



# FuturePlus Super

## Change of Insurance Arrangements

Please complete in capital letters and in BLACK INK only

This form is to be completed by members who wish to apply for or alter existing insurance arrangements.

Please refer to the "Insurance" section in the Product Disclosure Statement (PDS) for details on insurance cover. To obtain a copy of the PDS contact Member Services on 1800 067 059 or visit our website [www.futureplussuper.com.au](http://www.futureplussuper.com.au). You should also read the 'Important Notes' on the last page of this form.

### 1. Personal details

Member no.	<input type="text"/>	Date of birth (dd/mm/yyyy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Title	<input type="text"/> (e.g. Mr/Mrs/Ms/Miss/Dr)						
Family name	<input type="text"/>						
Given name(s)	<input type="text"/>						
<b>Contact Details (postal address, telephone, email)</b>							
No./Street/PO Box	<input type="text"/>						
Suburb/Town/City	<input type="text"/>						
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>		
Phone: Home no. (inc. STD/ISD)	<input type="text"/>			Business no. (inc. STD/ISD)	<input type="text"/>		
Mobile no.	<input type="text"/>			Fax no. (inc. STD/ISD)	<input type="text"/>		
E-mail address	<input type="text"/>						
<b>Residential Address</b>							
<input type="checkbox"/> Same as Postal Address above							
<input type="checkbox"/> Different from Postal Address above – you MUST complete below							
No./Street	<input type="text"/>						
Suburb/Town/City	<input type="text"/>						
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>		

### 2. Occupation details

2.1	<input type="checkbox"/>	Self-Employed or	<input type="checkbox"/>	Employee	<input type="checkbox"/>	Full Time or	<input type="checkbox"/>	Part Time	<input type="text"/>	hours p/week	<input type="text"/>	weeks p/year
2.2	Your Occupation <input type="text"/>						Industry <input type="text"/>					
2.3	Duties Performed <input type="text"/>											
2.4	Annual Salary (includes packaged items but excludes Bonuses/Commission) \$											<input type="text"/>

### 3. Group Medical Requirements

Death and Total Permanent Disability (Under 55 years of age)

Level of Cover	Initial Requirements
Up to \$1,000,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> </ul>
\$1,000,001 to \$1,250,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Blood Tests</li> </ul>
\$1,250,001 to \$3,000,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Blood Tests</li> <li>▪ Fast Check Medical</li> </ul>
Over \$3,000,000	<ul style="list-style-type: none"> <li>▪ Please contact us for requirements</li> </ul>



**Death and Total Permanent Disability (55 years and over)**

Level of Cover	Initial Requirements
Up to \$750,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> </ul>
\$750,001 to \$1,000,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Blood Tests</li> <li>▪ Medical Exam by own Doctor (Please contact us to obtain a medical examiner's report)</li> </ul>
\$1,000,001 to \$2,000,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Blood Tests</li> <li>▪ Fast Check Medical</li> </ul>
Over \$3,000,000	<ul style="list-style-type: none"> <li>▪ Please contact us for requirements</li> </ul>

**Group Salary Continuance (Age 16 – 65)**

Monthly Benefit	Initial Requirements
Up to \$8,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> </ul>
\$8,001 to \$12,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Blood Tests</li> </ul>
\$12,001 to \$20,000	<ul style="list-style-type: none"> <li>▪ Member's Personal Statement</li> <li>▪ Medical Examination by own Doctor</li> <li>▪ Fast Check Medical</li> </ul>

**4. Insurance Application**

Death Sum Insured	\$	<input type="text"/>	TPD Sum Insured	\$	<input type="text"/>	
Monthly Income Benefit	\$	<input type="text"/>	Benefit Period	<input type="text"/>	Waiting Period: 90 days	
4.1 Is this an increase?						<input type="checkbox"/> No <input type="checkbox"/> Yes
4.2 Have you ever held or applied for any life, disability, accident and sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused?						<input type="checkbox"/> No <input type="checkbox"/> Yes
4.3 Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party?						<input type="checkbox"/> No <input type="checkbox"/> Yes
4.4 Do you have, or are you applying for, any other life or disability cover?						<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If Yes to 4.2, 4.3 and/or 4.4, please provide full details below:</i>						
Name of Company	Cover Type	Sum Insured	Date of Application	Accepted/Loaded Exclusion/Declined	To be Replaced?	
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes	
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes	
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes	

**5. Habits and Activities**

5.1 Do you drink alcohol? <i>If Yes, state type and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.2 Have you smoked in the past 12 months? <i>If Yes, state form and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.3 Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? <i>If Yes, state type and daily quantity below</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.4 Do you currently, or do you intend to engage in, any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or other extreme sport? <i>If Yes, please complete a sports and pastimes statement</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes



5.5 Do you intend travelling outside Australia within the next two years?  
*If Yes, please provide details below (where, when, duration and reason)*  No  Yes

5.6 Are you an Australian or New Zealand Citizen?  No  Yes

5.7 Do you hold an Australian Permanent Resident's Visa?  No  Yes

*If No to 5.6 and/or 5.7, please provide full details below:*

### 6. Personal Statement

6.1 Please state your Height  (cm) Weight  (kg)

6.2 Name and Address of your usual Doctor

Name of doctor

Street/PO Box no.

Suburb/Town/City

State/Territory  Postcode  Country (if outside Australia)

Doctor's phone no. (inc. STD/ISD)

6.3 Details of last medical consultation with your usual Doctor

Date (dd/mm/yyyy)

Reason

Outcome/Results

6.4 If you have attended that Doctor for less than 12 months, please state the Name and Address of your previous Doctor

Name of doctor

Street/PO Box no.

Suburb/Town/City

State/Territory  Postcode  Country (if outside Australia)

Doctor's phone no. (inc. STD/ISD)

6.5 a) Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquilisers?  No  Yes

b) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation?  No  Yes

c) Have you EVER had any blood tests which revealed an abnormality eg. raised blood sugar, liver function, renal function results or anaemia, etc?  No  Yes

d) Do you contemplate seeking any medical examination, advice, treatment or surgery in the future?  No  Yes



Please provide full details for all 6.5 Yes answers

Question	Dates (From/To)	Name and address of Doctor, Hospital or Clinic	Condition, Medications, Treatment and Time off work	Recover %

6.6 Have you ever had, been advised that you had, or received advice or treatment for any of the following:

Please provide details for all Yes answers in 7. General Medical Questionnaire.

- a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder?  No  Yes
- b) Bowel, stomach or intestinal problem, gallbladder or liver disease?  No  Yes
- c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks?  No  Yes
- d) Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition?  No  Yes
- e) Diabetes, sugar in urine, pancreatic or thyroid problems?  No  Yes
- f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind?  No  Yes
- g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis?  No  Yes
- h) Impairment of sight, hearing or speech?  No  Yes
- i) Asthma, bronchitis, any lung complaint?  No  Yes
- j) Leukaemia, haemochromatosis, any blood problem?  No  Yes
- k) Kidney, bladder problems?  No  Yes
- l) Psoriasis, eczema, any skin problem,?  No  Yes
- m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury?  No  Yes
- n) To the best of your knowledge do you, or any of your current or past sexual partners, have HIV/AIDS, or are you experiencing any unexplained night sweats or unintentional weight loss, or do you/have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus?  No  Yes

**FEMALES ONLY**

- o) Have you ever had any gynaecological conditions (eg: endometriosis, abnormal pap smear, etc.)?  No  Yes
- p) Have you ever had any complications of pregnancy or childbirth?  No  Yes
- q) Are you currently pregnant? If Yes, what is the expected delivery date? (dd/mm/yyyy)  / /  No  Yes
- r) Have you ever had a breast lump (even if you have not seen a doctor about it)?  No  Yes



6.7 Family History. Please give details of your family medical history				
Relative	Living Relatives		Deceased Relatives	
	Current Age	Specify current state of health	Age at Death	Specify cause of death
Mother				
Father				
Sisters				
Brothers				

6.8 Have any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia?  No  Yes

*If Yes, please provide full details below*

## 7. General Medical Questionnaire

Please provide full details for all Yes answers in 6.6 a) to r). Please continue on a separate sheet if required

Question No.	Q	Q	Q	Q
Specific Condition				
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side of the body was affected?				
C. What was the medical diagnosis including results of x-rays and investigations?				
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
F. How long were you unable to work or perform your normal duties/activities?				
G. If a hospital visit was required, please provide date and duration of your stay.				



Question No.	Q	Q	Q	Q
Specific Condition				
H. What advice/treatment did you receive?				
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
J. Date treatment/ medication ended.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)				
M. Please supply the name and address of all documents, hospitals or other practitioners consulted.				

### 8. Member declaration

I acknowledge that I have read the notice in 'Important Notes' explaining my duty of disclosure overleaf and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or Personal Health Statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Applicant, authorise and direct any medical or other practitioner to divulge at any time to TOWER Australia Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TOWER Australia Limited or its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information TOWER Australia Limited collects on this form or future forms in relation to this insurance.

I  hereby declare that the

above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written by me or by any person on my behalf.

Signed

Date (dd/mm/yyyy)

 /  / 

### 9. Medical Authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to Tower Australia Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full Name of Member

Signature of member

Date (dd/mm/yyyy)

 /  / 


## IMPORTANT NOTES

You should read the Product Disclosure Statement (PDS) before completing this form. The PDS is available from Member Services and the Fund's website.

### Your Duty of Disclosure

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

You have the same duty to disclose those matters to us before you extend, vary or reinstate a contract of life insurance. Your duty however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of his business, ought to know
- disclosure of which is waived by the insurer.

### Non-Disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may void the contract within three years of entering into it.

If your non-disclosure is fraudulent, the insurer may void the contract at any time.

An insurer who is entitled to void a contract of life insurance may within three years of entering into it, elect not to void it, but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

### GIVING YOUR TAX FILE NUMBER

If you have not already given us your Tax File Number (TFN) you should consider doing so now.

**To give us your TFN, complete the attached "Notification of Tax File Number" Form and send it to us with this form.**

### Where to send this form/enquiries

FuturePlus Super  
PO Box N835  
Grosvenor Place NSW 1220  
website: [www.futureplussuper.com.au](http://www.futureplussuper.com.au)

Phone: 1800 067 059  
(8.30 am – 5.00 pm Mon – Fri)

enquiries: [info@futureplussuper.com.au](mailto:info@futureplussuper.com.au)

**DO NOT FAX THIS FORM AS YOUR ORIGINAL AUTHORISATION IS REQUIRED**

### Payment of Invoice

Please have any invoices made out to **TOWER Australia Limited**

### PROTECTING YOUR PRIVACY

Some of the personal information you are requested to provide is required to establish and maintain your membership in the FuturePlus Super Fund while other information is required under Australian Government Anti-Money Laundering and Counter-Terrorism Financing measures.

The Trustee is fully committed to comply with the National Privacy Principles in the way in which your personal information is stored and used. Full details of how this is achieved are contained in the Trustee's Privacy Policy, which is available from Member Services or the Fund's website at [www.futureplussuper.com.au](http://www.futureplussuper.com.au)

### TRUSTEE INFORMATION

Please note that the information contained in this document is of a general nature only and is not for personal advice and has not taken into account your personal objectives, financial situation or needs. Any advice in this document is provided by Chifley Financial Services Limited (ABN 75 053 704 706), as an Australian Financial Services Licensee (AFSL 231148). Chifley Financial Services Limited is an APRA Registrable Superannuation Entity Licensee (RSEL: L0001120) and the trustee of FuturePlus Super (ABN 76 829 356 693). FuturePlus Super is a Registered Superannuation Entity (RSE: R1004366). Chifley Financial Services Limited is co-owned by the Local Government Superannuation Scheme, the Energy Industries Superannuation Scheme and Unions NSW.

Members should not rely solely on this information and should consider their own personal objectives, financial situation and needs before acting on this information. Prior to making any decision you should obtain and consider the relevant Product Disclosure Statement (PDS) pertaining to your membership.





# FuturePlus Super

## Notification of Tax File Number (TFN)

Under Superannuation Law, the Trustee must request that you supply your Tax File Number for superannuation purposes. Collection of your TFN by the Trustee is authorised by tax laws, the Superannuation Industry (Supervision) Act 1993 and the Privacy Act 1988.

### 1. Your details. Please complete in capital letters and in BLACK INK only

Member no.	«M_Number»	Date of birth (dd/mm/yyyy)	«M_DOB»
Title	«M_Title»	(e.g. Mr/Mrs/Ms/Miss/Dr)	
Family name	«M_Surname»		
Given name(s)	«M_First»		
<b>Contact Details (postal address, telephone, email)</b>			
No./Street/PO Box	«M_Address1» «M_Address2» «M_Address3»		
Suburb/Town/City	«M_Suburb»		
State/Territory	«M_Sta»	Postcode «M_Postcode»	Country (if outside Australia) «M_Country»
Phone: Home no. (inc. STD/ISD)	«M_Home»	Business no. (inc. STD/ISD)	«M_Business»
Mobile no.	«M_Mobile»	Fax no. (inc. STD/ISD)	«M_Fax»
E-mail address	«M_EMail»		

### Residential Address

- Same as Postal Address above
- Different from Postal Address above – you MUST complete below

No./Street			
Suburb/Town/City			
State/Territory	Postcode	Country (if outside Australia)	

### 2. Applicant declaration

**For the purposes allowed under superannuation law:**

I agree to supply my Tax File Number: [ ] - [ ] - [ ] to the Trustee.

**OR**

I do not wish to supply my Tax File Number to the Trustee. I understand the consequences.

Signed [ ] Date (dd/mm/yyyy) [ ] / [ ] / [ ]

### Where to send this form/enquiries

FuturePlus Super PO Box N835 Grosvenor Place NSW 1220 website: www.futureplussuper.com.au	Phone: 1800 067 059 (8.30 am – 5.00 pm Mon – Fri)  enquiries: info@futureplussuper.com.au
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**DO NOT FAX THIS FORM AS YOUR ORIGINAL AUTHORISATION IS REQUIRED**



## IMPORTANT NOTES

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You should read the Product Disclosure Statement (PDS) before completing this form. The PDS is available from Member Services and the Fund's website.

### REASONS FOR SUPPLYING YOUR TAX FILE NUMBER (TFN) TO THE TRUSTEE

We are required to tell you the following things before you provide your tax file number (TFN) to the Trustee of the Fund. Your TFN is confidential, and you should know the following things before you decide to provide it.

We can collect your tax file number under the Superannuation Industry (Supervision) Act 1993.

If you do provide your tax file number to us, we will use it only for legislative purposes. This includes finding or identifying your superannuation benefits where other information is insufficient, calculating tax on any superannuation benefits you may be entitled to, and providing information to the Commissioner of Taxation (amongst other things to enable the Commissioner of Taxation to assess any tax payable on superannuation contributions made by or for you). These legislative purposes may change in the future.

You are not compelled to provide your TFN and deciding not to quote your TFN is not an offence. However, if you do not provide your TFN you may pay more tax on your superannuation benefits than is required – any additional tax may be reclaimed through the tax assessment process if you subsequently provide your TFN. It may also be more difficult to locate or amalgamate your superannuation benefits in the future to pay you any benefits you are entitled to.

These consequences may also change in the future due to legislative change.

If you provide your tax file number to us, we may provide it to the trustee of another superannuation fund or to an RSA provider where the RSA provider or trustee is to receive your transferred benefits in the future. We will not pass on your tax file number to such a trustee or RSA provider if you tell us in writing that you do not want us to do that. We may also give it to the Commissioner of Taxation. Otherwise your tax file number will be treated as confidential.

As a result of recent changes to legislation arising out of the 2006 Federal Budget it is important that you consider giving us your TFN.

**If you or your employer do not provide your TFN to the Fund by the end of the financial year, then all of your concessional contributions will be taxed at the top marginal tax rate, plus the Medicare levy, if they exceed \$1,000. For any accounts that begin after 1 July 2007, the \$1,000 threshold does not apply. Furthermore, your Fund will not be able to accept any non-concessional contributions from you if we do not have your TFN.**

For this reason it is crucial that you consider providing your TFN to the Fund, either directly or through your employer, as soon as possible (if you have not already done so). You should also check your Member Benefit Statement to ensure that your TFN is correctly recorded. For more information please see the PDS or contact Member Services.

### PROTECTING YOUR PRIVACY

Some of the personal information you are requested to provide is required to establish and maintain your membership in the FuturePlus Super Fund while other information is required under Australian Government Anti-Money Laundering and Counter-Terrorism Financing measures.

The Trustee is fully committed to comply with the National Privacy Principles in the way in which your personal information is stored and used. Full details of how this is achieved are contained in the Trustee's Privacy Policy, which is available from Member Services or the Fund's website at [www.futureplussuper.com.au](http://www.futureplussuper.com.au)

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