APPLICATION FOR INCREASE OR ALTERATION

Encompass PROTECTION

Please use this form to request:

- An increase in cover or addition to an existing policy
- Any alteration that requires underwriting (e.g. a reduction of waiting period)
- A review of a loading/exclusion.

If your policy is less than six months old, or your request is to review an exclusion only, please contact us to discuss faster ways of assessing your alteration.

How to complete this form

The form is writable, so you can save a copy to your computer, type in your responses, print, sign and email the completed form to **customer@encompassprotect.com.au**

Important: The form must be emailed to us from the insured person's email address or be signed by the insured person.

If the form is being sent by a financial adviser, the insured person and policy owner must sign the declarations and a scanned copy should be emailed to **customer@encompassprotect.com.au**

Privacy statement

By completing this form, you consent to any personal information we may collect about you in the normal course of our business being used as outlined in our privacy policy. Our policy, which is designed to protect your interests and is consistent with the Privacy Act, can be found on our website at **www.encompassprotect.com.au/privacy-policy**

Duty to take reasonable care not to make a misrepresentation

When applying for insurance, you agree to take reasonable care not to make a misrepresentation to us before we issue your contract of insurance. The duty to take reasonable care is set out in the Encompass Protection Product Disclosure Statement and Policy Document (PDS) available on our website **www.encompassprotect.com.au/PDS**

What is a misrepresentation?

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

If you do not meet your duty to take reasonable care

If you do not take reasonable care not to make a misrepresentation, this can have serious impacts on your insurance. Your policy and/or cover could be cancelled and/or avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Questions?

We're here to help. If you have any questions in relation to this form, please contact us on **1300 476 030** or email us at **customer@encompassprotect.com.au**. Alternatively, please contact your financial adviser.

encompassprotect.com.au
GPO Box 239, Sydney NSW 2001
e: customer@encompassprotect.com.au **t:** 1300 476 030

EFC011_0824

Policy details

Policy number/s

Insured person

Adviser name
If applicable

Adviser code
If applicable

If further information is needed to assess your application, can we call you to collect this information over the phone? ☐ Yes ☐ No

Application details

Please select one or more boxes as required

☐ Increase benefit amount
☐ Review of loading
☐ Review of occupation category
☐ Increase benefit period
☐ Reduce waiting period
☐ Add option
☐ Additional benefit

☐ Other alteration (please specify)

Increase or addition

Cover type	Current benefit amount	Proposed benefit amount
Life Cover	$	$
TPD Cover	$	$
Critical Illness Cover	$	$
Income Protection Cover	$	$

Change of waiting period or benefit period for Income Protection Cover

Current waiting period		Current benefit period	
New waiting period		New benefit period	

Please provide any further details to assist us with the assessment of your alteration

1. Contact details

1.1 Phone and email address

Email

Telephone

Home | Mobile | Business hours

Please note that sensitive/personal information may be sent to your email address.

1.2 Residential address

Unit number | Street number | Street name

Suburb | State | Postcode | Country

1.3 Postal address

Unit number/ PO Box number | Street number | Street name

Suburb | State | Postcode | Country

2. Existing insurance details

2.1 Do you have any existing Life, Total and Permanent Disability (TPD), Critical Illness/Trauma or Income Protection insurance with another insurance company or via a group arrangement with your employer?

☐ Yes ☐ No

If **YES**, please confirm your total level of cover across all of the policies you have for each cover type:

	Total cover *(excluding any Encompass Protection cover type being applied for)*	**Is cover being replaced?**
Life Cover	**$**	☐ Yes ☐ No
TPD Cover	**$**	☐ Yes ☐ No
Critical Illness Cover	**$**	☐ Yes ☐ No
Income Protection Cover ☐ WP ☐ BP	**$**	☐ Yes ☐ No

3. Occupation and income

Occupation

Employer name / business name / industry type

3.1 **Which of the following best describes your employment situation?**

- ☐ Employee – permanent full-time or part-time, or employed contractor
- ☐ Self-employed – via a partnership/company/trust structure or sole trader or self-employed contractor
- ☐ Casual worker. If selected, have you been working for the same employer for the last two years? ☐ Yes ☐ No
- ☐ Retired or unemployed

Complete only if you're an employee

3.2 **What is your current annual income before tax?** $

*For **employed** individuals (those that have no direct or indirect ownership in the business they are employed in) - this is your gross monthly income earned from personal exertion by way of total remuneration package including salary, regular overtime, salary sacrifice amounts, bonuses, commissions, share of profits and other fringe benefits. Bonuses, commissions, share of profits and other similar payments should only be included if they are reliably recurrent. Compulsory superannuation payments should not be included here (salary sacrificed superannuation can be included).*

*For **self-employed** individuals: This is your share of the gross monthly income generated by the business, or professional practice, as a result of your personal exertion less your share of the allowable business expenses necessarily incurred in generating that income.*

Complete only if you're self-employed

3.3 **How much did you personally earn in the last full financial year?** $

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

Complete only if you're an employee

3.4 **How much did you personally earn in the full financial year prior to your answer to question 3.2?** $

Complete only if you're self-employed

3.5 **How much did you personally earn in the full financial year prior to your answer to question 3.3?** $

3. Occupation and income continued

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

Complete only if you're self-employed

3.6 **Do you expect to earn at least as much in this financial year as you did last financial year? (i.e. the amount you entered into question 3.3?)**

Answer ***NO*** if your earnings reduced since the end of the last financial year to now.

☐ Yes ☐ No

If **NO**, please explain why your earnings have reduced from the LAST full financial year to now:

3.7 **In either of the last two full financial tax years, did you receive net passive income greater than 25% of your personal income and/or unearned income or net investment income over $20,000?**

☐ Yes ☐ No

Passive income means income which you receive that is not income earned from personal exertion, working or from the conduct of a business. Passive income includes income such as interest, dividends, net rental income, ongoing contractual royalties, annuities, or other similar income

If **YES**, please provide further details where this income is derived from, and the amount received for each of the last two years and what you expect to receive this year.

3.8 **How many hours do you work in a typical working week?** Hours

If you work less than 20 hours or more than 50 hours per week, please provide full details of your working pattern and hours worked over the last four weeks.

3.9 **Are you currently off work, working reduced hours or have you altered your work duties due to illness or injury?**

☐ Yes ☐ No

If **YES**, please confirm the reason and provide full details.

3. Occupation and income continued

3.10 **Do you have any definite plans to change your occupation, work duties, working hours or employment status or are you aware of any future change that may impact this?**

This includes any plans to start your own business, change industry, take extended leave or parental leave, within the next 12 months.

☐ Yes ☐ No

If **YES**, please describe the intended change in detail including any change in your occupation/duties, the number of hours worked or employment status:

3.11 **Do you have another occupation?**

☐ Yes ☐ No

If YES, do you spend more than 10% of your total working hours performing the duties of your second occupation?

☐ Yes ☐ No

Have you included any income from your second occupation in the income amounts you provided above for the last full financial year and the previous full financial year?

☐ Yes ☐ No

If **YES**, please provide full details of your second occupation and your duties as well as the income being included from each occupation (if any at all).

TO BE COMPLETED FOR INCOME PROTECTION ONLY

3.12 **Have you been continuously working in your occupation, trade or profession for the last two years?**

☐ Yes ☐ No

If **NO**, please explain the reason and provide a description of your previous occupation.

3. Occupation and income continued

Complete only if you're an employee

3.13 **Do you receive any variable income (for example commission or bonuses) that would make up more than 30% of your base salary?**

☐ Yes ☐ No

If **YES**, please provide further details where this income is derived from, and the amount received for each of the last two years and what you expect to receive this year.

Complete only if you're self-employed

3.14 **How many employees are there in your business (not including yourself)?**

Please answer only in whole numbers (and round up or down). For example, if you have two full-time employees and one part-time employee working three days a week (0.6 FTE), the answer would be '3'.

3.15 **How many of these are income producing employees (not including yourself)?**

An employee whose activities generate revenue for the business, that is not dependent on the involvement of the insured person?

3.16 **Has your business been trading profitably for each of the last two full financial years?**

☐ Yes ☐ No

If **NO**, please provide full details of the reason why.

3.17 **Would your business continue if you were unable to work in the business?**

☐ Yes ☐ No

If **YES**, would your income continue for more than 30 days in the event you were unable to work?

☐ Yes ☐ No

If **YES**, then please provide full details.

3. Occupation and income continued

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

3.18 **Are you or any business you're associated with, contemplating voluntary administration, or have you or any business you're associated with been bankrupt or placed into receivership, involuntary liquidation or under administration?**

☐ Yes ☐ No

If **YES**, please provide full details including the date, the circumstances that led to this and whether it's been discharged.

TO BE COMPLETED FOR ALL COVER

For occupation categories white collar (WCA) and white collar professionals (WCP) only

3.19 **Do your occupation duties include any manual work or hazardous duties?**

This includes but is not limited to regular lifting, driving heavy machinery and / or working at heights, working underground, working with explosives or underwater diving.

☐ Yes ☐ No

If **YES,** please advise what percentage of time is spent performing these duties, the type of duties performed and whether they are considered normal for the occupation you have been quoted.

Please note that for white collar (WCA) and white collar professionals (WCP), the manual duties question will only be asked for TPD and Income Protection, whereas the hazardous duties question will be asked for all benefits.

For occupation categories WCM, LBC, BC, HB, SRA, SRB, SRC, IC, UI only

3.20 **Do your occupation duties include working at heights above 10 metres, working underground, working with explosives or underwater diving?**

☐ Yes ☐ No

If **YES** to working at heights, please advise how many hours are worked at heights 10-20 metres, above 20 metres, whether this involves working outside of a fixed structure, average and maximum heights worked, and duties being performed.

If **YES** to working underground, please advise percentage of weekly working hours spent underground and the type of duties being performed.

If **YES** to working with explosives, please advise percentage of weekly working hours spent working with explosives, duties performed, details of safety measures in place and environment worked in.

If **YES** to underwater diving, please advise average depths dived at, maximum depths dived at, duties performed whilst underwater diving, percentage of weekly work spent underwater diving, whether in local Australian waters only and whether any search and rescue or salvage work.

4. Purpose of cover

4.1 What is your purpose for applying for Encompass Protection life insurance?

☐ Personal ☐ Business / keyman insurance ☐ Combination of personal and business

If the purpose of your insurance is to provide buy/sell cover, please explain how your business has been valued and by whom. If the purpose is for loan protection cover, please provide details of all current loan facilities and drawn down amounts. If the purpose is for key person cover, please provide an overview of the key person's duties, skills, remuneration package and any other relevant background information.

5. Personal details

5.1 What is your height?

Please state your height in metres and centimetres e.g. 1.75

5.2 What is your weight?

Please state your weight in kilograms. If you're currently pregnant, please tell us your weight immediately before your pregnancy.

6. Tobacco usage history

6.1 Which of the following are you?

☐ Non-smoker (life-long)
☐ Ex-smoker (please complete 6.2)
☐ Smoker (please complete 6.3)
☐ Very occasional smoker
☐ User of e-cigarettes or vapes in the last year
☐ User of other nicotine replacement products in the last year

6.2 If you've ticked the ex-smoker box, please confirm the date you last smoked. ☐☐ / ☐☐ / ☐☐☐☐

6.3 If you've ticked the smoker box, please confirm what you smoke and the quantity.

7. Family history

7.1 **Have your parents, or siblings (related by blood) had any of the following conditions before the age of 65? Please tick all applicable boxes.**

You don't need to indicate (tick) anything if your family member was 65 or older when they were first diagnosed, or they first suffered symptoms.

- ☐ Heart disease, heart attack, angina or stroke
- ☐ Cardiomyopathy
- ☐ Cerebral Aneurysm
- ☐ (Females only) Breast or ovarian cancer
- ☐ Bowel cancer
- ☐ Other cancer
- ☐ Diabetes
- ☐ Haemochromatosis
- ☐ Polycystic kidney disease (PCKD)
- ☐ Retinitis Pigmentosa
- ☐ Muscular dystrophy, Huntington's disease or Motor Neurone disease
- ☐ Parkinson's disease or multiple sclerosis
- ☐ Any other hereditary disorder
- ☐ No contact with family members/don't know
- ☐ None of the above

If you've ticked any of the boxes above with the exception of the last two check boxes, please confirm how many family members are/were affected, the condition and the age of each family member at diagnosis:

8. Medical history

Important: Please be aware that we may not pay a claim and could cancel your policies if you do not answer the following questions truthfully and accurately. We won't always write to your doctor, so make sure you answer these questions honestly and in full. If you are unsure about whether you should include information, please include it.

Last five years

8.1 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Raised blood pressure or cholesterol
- ☐ Diabetes, raised blood sugar, (females: pregnancy related diabetes) or sugar in your urine
- ☐ Hypothyroidism, hyperthyroidism, Graves' disease, goitre or thyroiditis
- ☐ Anaemia haemochromatosis, varicose veins, deep vein thrombosis (DVT), pulmonary embolism, thrombosis or anything else affecting your blood
- ☐ None of the above

8.2 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Asthma, sleep apnoea, COVID-19 or anything else affecting your lungs or breathing
- ☐ (Females only) Abnormal mammogram, cervical smear, HPV test or other gynaecological disorder
- ☐ Crohn's, colitis, IBS, diverticulosis, bowel polyps, bleeding from the bowel or anything else affecting your stomach, bowel or digestive system
- ☐ Reflux, hernia, ulcer or gall bladder conditions
- ☐ (Females only) Kidney stones, kidney/urinary tract infection (UTI), nephritis, cystitis, polycystic kidney disease, blood in urine or anything else affecting your kidneys, bladder or urine
- ☐ (Males only) Kidney stones, kidney/urinary tract infection (UTI), nephritis, cystitis, polycystic kidney disease, enlarged prostate, blood in urine or anything else affecting your kidneys, bladder, urine or prostate
- ☐ Hepatitis (excluding hepatitis A if fully recovered), fatty liver or cirrhosis of the liver or anything affecting your liver or pancreas
- ☐ None of the above

8.3 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Tinnitus, labyrinthitis or anything else affecting your ears or balance
- ☐ Impaired vision, optic neuritis or anything else affecting your eyes (you don't need to disclose short-sightedness or long-sightedness corrected by glasses or contact lenses)
- ☐ Persistent headaches or migraines, fainting or dizziness, numbness pins and needles, muscle weakness or any other neurological symptoms
- ☐ Growths, lumps or cysts
- ☐ Skin lesions, moles, keratosis, sunspots, Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), skin lesion(s) for which you have sought advice or been advised to have treatment for
- ☐ None of the above

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

8.4 In the last five years have you had symptoms of, or been diagnosed with, or had treatment or medication for:

- ☐ Fractures, muscle, ligament or tendon injuries, repetitive strain injury (RSI), carpal tunnel syndrome, tenosynovitis, gout, arthritis, osteopenia or osteoporosis or anything else affecting your bones, joints, ligaments, tendons or muscles
- ☐ Chronic fatigue syndrome, chronic pain, myalgic encephalomyelitis (ME) or fibromyalgia
- ☐ Eczema, psoriasis, dermatitis or other skin conditions
- ☐ None of the above

8. Medical history continued

If you have ticked any of the boxes above, please complete the additional info box below:

Section 8.1-8.4	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

Lifetime

8.5 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Cancer, melanoma, leukaemia, lymphoma, Hodgkin's disease or any other tumour whether malignant or benign
- ☐ Heart attack, heart disease, irregular heartbeat, angina, chest pain, heart murmur, heart palpitations, heart surgery or anything else affecting your heart
- ☐ Valve diseases, stenosis, regurgitation, rheumatic fever
- ☐ A stroke, TIA, brain haemorrhage or damage or surgery to your brain
- ☐ Multiple sclerosis, Alzheimer's disease, dementia or motor neurone disease (MND), paralysis, epilepsy, seizures or any other neurological condition
- ☐ Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, lupus or any other autoimmune conditions
- ☐ A positive test for HIV/AIDS, hepatitis screening, are you awaiting results or considering having such a test or have you been recommended to take PrEP (Pre-exposure prophylactics)
- ☐ None of the above

If you have ticked any of the boxes above, please complete the additional info box below:

Section 8.5	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

8. Medical history continued

Please only complete question 8.6 if your total industry cover including this application exceeds any of the following amounts: Life or TPD $500,000, CI of $200,000 or Income Protection over $4,000 per month.

8.6 **Have you ever had a genetic test of any kind?**

☐ Yes ☐ No

If **YES**, please provide the type of genetic testing, reason, and the result.

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

8.7 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

☐ Back pain, sciatica, whiplash, spondylitis, fracture, or anything else affecting your back or neck

☐ Any back, neck or joint replacement surgery

☐ Any other musculoskeletal (bone, muscle, ligament or tendon) condition requiring surgery

☐ Any illness or injury that required more than one month off work

☐ Any illness or symptoms that required medical treatment (for example medication, counselling, physio) for more than 12 months, either as one episode or in total from recurring episodes

☐ None of the above

If you have ticked any of the boxes above, please complete the additional info box below:

Section 8.7	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

8.8 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

☐ Bipolar disorder, a personality disorder or schizophrenia

☐ Post-traumatic stress disorders (PTSD)

☐ Severe or manic depression

☐ Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)

☐ An eating disorder such as anorexia or bulimia

☐ None of these

8. Medical history continued

8.9 **In your lifetime have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

- ☐ Depression, anxiety or adjustment disorder
- ☐ Stress
- ☐ Current or prolonged difficulties with grief lasting more than 3 months
- ☐ Insomnia
- ☐ Prolonged fatigue lasting more than 4 weeks
- ☐ Panic attacks
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Any other symptoms that have impacted your mental health and resulted in treatment, counselling or a mental health care plan
- ☐ None of the above

If you have ticked any of the boxes above, please complete the additional info box below:

Sections 8.8 and 8.9	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

Recent health

8.10 **In the last two years, have you had symptoms of, or been diagnosed with, or had treatment or medication for:**

You don't need to indicate (tick) any of the below options if you've already told us about it/them as part of your answer to the preceding questions and your completed medical questionnaire.

The following should not be included:

- *Antibiotics for one-off chest infections*
- *Dental surgery from which you have made a full recovery*
- *Infertility treatments; and*
- *Details related to pregnancy and/or pregnancy termination (females only).*

- ☐ I've been prescribed or have received treatment for four weeks or more
- ☐ I have seen either a Chiropractor, Physiotherapist or Osteopath for treatment
- ☐ I've been asked to attend follow-ups with a GP medical practice, specialist, hospital or clinic
- ☐ I've been referred to a specialist or advised to have tests or investigations
- ☐ I've had surgery or an operation
- ☐ None of the above

If you have ticked any of the boxes above, please complete the additional info box below:

8. Medical history continued

Section 8.10	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

8.11 **Have you had any of these in the last three months?**

You don't need to indicate (tick) any of the below options if you've already told us about it/them as part of your answer to the preceding questions and your completed medical questionnaire.

- ☐ Persistent cough lasting more than three weeks
- ☐ Onset of fits or seizures
- ☐ A mole or skin lesion/blemish which is new or has changed in appearance or that bleeds
- ☐ Bleeding from the bowels or change in bowel habit
- ☐ A lump or growth including swelling or hardening of any kind
- ☐ Unexplained weight loss
- ☐ None of the above

If you have ticked any of the boxes above, please complete the additional info box below:

Section 8.11	Condition/symptoms	Date started	Date of last symptoms or treatment	Time off work	Please provide full details, including symptoms, treatment, medication and any tests, investigations or surgery planned or awaited
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		
		DD/MM/YYY	DD/MM/YYY		

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

8.12 **Are you pregnant (females only)?**

☐ Yes ☐ No

If **YES**, please advise how many weeks you're into your pregnancy and whether you've had any complications or if you're waiting on any investigations outside routine pre-natal screenings.

9. Insurance and claims history

9.1 **Have you ever had an application for Life, TPD, Critical Illness/Trauma or Income Protection insurance declined or accepted on modified/revised terms?**

☐ Yes ☐ No

If **YES**, please provide details of the reason for the decline or for the modified/revised terms, including the name of the insurance company, cover type, date declined/revised and details of any premium loading or exclusion(s) applied.

TO BE COMPLETED FOR TPD, CRITICAL ILLNESS AND INCOME PROTECTION COVER ONLY

9.2 **Have you ever made a claim for any type of accident, illness or injury?**

☐ Yes ☐ No

If **YES**, please tell us the condition you claimed for, the type of claim you made (for example, an accident, illness or injury, or workers compensation claim), the date you applied for the claim and how long you received claim payments for (if applicable).

10. Lifestyle details

Travel and residency

10.1 **Do you have any definite plans to travel outside of Australia within the next 12 months?**

☐ Yes ☐ No

If **YES**, please list the countries/regions you intend to travel to and when this is expected to occur and the duration of travel.

10. Lifestyle details continued

10.2 **Do you intend to live outside of Australia?**

☐ Yes ☐ No

If **YES**, please provide full details including whether this is for employment purposes, whether you've an employment contract in place, where you'll be residing and whether you intend to return to Australia in the next five years.

If you're applying for Income Protection Cover, please also confirm whether you'll be employed full-time in the same occupation and earning equal to or greater than your current salary.

10.3 **Are you a citizen or permanent resident of Australia?**

☐ Yes ☐ No

If **NO**, please advise how long you've been in Australia, your future intentions and whether you've applied for permanent residency.

Activities

10.4 **Do you participate in any of the following activities?**

The following should not be included:

- *flying as a fare-paying passenger or cabin crew on a scheduled or charter aircraft*
- *recreational skiing or snowboarding within ski resort boundaries*
- *'track' or 'one-off experience' days*
- *a one-off parachute jump*
- *a one-off scuba dive*

☐ Australian defence force reserve
☐ Scuba diving
☐ Private flying, gliding, parachuting or ballooning
☐ Emergency aviation/flying services, e.g. evacuation, rescue, medical/CareFlight, firefighting that includes aviation activities
☐ Motor car or motorcycle sport
☐ Mountaineering or rock climbing
☐ Sailing at sea or powerboat racing
☐ Martial arts or combat sports
☐ Competitive horse riding
☐ Football (any code)
☐ Professional or semi-professional sport
☐ Extreme sports including base jumping, ice climbing and free soloing
☐ None of the above

10. Lifestyle details continued

If **you've ticked any of the boxes above**, please provide full details of the activities you participate in, how often you do them and where:

Alcohol

10.5 **How many standard drinks do you consume in a typical week?**

1 standard drink = 375ml mid-strength beer, 100ml serve of wine, 1 nip of a spirit.
1 schooner of full strength beer = 1.5 standard drinks.

Recreational drugs

10.6 **In the last 10 years, have you used recreational drugs or drugs not prescribed by a doctor?**

This includes any drug swallowed, inhaled or injected, but does not include vitamins, supplements, over the counter medications or the oral contraceptive pill. If you smoke cannabis, please also confirm whether you use tobacco products.

☐ Yes ☐ No

If **YES** please confirm which drugs you've taken, whether you've injected them, when you last took each of them and the quantity taken.

10.7 **In the last 10 years, have you misused or been addicted to any prescription or over-the-counter drugs (such as pain killers or sedatives), even if they were prescribed for you?**

☐ Yes ☐ No

If **YES**, please confirm which drugs you've taken, whether you've injected them, when you last took each of them and the quantity taken.

10.8 **Have you ever been advised by a medical professional to reduce, stop or seek support for any drug or alcohol consumption?**

☐ Yes ☐ No

If **YES**, please confirm the type of advice received and the first and last date you received any treatment and/or advice.

10.9 **Final acknowledgement**

Finally, please confirm the following statement is true and correct:
I have understood all the questions asked during the application process and have answered the questions truthfully and accurately.

☐ Agree ☐ Disagree

11. General practitioner details

Name of general practitioner

Street address

Unit number | Street number | Street name

Suburb | State | Postcode

Telephone number

12. Any other practitioner details

Name of general practitioner

Street address

Unit number | Street number | Street name

Suburb | State | Postcode

Telephone number

Policy Declaration

Declaration and Authority for the policy owner (where they are an individual) and the insured person (if they are not the policy owner)

You must carefully read the following declarations.

Note: By selecting "I/we Agree" to each declaration, you have indicated your consent to the Declaration and Authority.
By selecting "Yes, I/we Agree" you have indicated your acceptance to all the terms and conditions as set out in the PDS.

I/we declare that I/we have read the following statements and I/we agree and acknowledge that:

- I/we consent to receive the PDS and all notices electronically.
- I/we have read and understood the PDS, which I/we received in Australia.
- I/we have read and understood the notification of 'Your duty to take reasonable care not to make a misrepresentation'.
- I/we have provided the Insurer and/or the Administrator with true, accurate and complete answers in my/our increase/alteration application (including this increase/alteration application form, quotes and all other forms, questionnaires and other information I/we have provided to the Administrator), whether answered by me/us personally or by my adviser.
- My/our decision to increase/alter my/our policy is based on the information in the PDS. I/we understand that subject to specific terms and conditions, changes to my/our policy will not commence until my/our increase/alteration application is accepted and a Policy Schedule is issued, except for Interim Accident Cover and Interim Rollover Cover that will apply subject to specific terms and conditions.
- I/we have read and understood the section in the PDS headed "Your Privacy". I/we consent to the collection, use and disclosure of my/our personal information in accordance with that section.
- I/we authorise the Insurer to forward any information obtained by it to any health practitioner or service, reinsurer, service provider or third party as is reasonably required for the purpose of assessing the application, administration of the insurance policy, assessment of a claim made under the policy and as otherwise may be required to comply with legal obligations.
- I/we consent to the Insurer and Administrator sending notices or communications regarding my application or insurance to an email address or mobile number provided by me/us and agree that any communications received by the Insurer or Administrator from this email or mobile number will constitute valid communications or instructions from me/us. I/we acknowledge my/our personal and sensitive information may be sent to that email address.
- In relation to any tax returns submitted in support of this application, I/we confirm that these tax returns were submitted to the Australian Taxation Office and no subsequent adjustments have been made or are expected.

Policy Declaration continued

Additional Declaration and Authority for the Policy Owner

- I understand that my financial adviser is my agent and is not the agent of the insurer.
- I understand and agree that the insurer and/or the Administrator may accept information from me or from my financial adviser (or their representative), by any means acceptable to the Insurer (including electronically) and that they will rely on any such information in deciding whether or not to accept my increase/alteration application and in relation to all matters of administration.
- I consent to the Insurer and/or Administrator disclosing or discussing with my financial adviser any matter relevant to the assessment of my application for insurance increase/alteration including financial, medical and other matters, whether disclosed in this application, obtained from third parties (e.g. doctors, accountants) or otherwise discovered as part of the assessment process.
- In the event my increase/alteration application is not accepted on standard terms:
  - I authorise the Insurer and/or Administrator to inform my financial adviser, or their representative, of the reasons for that decision.
  - I understand that the Insurer and/or Administrator will not provide copies of medical or other reports to my financial adviser, or their business, without first obtaining my consent (and the insured person's consent if they are different to the policy owner); and
  - I authorise my financial adviser, or their representative, to communicate to the Insurer and/or Administrator my acceptance of any revised terms on my behalf.

I declare that the answers to the preceding questions are true and complete and I have not withheld any material from this increase/alteration application.

☐ Yes, I agree as the insured person

Insured person

Signature X Date ☐☐ / ☐☐ / ☐☐☐☐

☐ Yes, I agree as the policy owner

Policy owner 1 full name (please print)

Signature X Date ☐☐ / ☐☐ / ☐☐☐☐

Policy owner 2 full name (please print)

Signature X Date ☐☐ / ☐☐ / ☐☐☐☐

encompassprotect.com.au
GPO Box 239, Sydney NSW 2001
e: customer@encompassprotect.com.au **t:** 1300 476 030

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