose your TFN to any other person or body.

2. ADVANTAGES OF PROVIDING YOUR TFN

Giving your TFN may have the following advantages, which may not otherwise apply:

- the Fund will be able to accept all of the types of contributions outlined in the PDS to your account;
- the tax rate on certain contributions to your superannuation account(s) will not be higher than the concessional tax rate; and
- other than the tax that may ordinarily apply, no additional tax will be deducted when you receive your superannuation benefits.

These advantages may change in the future.

For more information, please contact the Customer Relations Centre on 1300 553 764 8.00am to 6.30pm (Sydney time), Monday to Friday.

Alternatively, you may wish to contact the ATO Superannuation Hotline on 131 020.

Name

I agree to provide my Tax File Number to the Trustee of the Fund.

Insured Member's TFN

Date / /

SECTION 6 – PREMIUM PAYMENT DETAILS – SUPERANNUATION

Complete this section for all Policies held in Retirement Wrap. All Policies in this policy group will have their premiums debited from the same account details provided below.

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder signature(s)

X

Date / /

Account holder signature(s)

X

Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy)

/

Cardholder's signature(s)

X

Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

E. ONGOING PARTIAL ROLLOVER – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by partial rollover from another superannuation fund.

☐ Please submit an 'Ongoing Partial Rollover Request' form.

SECTION 7– FLEXIBLE PREMIUM PAYMENT DETAILS

*Complete this section if you have selected **Flexible Linking Plus or Income Linking Plus**.*

Only complete one payment section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder signature(s)

X

Date / /

Account holder signature(s)

X

Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy)

/

Cardholder's signature

X

Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

SECTION 8 – DECLARATION

I/We declare and agree that:

- I/we have received and read the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application;
- I/we have read the completed application and declare that the statements made and 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 PDS and I/we agree to the various uses and disclosures of my/our personal information set out in that section. I/We also agree to make any beneficiary nominated by me/us aware of the matters set out in that section;
- this application, the attached Product Illustration, the accompanying Personal Statement(s) (if applicable), Advice Service Fee form (if applicable) and any related documents (including the PDS) shall form the basis of any contract issued;
- I/we have read and understood the duty of disclosure contained in the PDS. I/We declare that I/we have complied with the duty of disclosure;
- I/we understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my/our Policy, or any claim not being paid in accordance with my/our expectations;
- I/we understand that the duty of disclosure extends beyond my/our completion of this application up until the Insurer accepts this application and issues a Policy;
- I/we understand that for replacement cover that is not being underwritten, the Insurer will rely on the information in all previous applications made to the Insurer (including any increase, addition, variation, or reinstatement) for the existing Policy being replaced in assessing any future claims under the replacement Policy;
- for any increase in cover, the duty of disclosure in the Personal Statement will apply for that increased cover;
- I, the Insured Member am eligible to contribute to superannuation or to have contributions made to superannuation on my behalf. I agree to be bound by the terms of the Trust Deed of Retirement Wrap;
- the email address(es) provided in this application may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- details of any Policy(ies) owned by me/us that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

TERM LIFE AS SUPERANNUATION OR INCOME PROTECTION AS SUPERANNUATION APPLICATIONS (MUST BE COMPLETED)

Insured Member

X

Date / /

WITNESS DECLARATION FOR NOMINATION OF BENEFICIARIES FOR TERM LIFE AS SUPERANNUATION POLICIES

I declare that I am 18 years or over, I am not a named beneficiary on this form and the Insured Member's signature was signed and dated by the Insured Member in my presence.

Name of Witness

Signature

X

Date / /

FLEXIBLE LINKING PLUS OR INCOME LINKING PLUS APPLICATIONS

Please complete individual or company application signatures if Flexible Linking Plus or Income Linking Plus is selected.

INDIVIDUAL APPLICATIONS

Policy Owner 1

X

Date / /

Policy Owner 2

X

Date / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

COMPANY APPLICATIONS

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of Director / Sole Director

Signature

X

Date / /

Name of Director / Secretary

Signature

X

Date / /

SECTION 9 – ADVISER DETAILS (ADVISER TO COMPLETE)

Adviser Name 1

Adviser number 1

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

Adviser Name 2

Adviser number 2

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

PRIVACY DISCLOSURE

For our customers located in the European Union

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

Please refer to our EU Data Protection Policy on our website at westpac.com.au/privacy/eu-data-protection-policy/ for information about how we manage your personal data under the GDPR.

FORM D

Ownership Structure – Trustee of SuperWrap or Panorama Super

SECTION 1 – DETAILS OF POLICY OWNER(S)

POLICY OWNER

BT Funds Management Limited ABN 63 002 916 458.

Is there Flexible Linking Plus or Income Linking Plus attached to this Policy? ..... ☐ **Yes** ☐ **No**

If Yes > please provide details below if the Insured Person is not to be the Policy Owner.

If No > please go to section 2.

POLICY OWNER 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

POLICY OWNER 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

If there are more than two Policy Owners, please attach the corresponding information on a separate sheet.

SECTION 2 – ADDRESS FOR NOTICES

All notices for the Policies in this policy group will be sent to this address.

Residential address

Postcode

Country, if not Australia

Postal address *(if different from the residential address)*

Postcode

Country, if not Australia

SECTION 3 – PREMIUM PAYMENT DETAILS – SUPERANNUATION

*Complete this section for all policies held in **SuperWrap or Panorama Super.** All policies in this policy group will have their premiums debited from the same account details provided below.*

PAYMENT METHOD

PLATFORM SUPER ACCOUNT AUTHORISATION

(Only complete if premium payment is by a SuperWrap or Panorama Super account).

Please provide one of the following superannuation account numbers for the deduction of premium payments.

SuperWrap investor number (for existing SuperWrap accounts)

M

Panorama Super account number (for existing Panorama Super accounts)

I, as a superannuation account holder whose superannuation account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our superannuation account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our superannuation account in a manner described in the current disclosure document for my/our superannuation account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our superannuation account, however, I/we am/are able to transfer this Policy to a new Policy paid outside of a superannuation account without any further underwriting as described in the PDS for BT Protection Plans; and
- I acknowledge that if the administrator of my superannuation account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

✗

Date / /

SECTION 4 – FLEXIBLE PREMIUM PAYMENT DETAILS

*Complete this section if you have selected **Flexible Linking Plus or Income Linking Plus.***

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder signature(s)

X

Date / /

Account holder signature(s)

X

Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy)

/

Cardholder's signature

X

Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

SECTION 5 – DECLARATION

I/We declare and agree that:

- I/we have received and read the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application;
- I/we have read the completed application and declare that the statements made and 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 PDS and I/we agree to the various uses and disclosures of my/our personal information set out in that section. I/We also agree to make any beneficiary nominated by me/us aware of the matters set out in that section;
- this application, the attached Product Illustration, the accompanying Personal Statement(s) (if applicable), Advice Service Fee form (if applicable) and any related documents (including the PDS) shall form the basis of any contract issued;
- I/we have read and understood the duty of disclosure contained in the PDS. I/We declare that I/we have complied with the duty of disclosure;
- I/we understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my/our Policy, or any claim not being paid in accordance with my/our expectations;
- I/we understand that the duty of disclosure extends beyond my/our completion of this application up until the Insurer accepts this application and issues a Policy;
- I/we understand that for replacement cover that is not being underwritten, the Insurer will rely on the information in all previous applications made to the Insurer (including any increase, addition, variation, or reinstatement) for the existing Policy being replaced in assessing any future claims under the replacement Policy;
- for any increase in cover, the duty of disclosure in the Personal Statement will apply for that increased cover;
- the email address(es) provided in this application may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- details of any Policy(ies) owned by me/us that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

SUPERWRAP AND PANORAMA APPLICATIONS MUST BE COMPLETED)

Insured Member

X

Date / /

FLEXIBLE LINKING PLUS OR INCOME LINKING PLUS APPLICATIONS

Please complete individual or company application signatures if Flexible Linking Plus or Income Linking Plus is selected.

INDIVIDUAL APPLICATIONS

Policy Owner 1

X

Date / /

Policy Owner 2

X

Date / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

COMPANY APPLICATIONS

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of Director / Sole Director

Signature

X

Date / /

Name of Director / Secretary

Signature

X

Date / /

SECTION 6 – ADVISER DETAILS (ADVISER TO COMPLETE)

Adviser Name 1

Adviser number 1

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

Adviser Name 2

Adviser number 2

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

PRIVACY DISCLOSURE

For our customers located in the European Union

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

Please refer to our EU Data Protection Policy on our website at westpac.com.au/privacy/eu-data-protection-policy/ for information about how we manage your personal data under the GDPR.

FORM E Ownership Structure – Trustee of Platform Super

SECTION 1 – DETAILS OF POLICY OWNER(S)

POLICY OWNER (Please select one)

☐ *BT Funds Management Limited ABN 63 002 916 458 (for Asgard)*

☐ *CCSL Limited ABN 51 104 967 964 (for LifeFocus)*

☐ *CCSL Limited ABN 51 104 967 964 (for Personal Choice Private)*

Is there Flexible Linking Plus or Income Linking Plus attached to this Policy? ..... ☐ **Yes** ☐ **No**

If Yes > please provide details below if the Insured Person is not to be the Policy Owner.

If No > please go to section 2.

POLICY OWNER 1

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

POLICY OWNER 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname / Name of company (Including ACN or ABN)

Date of Birth

/ /

Home Phone ( )

Work Phone ( )

Mobile Phone

CIS Number (if known)

Email Address

SECTION 2 – ADDRESS FOR NOTICES

All notices for the Policies in this policy group will be sent to this address.

Residential address

Postcode

Country, if not Australia

Postal address *(if different from the residential address)*

Postcode

Country, if not Australia

SECTION 3 – PREMIUM PAYMENT DETAILS – SUPERANNUATION

*Complete this section for all policies held in **Platform Super**. All policies in this policy group will have premiums debited from the same account details provided below.*

***Please note:** BT Protection Plans policies are not available through Employee Superannuation Accounts.*

PAYMENT METHOD

SUPER ACCOUNT AUTHORISATION

Super account number (for existing super accounts)

- 2 -

I, as a super account holder whose super account number appears above, declare and agree that:

- I direct and authorise the administrator of my super account, to deduct the premium(s) for this Policy from my super account in a manner described in the current disclosure document for my super account (including any 'drawdown facility');
- I acknowledge and agree that this Policy will not be available if I close my super account, however, I am able to transfer this Policy to a new policy paid outside of a super account without any further underwriting as described in the PDS for BT Protection Plans; and
- I acknowledge that if the administrator of my super account, or its agent, reasonably believed the signature on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature was not genuine or was made fraudulently.

Name

Signature

✗

Date / /

SECTION 4 – FLEXIBLE PREMIUM PAYMENT DETAILS

*Complete this section if you have selected **Flexible Linking Plus or Income Linking Plus**.*

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if premium payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number

Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder signature(s)

X

Date / /

Account holder signature(s)

X

Date / /

B. CREDIT CARD AUTHORITY

Only complete if premium payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy)

/

Cardholder's signature

X

Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/were made fraudulently.

Name

Signature

X

Date / /

Name

Signature

X

Date / /

D. CHEQUE – ANNUAL PREMIUMS ONLY

Only complete if premium payment is by cheque.

☐ **Please make cheques payable to 'BT Protection Plans'.**

SECTION 5 – DECLARATION

I/We declare and agree that:

- I/we have received and read the BT Protection Plans Product Disclosure Statement and Policy Document (PDS), current at the date of this application;
- I/we have read the completed application and declare that the statements made and 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 PDS and I/we agree to the various uses and disclosures of my/our personal information set out in that section. I/We also agree to make any beneficiary nominated by me/us aware of the matters set out in that section;
- this application, the attached Product Illustration, the accompanying Personal Statement(s) (if applicable), Advice Service Fee form (if applicable) and any related documents (including the PDS) shall form the basis of any contract issued;
- I/we have read and understood the duty of disclosure contained in the PDS. I/We declare that I/we have complied with the duty of disclosure;
- I/we understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my/our Policy, or any claim not being paid in accordance with my/our expectations;
- I/we understand that the duty of disclosure extends beyond my/our completion of this application up until the Insurer accepts this application and issues a Policy;
- I/we understand that for replacement cover that is not being underwritten, the Insurer will rely on the information in all previous applications made to the Insurer (including any increase, addition, variation, or reinstatement) for the existing Policy being replaced in assessing any future claims under the replacement Policy;
- for any increase in cover, the duty of disclosure in the Personal Statement will apply for that increased cover;
- the email address(es) provided in this application may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me/us, including important information in relation to my/our application and my/our insurance;
- details of any Policy(ies) owned by me/us that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

PLATFORM SUPER APPLICATIONS (MUST BE COMPLETED)

Insured Member

X

Date / /

FLEXIBLE LINKING PLUS OR INCOME LINKING PLUS APPLICATIONS

Please complete individual or company application signatures if Flexible Linking Plus or Income Linking Plus is selected.

INDIVIDUAL APPLICATIONS

Policy Owner 1

X

Date / /

Policy Owner 2

X

Date / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

COMPANY APPLICATIONS

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of Director / Sole Director

Signature

X

Date / /

Name of Director / Secretary

Signature

X

Date / /

SECTION 6 – ADVISER DETAILS (ADVISER TO COMPLETE)

Adviser Name 1

Adviser number 1

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

Adviser Name 2

Adviser number 2

F

Initial split %

Renewal/Level split %

Signature

X

Date / /

PRIVACY DISCLOSURE

For our customers located in the European Union

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

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FORM F — Advice Service Fee

SECTION 1 – DETAILS OF ADVICE SERVICE FEE

Please outline the fee amount and the frequency at which you choose to pay.

Initial Fee* _____ per

☐ Month ☐ Quarter ☐ Half-Year ☐ Year

Renewal Fee* _____ per

☐ Month ☐ Quarter ☐ Half-Year ☐ Year

Apply Indexation to the Renewal fee ☐ Yes ☐ No

*The Advice Service Fee amounts shown above are inclusive of GST.

SECTION 2 – PAYMENT DETAILS

Only complete one payment method section below.

PAYMENT METHOD

A. DIRECT DEBIT AUTHORITY

Only complete if payment is by bank account direct debit.

I/We request and authorise the Insurer (Debit User ID No. 002631) to debit my/our account referred to below, for any amounts which become payable, which the Insurer may debit or charge me/us through the direct debits payments system (also known as the Bulk Electronic Clearing System), in relation to my/our Policy.

Name of financial institution

Account name

BSB number | Account number

I/We understand and acknowledge that this direct debit arrangement is governed by the terms of the 'Direct Debit Request Service Agreement' in the PDS and the terms and conditions of my/our Policy.

Account holder 1 signature(s)

X Date / /

Account holder 2 signature(s)

X Date / /

B. CREDIT CARD AUTHORITY

Only complete if payment is by credit card.

I/We authorise the Insurer to:

- arrange for any amounts which become payable in relation to my/our BT Protection Plans Policy to be debited to the credit card I/we have nominated, including any credit card issued in place of the nominated card as a result of that card being lost, stolen, upgraded or replaced; and
- obtain an updated expiry number from time to time if necessary from my/our financial institution.

TYPE OF CREDIT CARD

☐ Mastercard ☐ Visa

Credit card number

Name on card

Expiry (mm/yy) / /

Cardholder's signature

X Date / /

C. PLATFORM INVESTMENT ACCOUNT AUTHORISATION

(Only complete if premium payment is by a Wrap or Panorama Investments account).

Please provide one of the following investment account numbers for the deduction of premium payments.

Wrap investor number (for existing Wrap accounts)

M

Panorama Investments account number (for existing Panorama Investments accounts)

I/We, as an investment account holder whose investor/account number appears above, declare and agree that:

- I/we direct and authorise the administrator of my/our investment account, BT Portfolio Services Limited, to deduct the premium(s) for this Policy from my/our investment account in a manner described in the current disclosure document for my/our investment account (including the 'drawdown facility');
- I/we acknowledge and agree that this Policy will not be available if I/we close my/our investment account, however, I/we am/are able to transfer this Policy to a new policy paid outside of an investment account without any further underwriting as described in the PDS for BT Protection Plans; and
- I/we acknowledge that if the administrator of my/our investment account, BT Portfolio Services Limited (or its agent), reasonably believed the signature(s) on this application to be genuine, they (or their agent) will not be liable for any loss we may suffer if it is later found that the signature(s) was/were not genuine or was/ were made fraudulently.

Name

Signature

X Date / /

Name

Signature

X Date / /

D. CHEQUE – ANNUAL FREQUENCY ONLY

Only complete if payment is by cheque.

☐ Please make cheques payable to 'BT Protection Plans'.

FORM G Cancellation Of Existing Policy For Replacements

This section is to be completed by all Policy Owner(s) of the existing Policy(ies), except for Policies paid through a Super Fund (this section is to be completed by the Insured Person).

Please note we cannot cancel a policy that is held with another insurer. Cancellation of an existing cover with another insurer will need to be arranged by the Policy Owner.

Policy number(s)

- I/We request for the above Policy(ies) to be cancelled after a replacement Policy has been issued. I understand that Westpac Life Insurance Services Limited (WLIS) will only cancel these Policy(ies) after a replacement Policy has been issued.

INDIVIDUAL POLICY OWNERS

Must be signed by all Policy Owners.

Policy Owner

Full Name

Date of Birth / /

Signature

✗

Date / /

Policy Owner 2

Full Name

Date of Birth / /

Signature

✗

Date / /

Policy Owner 3

Full Name

Date of Birth / /

Signature

✗

Date / /

Policy Owner 4

Full Name

Date of Birth / /

Signature

✗

Date / /

COMPANY/TRUST

Must be signed by:

- two directors of the company;
- a director and company secretary; or
- for a company with a sole director who is also the company secretary, only that director.

Name of company/trust

Name of Director/Sole Director/Trustee

Position

Signature

X

Date

/ /

Name of Director/Secretary/Trustee

Position

Signature

X

Date

/ /

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PERSONAL STATEMENT

Insurer: Westpac Life Insurance Services Limited
ABN 31 003 149 157 AFSL 233728.

Name of Insured Person

Adviser Name

Adviser number

F

INSURANCE APPLICATIONS TO WHICH THIS PERSONAL STATEMENT APPLIES (ADVISER TO COMPLETE)

DETAILS OF APPLICATION

Policy number

Or ☐ New Policy

☐ Personal
☐ Partnership/Buy-Sell
☐ Loan Cover/Debt Protection
☐ Key Person Revenue/Income
☐ Key Person Capital/Debt Cover
☐ Estate Equalisation

SECTION 1 – DUTY OF DISCLOSURE

(Please read before completing this form)

What you need to tell us, who needs to tell us and when

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 of disclosure applies before you enter into, extend, vary or reinstate a Policy, and applies until the time when we issue a policy schedule, membership certificate or other written confirmation of the issue, extension, variation or reinstatement.

If any information provided to us changes (including any change to an Insured Person's health, occupation or pastimes) before we send the policy schedule, membership certificate or other written confirmation of cover to you, you must tell us.

What you do not need to tell us

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.

SECTION 2 – PRIVACY INFORMATION

(Please read before completing this form)

Why we collect your personal information

We collect personal information from you to process your application, provide you with your product or service, calculate your premium, assess any claims made by you and manage your product or service. We may also use your information to comply with legislative or regulatory requirements in any jurisdiction, prevent fraud, crime or other activity that may cause harm in relation to our products or services, and help us run our business. We may also use your information to tell you about products or services we think may interest you.

If you do not provide all the information we request, we may need to reject your application or claim, or we may no longer be able to provide a product or service to you.

How we collect and disclose your personal information

We may collect your personal information from, and disclose it to, other members of the Westpac Group*, anyone we engage to do something on our behalf such as a service provider, and other organisations that assist us with our business. We may also collect your personal information, excluding your sensitive information (e.g. health information) from, and disclose it to third parties such as your Adviser, Policy Owner(s), insurance reference services, your employers (past and present), your accountant and, if you are or have been bankrupt, the Trustee of your estate.

For the purpose of assessing your application, we may also collect your personal information, including sensitive information (e.g. health information) from, and disclose it to:

- the proposed Policy Owner(s);
- other insurers;
- reinsurers;
- any medical practitioner or other health care professional (e.g. physiotherapists, chiropractors, psychologists); and
- any hospital or other health service provider, including paramedical service providers, attended by you or retained by us.

We may disclose your personal information to an entity which is located outside Australia. Details of the countries where the overseas recipients are likely to be located are in the BT Privacy Policy.

As a provider of financial services, we have obligations to disclose some personal information to government agencies and regulators in Australia, and in some cases offshore. We are not able to ensure that foreign government agencies or regulators will comply with Australian privacy laws, although they may have their own privacy laws. By using our products or services, you consent to these disclosures.

Other important information

We are required or authorised to collect personal information from you by certain laws. Details of these laws are in the BT Privacy Policy.

The BT Privacy Policy is available at bt.com.au or by calling 132 135. It covers:

- how you can access the personal information we hold about you and ask for it to be corrected;
- how you may complain about a breach of the Australian Privacy Principles, or a registered privacy code and how we will deal with your complaint;
- how we collect, hold, use and disclose your personal information in more detail.

The BT Privacy Policy will be updated from time to time.

Please read and understand the 'Protection of your privacy' information contained in the PDS.

Where you have provided information about another individual, you must make them aware of that fact and the contents of this Privacy Statement.

We will use and disclose your personal information to contact you or send you information about other products and services offered by the Westpac Group or its preferred suppliers. If you do not wish to receive marketing communications from us please call us on 132 135.

** The Westpac Group means Westpac Banking Corporation ABN 33 007 457 141 and its related bodies corporate which includes the Insurer and BTFM.*

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SECTION 3 – PERSONAL DETAILS

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Other (please specify)

Given Name(s)

Surname

Date of birth (dd/mm/yyyy) / /

Gender Male ☐ Female ☐

Home Phone Number ( )

Work Phone Number ( )

Mobile Phone Number

Number of financial dependants

Email Address

Cross [✘] the relevant box.

Most convenient phone number to call, to clarify any information?	☐ Home ☐ Work ☐ Mobile
Please indicate your preferred contact day(s) and time?	Day(s) ☐ Morning ☐ Afternoon ☐ Evening Time

SECTION 4 – INSURANCE DETAILS

Do you have, are you applying for, or do you intend to apply for other life, total and permanent disability (TPD), trauma (critical illness/living), income protection, key person income or business expenses insurance? Yes ☐ No ☐

Please note, this includes benefits under superannuation, business or credit insurance, and insurance that is provided by an employer.

If Yes ➤ please provide details:

Insurer	Type of insurance	Reason for cover	Was this cover underwritten?	Date commenced	Insured amount	Waiting period & benefit period (if applicable)	Will this insurance be retained?
			☐ Yes ☐ No	/ /	$		☐ Yes ☐ No
			☐ Yes ☐ No	/ /	$		☐ Yes ☐ No
			☐ Yes ☐ No	/ /	$		☐ Yes ☐ No
			☐ Yes ☐ No	/ /	$		☐ Yes ☐ No
			☐ Yes ☐ No	/ /	$		☐ Yes ☐ No

Please note: If you have indicated that you will cancel any insurance and you do not do so, we will reduce any benefit you are entitled to from the Insurer by the amount paid or payable from the other policy that was not cancelled.

SECTION 5 – EMPLOYMENT DETAILS

Please complete questions 1 to 5 for all applications.

1. What is your current occupation and industry?

2. What is your current annual income?

a. For employees: including paid salary, super contributions, regular overtime and bonuses, but excluding income not derived from personal exertion (such as dividends and interest), before tax?

$

b. For self-employed: after business expenses but before tax?

$

3. Are any duties associated with your occupation hazardous (e.g. lifting heavy goods over 20kg without any human or mechanical assistance, working at heights over 10 metres, working underground or offshore more than 40% of the time, working underwater, handling of chemicals, gases, radioactive substances or explosives)? Yes ☐ No ☐

If Yes ➤ please provide details including a description of the duties performed, and the amount of time performing each duty.

4. Do you intend (or anticipate) to change your occupation, duties, working hours, or employment status in the next 12 months? Yes ☐ No ☐

If Yes > please detail when you anticipate a change, and the expected change to your occupation, duties, working hours, or employment status.

5. Have you ever been declared bankrupt, or have any entities owned or controlled by you been placed under administration or into liquidation or in receivership? Yes ☐ No ☐

If Yes > please provide the details below.

Date declared bankrupt, placed under administration, into liquidation or in receivership:	/ /
Date discharged:	/ /
Reason for bankruptcy/administration/liquidation/receivership:	

Please note: Completing the **Bankruptcy Questionnaire** will assist in the timely assessment of your application.

PLEASE ONLY COMPLETE QUESTIONS 6 TO 14 IF APPLYING FOR INCOME PROTECTION, KEY PERSON INCOME, BUSINESS OVERHEADS OR TOTAL AND PERMANENT DISABLEMENT (TPD).

6. Please describe the duties of your current occupation and approximate percentage of time spent performing each duty:

Duties (please describe in detail the duties performed)	Location (e.g. office, home, at site)	Percentage Performed
1.		%
2.		%
3.		%
4.		%
	TOTAL	0 %

7. How many hours per week and weeks per year do you work in your current occupation?

hours per week weeks per year

8. How long have you been in your current occupation (this means performing the same occupation duties even though you might have changed jobs or employer)?

years months

9. Have COVID-19 related restrictions had any impacts on your usual income, work hours or work duties (other than change to work location)? Yes ☐ No ☐

If Yes > please detail how your income, work hours and work duties have been affected.

10. Are you receiving, applying for, or considering applying for the *JobKeeper* payment? Yes ☐ No ☐

11. Please provide the name and address of your current employer or business if self-employed (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).

Name

Address

State *Postcode*

12. Please provide details of your employment history over the last three years.

Previous occupation	Industry	Date from	Date to	Employed or self-employed?
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

13. Do you have any trade, professional or tertiary qualifications? Yes ☐ No ☐

If Yes > please provide the details below.

Qualification	Institution	Date attained
		/ /
		/ /
		/ /
		/ /

14. Do you have a second occupation? Yes ☐ No ☐

If Yes > please provide the details below.

Hours worked per week

Weeks worked per year

How long have you been in this occupation? years

Current annual income after business expenses but before tax from second occupation: $

Please provide details of your second occupation, including description, employer and details of duties:

PLEASE ONLY COMPLETE QUESTIONS 15 AND 16 IF APPLYING FOR INCOME PROTECTION (HOME DUTIES).

15. Do you currently perform all normal household duties in order to maintain the home? Yes ☐ No ☐

If No > please provide details of the duties not performed.

16. Are you currently working in any gainful occupation for income? Yes ☐ No ☐

If Yes > please provide details of the type of occupation, amount of time spent performing the occupation and income generated.

SECTION 6 – INCOME DETAILS

Please only complete this section if applying for Income Protection (Own Occupation, or General Cover and earning an income), Key Person Income or Business Overheads.

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

1. 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	**$** 0.00	**$** 0.00

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

3. 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.

1. What percentage of the business do you own?

%

2. What percentage of the business does your spouse own?

%

3. How many people do you employ other than yourself and your spouse?

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

Description	**Year ending** / /	**Year ending** / /
a) Total business income	**$**	**$**
b) Less total expenses	**$**	**$**
c) Equals income before tax	**$** 0.00	**$** 0.00
d) % Ownership	**%**	**%**
Multiply (c) x (d)	**$** 0.00	**$** 0.00
Add back any personal salary/wages, motor vehicle for personal use, director's fee, personal superannuation	**$**	**$**
ANNUAL INCOME	**$** 0.00	**$** 0.00

5. 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?

6. 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	**$**
Income after twelve months of total disability	**$**
Source of income	

PART C – TO BE COMPLETED BY ALL INSURED PERSONS APPLYING FOR GREATER THAN $20,000 MONTHLY BENEFIT.

1. Do you have a net investment income greater than $250,000 per year? Yes ☐ No ☐

If Yes > please provide details below:

Source of investment income:	
Amount of investment income you receive:	**$**
Frequency of income receipt (e.g. annual, one-off):	
How long do you expect you will continue to receive this income?	

2. Do your net assets (excluding the family home and superannuation) value greater than $5 million? Yes ☐ No ☐

If Yes > what is the net value of your assets (excluding the family home and superannuation)?

Investment assets (e.g. shares, property) $

Non-investment assets (e.g. boat, collectibles) $

SECTION 7 – BUSINESS OVERHEADS EXPENSES

Please only complete this section if you have applied for Business Overheads.

1. What percentage of the business do you own?

Business expenses do not include the cost of books, equipment, fittings, goods, implements, or products used in the business, depreciation of real estate, depreciation of equipment and vehicles, repayment of mortgage or loan principal, expenses of private or domestic nature, the Insured Person's salary and salary related costs, salaries and related costs of income producing employees or Insured Person's relatives, and any other expenses of the business for which the Insured Person is not normally liable.*

Accounting, auditing fees and/or advertising	**$**
Cleaning/electricity/gas/heating/laundry/telephone (including mobile phone)/water	**$**
Leasing costs of equipment and vehicles	**$**
Rent or mortgage interest payments	**$**
Professional dues or subscriptions	**$**
Property rates, taxes and business insurance premiums	**$**
Salaries/superannuation/payroll tax of non-income producing employees	**$**
Net costs associated with employing a locum	**$**
Other fixed expenses (give details)	**$**
TOTAL AVERAGE MONTHLY EXPENSES	**$** 0.00

**Unless the relative has been a full-time employee of the Insured Person's business for at least six months prior to the commencement of total disability.*

2. **What percentage of your business' income is produced solely from your personal exertion?** %

3. **What percentage of the above Total Average Monthly Expenses do you meet personally?** %

Please provide details of business expenses shared with partners and/or income producing employees:

Name of partner or employee	Duties	Monthly remuneration	Interest in business
		$	%
		$	%
		$	%
		$	%
		$	%
		$	%

SECTION 8 – TRAVEL AND RESIDENCY

1. **Are you a permanent resident of Australia?** Yes ☐ No ☐

If No > provide details (date of entry, category of visa held, expiry of visa etc):

2. **Do you have definite plans or intentions to travel or reside outside Australia in the next 12 months?** Yes ☐ No ☐

If Yes > please provide details including reason (if known):

When will your travel commence? / /

Total duration of travel days

Countries and regions of travel within those countries:

Purpose of travel

☐ Business/work assignment ☐ Residing ☐ Holiday Other

SECTION 9 – PASTIMES

Do you currently engage in, or intend to engage in, any of the following pursuits, pastimes or activities? Yes ☐ No ☐

- any type of football (including, but not limited to, rugby union, rugby league, touch football, soccer, Australian football);
- motor sports (including, but not limited to, trail bike riding);
- recreational activities involving heights (including, but not limited to, rock climbing, abseiling, mountaineering, parachuting, hang-gliding);
- combat sports (including, but not limited to, boxing, martial arts, mixed martial arts);
- underwater recreational activities (including, but not limited to, scuba diving);
- water sports (including, but not limited to, canyoning, water skiing);
- underground activities (including, but not limited to, caving);
- flying (other than as a fare paying passenger on a regular airline service);
- skiing, snowboarding or skating; or
- any other competitive sport.

If Yes > please provide details:

Details of activity	Frequency (per month)	Competitive Nature (recreational, amateur, professional)

Please note: Completing the appropriate pastimes questionnaire to provide more details may assist in the assessment of your application.

SECTION 10 – FAMILY HISTORY

1. Have any of your blood related parents, brothers or sisters (living or deceased) been diagnosed with, or suffered from, any of the following conditions?

- Cystic fibrosis
- Familial polyposis of bowel (FAP)
- Huntington's disease
- Multiple Sclerosis
- Muscular dystrophy
- Motor neurone disease
- Parkinson's disease
- Polycystic kidney disease

Yes ☐ No ☐

2. Have any of your blood related parents, brothers or sisters (living or deceased) been diagnosed before the age of 60 with any of the following conditions?

- Alzheimer's disease or any other form of dementia
- Bowel cancer
- Breast cancer
- Cardiomyopathy
- Diabetes
- Heart attack, coronary artery bypass or had a stent
- Melanoma
- Ovarian cancer
- Prostate cancer
- Stroke
- Any other cancer
- Any other hereditary or familial disorder

Yes ☐ No ☐

3. If you have answered Yes to question 1 or 2 above > please provide details below:

Relationship (do not state name)	Condition or Disorder	Age diagnosed	Age at death (if applicable)

SECTION 11 – SMOKING AND ALCOHOL

1. Have you smoked tobacco, cigars or a pipe, or any other substance within the past 12 months or used a product containing nicotine in the last 3 months? Yes ☐ No ☐

If Yes > please provide details below:

Type: Cigarette, pipe, cigar or other (please specify)	Quantity (per day)

2. Do you consume alcohol? Yes ☐ No ☐

If Yes > please provide details (quantity is based on a 'standard' drink i.e. 250ml beer, 125ml wine, 30ml spirits):

Type:	Quantity (please specify per day or per week)

3. **Have you ever been advised by a health service provider to give up or reduce the amount of your smoking or alcohol consumption due to medical reasons?** Yes ☐ No ☐

If Yes > please provide details including the reason for the advice, when the advice was given, and list any conditions that resulted from your smoking and/or drinking:

SECTION 12 – HEIGHT AND WEIGHT

1. **Please provide your height and weight below:**

Height

cm ***OR*** ft in

Weight

kgs ***OR*** st lbs

2. **Has your weight changed more than 10kg in the past 12 months (excluding pregnancy)?** Yes ☐ No ☐

If Yes > please provide details:

SECTION 13 – DOCTOR'S DETAILS

Please provide the complete name and contact details or your usual doctor(s). If you have been attending this doctor for less than two years, please provide the details of your previous doctor.

Doctor's Name	Address	Phone Number	Years consulted (e.g. 2020–2021)
		( )	
		( )	

SECTION 14 – HEALTH DETAILS

1. **Have you ever had, or have you ever been told you have had, any of the conditions listed in A – F below:**

A ASTHMA OR CHRONIC BRONCHITIS? Yes ☐ No ☐

If Yes > have you had any symptoms or treatment in the last five years? Yes ☐ No ☐

If Yes > please indicate if any of the following apply:

	Yes	No
Have you had an attack of asthma or chronic bronchitis within the last two years?	☐	☐
Have you had more than five days off work or been on limited duties within the last two years due to asthma or chronic bronchitis?	☐	☐
In the last five years, have you been admitted to hospital, or required emergency treatment, including the use of systemic steroids for asthma or chronic bronchitis?	☐	☐
Do you require the use of non-steroidal inhalers on a daily or regular basis?	☐	☐

If you have answered Yes to any of the questions above > please complete an **Asthma Questionnaire.**

B BACK OR NECK PAIN, STRAIN OR DISORDER? Yes ☐ No ☐

If Yes > please indicate if any of the following apply:

	Yes	No
Has a back or neck disorder been diagnosed as anything other than muscular aches, strains, pains or spasms?	☐	☐
In the last 2 years have you experienced symptoms, received treatment (e.g. physiotherapy, chiropractic, osteopathy or prescription medications), or attended your health service provider for a back or neck disorder?	☐	☐
Have you ever attended, or do you plan to attend, a neurologist or orthopaedic surgeon, or undergone (or plan to have) an X-Ray, MRI, or CT scan for a back or neck disorder?	☐	☐
Have you ever had, or has it ever been recommended that you have, surgery to treat a back or neck disorder?	☐	☐

If you have answered Yes to any of the questions above > please complete a **Back and Neck Questionnaire.**

C SKIN LESION (INCLUDING, BUT NOT LIMITED TO, CYST, MOLE, GROWTH)? Yes ☐ No ☐

If Yes > please indicate if any of the following apply:

	Yes	No
Have you noticed or become aware of any change in size, shape, or colour of any skin lesion, whether or not you have consulted a doctor?	☐	☐
Have you had more than one lesion/cyst?	☐	☐
Has any lesion/cyst been confirmed by a specialist/consultant to be melanoma, basal cell carcinoma, squamous cell carcinoma or malignant (cancerous)?	☐	☐
Has any lesion been removed by a procedure other than being burnt/frozen off?	☐	☐
Were you advised to have any further tests (excluding genetic testing), treatments, checks or follow-ups for any lesion?	☐	☐

If you have answered Yes to any of the questions above > please complete a **Skin Lesion Questionnaire.**

D GOUT? Yes ☐ No ☐

If Yes > have you had any symptoms, treatment or time off work in the last three years due to your gout? Yes ☐ No ☐

If Yes > please complete a **Gout Questionnaire.**

E ANY VISION IMPAIRMENT OR EYE DISORDER? Yes ☐ No ☐

If Yes > please indicate if any of the following apply:

	Yes	No
Have you had any treatment for your vision impairment or eye disorder (excluding the use of glasses, contact lenses or successful corrective laser eye surgery (LASIK) to treat long or short sightedness or astigmatism)?	☐	☐
Is your vision impairment or eye disorder anything other than long or short sightedness or astigmatism?	☐	☐

If you have answered Yes to any of the questions above > please complete an **Eye Disorder Questionnaire.**

F JOINT OR MUSCLE DISORDER (INCLUDING PAIN, STRAIN, SPRAIN, TEAR, DISLOCATION OR FRACTURE)? Yes ☐ No ☐

If Yes > please indicate if any of the following apply:

	Yes	No
Have you ever had any joint or muscle disorder(s) that was anything other than a strain, sprain or fracture?	☐	☐
Have you ever had any joint or muscle disorder(s) that required surgical repair or reconstruction?	☐	☐
Have you had any symptoms from, or required any treatment for, any joint or muscle disorder(s) in the last two years?	☐	☐
Have you ever had more than five days off work or been on limited duties due to any joint or muscle disorder(s)?	☐	☐

If you have answered Yes to any of the questions above > please complete a **Joint Questionnaire.**

2. Mental health and wellbeing:

		Yes	No
A	Have you ever asked for or received advice or counselling for your mental health or wellbeing from a health professional (e.g. GP, counsellor, psychologist or psychiatrist)?	☐	☐
B	Have you ever been advised by a health professional that you have had a mental health condition, or received medical treatment for a mental health condition (including but not limited to anxiety, stress disorder, depression, bipolar disorder, attention deficit hyperactivity disorder (ADHD))?	☐	☐

If you have answered Yes to any of the questions above > please complete a **Mental Health Questionnaire.**

3. COVID-19

		Yes	No
A	Have you ever tested positive for COVID-19?	☐	☐
B	Have you an intention to have, or are you awaiting the result of, a COVID-19 test?	☐	☐
C	Have you been required to self-isolate or quarantine due to a possible exposure to COVID-19 in the last 30 days?	☐	☐
D	Have you, or anyone you reside with, returned to Australia from overseas or disembarked from a cruise ship in the last 30 days?	☐	☐
E	Have you, in the last 14 days, been in close contact* with someone confirmed to have COVID-19 or who has been quarantined or required to self-isolate due to exposure to COVID-19?	☐	☐

**Close contact means:*

- more than 15 minutes face-to-face contact with a confirmed case or someone with suspected exposure, including 48 hours before onset of symptoms in the confirmed case, or;
- sharing of a closed space with a **confirmed case or someone with suspected exposure** for more than 2 hours in the period extending from 48 hours before onset of symptoms in the confirmed case.

If you answered Yes to any part of question 3 > please provide full details including relevant dates, test results, ongoing symptoms and complications.

Question	Details including relevant dates, test results, ongoing symptoms and complications

4. Have you ever had, or been told you have had, any of the following symptoms or conditions that have not already been disclosed in question 1?

		Yes	No
A	Blood disorder (including, but not limited to, anaemia, haemophilia, blood transfusion, leukaemia, lymphoma)	☐	☐
B	**High Blood Pressure or High Cholesterol**	☐	☐
C	Heart or cardiovascular condition (including, but not limited to, **chest pain**, angina, rheumatic fever, heart complaint, blood vessel conditions)	☐	☐
D	Cancer, tumour, growth or lump (excluding skin lesions)	☐	☐
E	Kidney, bladder or prostate disorder (including, but not limited to, kidney stones, urinary tract infection, raised or rising PSA blood test result, prostate enlargement or inflammation)	☐	☐
F	**Bowel**, colon, gastro-intestinal disorder or reflux condition (including, but not limited to, hernia, ulcers – non mouth, irritable bowel syndrome, colitis, haemorrhoids)	☐	☐
G	**Arthritis**, Repetitive Strain Injury (RSI), Chronic Fatigue Syndrome (CFS), Occupational Overuse Syndrome (OOS), Tenosynovitis, Chronic Pain Syndrome, or Fibromyalgia	☐	☐
H	Stroke, Paralysis or nerve disorder (including, but not limited to, Bell's Palsy)	☐	☐
I	**Epilepsy** or fainting attacks	☐	☐
J	Any neurological disorder (including, but not limited to, headaches, dizziness, Multiple Sclerosis, dementia, meningitis, **head injury**, motor neurone disease, muscular dystrophy, Parkinson's disease)	☐	☐
K	Liver or gall bladder disorder (including, but not limited to, hepatitis, jaundice, haemochromatosis)	☐	☐

L	**Diabetes**, thyroid or glandular disorder (including, but not limited to, low/high blood sugar, pancreatic conditions)	☐	☐
M	**Respiratory or lung disorders** (including, but not limited to, bronchitis, pneumonia, emphysema or tuberculosis)	☐	☐
N	**Sleep apnoea** or any sleep disorder	☐	☐
O	**Ear**, or speech disorder or any other physical impairment	☐	☐
P	Skin conditions or varicose veins (including, but not limited to, psoriasis, eczema, dermatitis)	☐	☐
Q	Any other illness, injury or condition	☐	☐

If you have answered Yes to any of the questions above > please provide more details in the space provided in **section 15**.

If you answered Yes to any of the conditions in bold, there are specific questionnaires for these conditions. Completing these questionnaires will assist in the assessment of your application.

5. Other than already disclosed, have you in the last three years:

		Yes	No
A	Been prescribed or taken any medication, drug or tablet for at least 4 weeks in any 12 month period (other than antibiotics, contraception or hair loss treatment)?	☐	☐
B	Been referred to a medical specialist?	☐	☐
C	Had a surgical procedure?	☐	☐
D	Been diagnosed with a medical condition or disorder?	☐	☐
E	Had an investigation, test or consultation that resulted in advice to undergo further medical investigations, tests or consultations (excluding genetic testing)?	☐	☐

If you have answered Yes to any of the questions above > please provide more details in the space provided in **section 15**.

6. Have you used (by mouth, inhalation or injection) any recreational drugs or substances? Yes ☐ No ☐

If Yes > please complete a **Social Habits Questionnaire.**

7. Are you contemplating, or have you been told to seek any advice, tests, investigations or treatments not already disclosed (excluding genetic testing)? Yes ☐ No ☐

If Yes > please provide more details in the space provided in **section 15**.

NB: Please only answer question 8 if the combined total of insurance cover being applied for and any existing cover that you have with all companies (including individual and group insurance) exceeds:

- $500,000 Death cover
- $500,000 Total and Permanent Disability (TPD)
- $200,000 Trauma/Critical Illness/Living Benefit/Health Events
- $4,000 per month Income Protection/Salary Continuance Insurance (SCI)/Group Salary Continuance (GSC)/Business Overheads/Key Person Income

8. Genetic Testing

Have you ever had a genetic test or have you consented to having a genetic test? Yes ☐ No ☐

If Yes > have you received or do you expect to receive a result from your genetic test? Yes ☐ No ☐

If Yes > please provide full details of the genetic test including the result (if available) and any further treatment, investigation, test, consultation or operation you have had or intend to have.

If No > please advise the reason you have not received and do not expect to receive a result from your genetic test.

9. Are you infected with, or do you have an increased risk of exposure* to, the Human Immunodeficiency Virus (HIV), Hepatitis B, or Hepatitis C? Yes ☐ No ☐

Increased risk of exposure may include, but is not limited to, in the last 3 years:

- ***Sex with a person who injects non prescribed drugs, with a sex worker, or with someone you know or suspect to be HIV, hepatitis B or hepatitis C positive; or***
- ***Unprotected anal sex (except in a relationship where neither of you have had sex with anyone else in the last 3 years).***

If Yes > a **Confidential Lifestyle Questionnaire** will be sent to you to be completed.

FEMALES ONLY – QUESTIONS 10 TO 15

10. Have you ever had any gynaecological disorder (e.g. endometriosis, cervical cancer), abnormal cervical screening test (PAP smear) or positive HPV test? Yes ☐ No ☐

If Yes > please complete a **Gynaecological Questionnaire.**

11. Have you ever had breast lumps or an abnormal result from a breast examination? Yes ☐ No ☐

If Yes > please complete a **Gynaecological Questionnaire.**

12. Are you currently pregnant? Yes ☐ No ☐

If Yes > answer questions 13 to 15.
If No > go to **Section 16.**

13. Have you ever had any pregnancy complications (please do not include elective caesarean or a miscarriage within the first 15 weeks of pregnancy)? Yes ☐ No ☐

If Yes > please provide more details in the space provided in **Section 15.**

14. Are you in your final 10 weeks of pregnancy? Yes ☐ No ☐

If Yes > please provide more details in the space provided in **Section 15.**

15. Will you be returning to your usual occupation, duties, and hours after maternity leave? Yes ☐ No ☐

If No > please provide details of your plans below.

SECTION 15 – FURTHER HEALTH INFORMATION

Question number	Condition or diagnosis	Time off work due to condition	Please provide full details (including date of first symptoms, date of last symptom, degree of recovery, details of investigations and treatment, any ongoing treatment/follow up, and the name and contact details of any health service provider consulted)

Please provide any additional information that you wish to provide with regard to your application for insurance.

SECTION 16 – PREVIOUS INSURANCE DETAILS

1. **Are you currently in receipt of a claim, or have you ever made a claim, or expect to make a claim, from any source including:**
   - Sickness, accident or disability benefits;
   - Workers' compensation;
   - Veterans' Affairs benefits; or
   - Any other form of compensation such as a Centrelink Disability pension or sickness benefits (excluding unemployment benefits)?

   Yes ☐ No ☐

   If Yes > please provide details of each claim:

Date commenced	Date finalised	Source & amount	Reason
/ /	/ /		
/ /	/ /		
/ /	/ /		

2. **Have you ever had an application for life, total and permanent disability (TPD), trauma (critical illness/living), income protection, key person income or business expenses insurance either declined, deferred, cancelled or accepted with a loading, exclusion or special terms?**

   Yes ☐ No ☐

   If Yes > please provide details, including the assessment, reason and date occurred:

SECTION 17 – NON-ENGLISH SPEAKING DECLARATION

I (full name of interpreter)

confirm that I am able to communicate fluently in English and (language)

which is the language of (Insured Person)

who is applying for insurance with the Insurer.

I further confirm that I have fully explained to the Policy Owner(s) and/or Person to be Insured:

1. the various questions in the Personal Statement, and that the answers given to those questions have been transcribed as accurately as possible on the Personal Statement;
2. the declarations contained in the Personal Statement – particularly the Duty of Disclosure statement in Section 1 and Privacy Information in Section 2 of the Personal Statement; and
3. the details of the type of insurance cover being applied for.

Signature of **Interpreter**

Date (dd/mm/yy) / /

THE FOLLOWING MUST ALSO BE SIGNED BY THE POLICY OWNER(S) AND/OR THE INSURED PERSON.

I confirm that the information outlined above, has been fully explained to me.

Signature of **Insured Person/Policy Owner 1**

Date (dd/mm/yy) / /

Signature of **Policy Owner 2**

Date (dd/mm/yy) / /

If there are more than two Policy Owners, please attach their signatures on a separate sheet.

SECTION 18 – UNDERWRITING

(Adviser use only.)

Pre-Assessment and/or large quote underwriting reference number (if applicable)

	Yes	No
Direct contact with the client for 'Telephone Underwriting' is authorised?	☐	☐

(If this question is unanswered, a 'Yes' response will automatically be assumed).

If your client has/had a significant medical condition or engages in any hazardous activity, have you advised them that modified terms may be offered?	☐	☐

SECTION 19 – DECLARATION AND AGREEMENT

Please ensure that the following three sections are signed and dated.

I declare and agree that:

- I have read and understood this completed Personal Statement 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 the section titled 'Privacy Information' in this Personal Statement and I agree to the various uses and disclosures of my personal information set out in that section;
- this Personal Statement and any related documents including the BT Protection Plans Product Disclosure Statement and Policy Document (PDS) shall form the basis of any contract issued;
- I have read and understood the section titled 'Duty of Disclosure' in this Personal Statement. I declare that I have complied with the duty of disclosure;
- I understand that failure to comply with the duty of disclosure could result in avoidance, cancellation or variation of my insurance, or any claim not being paid in accordance with my expectations;
- I understand that the duty of disclosure extends beyond my completion of this form up until the Insurer accepts the application to which this Personal Statement relates and issues a policy;
- I fully understand my rights and obligations under this contract;
- I have read and understood the conditions regarding cancellation of my other insurance set out in Section 4 of this Personal Statement. I acknowledge that any failure to cancel my other insurance will result in reduction of any benefit I am entitled to from the Insurer by the amount paid or payable from the other policy that was not cancelled;
- the email address provided in this application may be used to electronically communicate with me, including important information in relation to my application and my insurance;
- the Panorama account details provided in this application (if any) may be used to electronically communicate with me, including important information in relation to my application and my insurance;
- details of any Policies owned by me that are funded by a Panorama account will be visible online to the owner of the Panorama account and their financial adviser; and
- the insurance I have applied for will not become effective until the application to which this Personal Statement relates to is accepted by the Insurer in writing.

☐ I, the Insured Person on this application, authorise the Insurer to disclose personal, medical and financial information obtained in the course of assessing the application for life insurance to the Adviser named in the 'Adviser Details' section. This may also include 'Sensitive Information' as defined in the Privacy Act.

I understand that the purpose of disclosing this information is to explain the reason for any loadings, exclusions or alternative terms that may be applied to the above policy. In addition, if the application on my life is declined, to explain the reason for this decision.

I understand that the Insurer will not provide copies of medical or other reports to my Adviser.

Signature of **Insured Person**

Date (dd/mm/yy) / /

Signature of **Witness**

Date (dd/mm/yy) / /

Paramedical Services Request Form

Fax the completed form to:

UHG	(03) 9692 7881

For enquiries, telephone:

UHG	1300 558 583

If any part of this form is left blank, it may cause delays.

Application number

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please specify)

Given name(s)

Surname

Residential address

Street

Suburb/City *State* *Postcode*

Country, if not Australia

Gender ☐ M ☐ F

Date of birth (dd/mm/yyyy) / /

Number of financial dependants

Home Phone ( )

Mobile Phone

Work Phone ( )

Fax Number ( )

INSURANCE DETAILS

Type and amount of cover being applied for:

Life Cover $

Trauma (Living) Cover $

Total and Permanent Disability Cover $

Income Protection/Business Overheads/Key Person Income Cover $ per month

Tests Required. Please tick [✓] tests required.

☐	CXR	Chest X-ray	☐	MBA20	Multiple Biochemical Analysis
☐	ECG_EX	Stress (exercise) Electrocardiogram	☐	MEDXAM	Medical Examination
☐	ECHOEX	Stress Echocardiogram	☐	MSU	Microscopic Urinalysis
☐	FBC	Full Blood Count	☐	PSA	Prostate Specific Antigen (PSA) test
☐	HEP B & C	Hepatitis B & C antibodies and antigens	☐	QCHECK	Quick Check
☐	HIV	Human Immunodeficiency Virus antibodies	☐	SPX	Specialist Physician Exam
☐	MAM	Mammogram test	☐	Other (please specify)	

ADVISER'S DETAILS

Adviser's name

Contact Number ( )

Mobile Phone

Control Number

Request for Paramedical Services from **Westpac Life Insurance Services Limited ABN 31 003 149 157 AFSL 233 728.**
Please fax all results to (02) 9274 5239.