APPLICATION FOR INCREASE OR ALTERATION

NEOS PROTECTION

Please use this form to request:

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

If your plan is less than 6 months old, or your request is to review an exclusion only, please contact NEOS 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 and email the completed form to **customerservice@neoslife.com.au**

Important: The form must be emailed to NEOS 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 person insured and plan owner must sign the declarations and a scanned copy should be emailed to **customerservice@neoslife.com.au**

Questions?

We're here to help. If you have any questions in relation to this form, please contact us on **1300 090 188** or email us at **customerservice@neoslife.com.au**. Alternatively, please contact your financial adviser.

Your duty to take reasonable care

When applying for insurance, you are agreeing that you will take reasonable care not to make a misrepresentation to us before we issue your contract of insurance. A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This obligation applies when you make new applications for insurance, when extending or amending existing insurance and when reinstating insurance, up until your application, amendment or reinstatement is accepted by us and the cover is issued.

If someone assists you to make this application, you are responsible for the information they give to us.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

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 plan 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.

Guidance for answering our questions

When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure about the meaning of any question, please ask us before you respond.
- Answer every question that we ask you.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it, or check with us.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would have answered our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, we may exercise our rights to put us in the position we would have been if that obligation had been met.

Failure to take reasonable care may result in the following:

- we may avoid your cover within three years of entering into it
- we may reduce your cover in accordance with a formula that takes into account the premium that would have been payable, if your duty had been met, or the misrepresentation hadn't been made. Any reduction in
- respect of the death of an insured person can only occur within three years of the cover commencement date
- we may vary your cover (except for Life Cover) in such a way as to place us in the position we would have been if your duty had been met
- if the misrepresentation is fraudulent, we may refuse to pay your claim at any time and we may treat your cover as having never existed; and/or
- in exercising the above rights, we may apply these rights separately to each type of cover.
- Whether we can exercise any of these rights depends on a number of factors, including:
- whether the person who answered our questions took reasonable care not to make a misrepresentation, depending on all the relevant circumstances
- whether the misrepresentation was fraudulent
- what we would have done if the duty had been met; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these rights, we will explain our reasons, how you can respond or provide further information, and also what you can do if you disagree.

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.neosprotect.com.au**

1. Plan details

Plan number/s:

Insured person:

Adviser name:

Adviser code:

If further information is needed to assess your application, can we call you to collect this information over the phone?

☐ Yes ☐ No

2. Application details

Please select one or more boxes as required:

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

☐ 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	$	$
Income Support Cover	$	$

Change of waiting period or benefit period for Income Support or 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:

3. Contact details (if changed)

3.1 Phone and email address

Mobile number:

Landline number:

Email address:

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

3.2 Residential address

Street address:

Suburb: | State: | Postcode:

3.3 Postal address

Street/PO Box address:

Suburb: | State: | Postcode:

4. Existing insurance details

4.1 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 *(inclusive of the NEOS 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

5. Occupation and income

Occupation:

Employer name / business name / industry type:

5.1 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 self-employed

5.2 How much did you personally earn in the LAST full financial year?

*For **self-employed** individuals. This is your share of the gross annual 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 an employee

5.3 What is your current annual income before tax?

*For **employed** individuals (those who have no direct or indirect ownership in the business they're employed in) – this is your gross annual 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).*

$

PLEASE ONLY COMPLETE QUESTIONS 5.4 TO 5.17 IF YOU ARE APPLYING FOR OR INCREASING TPD, INCOME PROTECTION OR INCOME SUPPORT COVER

Complete only if you're self-employed

5.4 How much did you personally earn in the PREVIOUS full financial year?

$

Complete only if you're an employee

5.5 How much did you personally earn in the LAST full financial year?

$

Complete only if you're self-employed

5.6 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 5.2)?

*Answer **NO** if your earnings reduced down 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:

5.7 How many hours do you work in a typical working week?

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

5.8 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:

5.9 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:

5.10 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):

Complete only if you're self-employed

5.11 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:

TO BE COMPLETED FOR INCOME PROTECTION AND INCOME SUPPORT COVER ONLY

5.12 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:

Complete only if you're an employee

5.13 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 2 years and what you expect to receive this year?

For Income Support - only required where the total monthly benefit is over $10,000
For Income Protection - required for all monthly benefits

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

☐ Yes ☐ No

If **YES**, would your business continue to operate for over 90 days if you were unable to work in the business?

☐ Yes ☐ No ☐ Unsure

If **YES**, would you continue to receive 30% or more of your regular income in the event of your disablement?

☐ Yes ☐ No ☐ Unsure

If **YES** or **UNSURE**, please provide the following information:

What is your percentage ownership interest in the business?

What would happen in the event of your disablement i.e., how much income would you be entitled to receive, what is the nature of the income (i..e. how is it generated), and for how long would it continue?

Occupation titles / roles and duties of all employees (also confirm which, if any, are other owners in the business.)

Please complete if the total industry monthly benefit including any superannuation contribution option exceeds $20,000.

5.15 Do you have net assets (excluding the personal residence/family home and superannuation) exceeding $5 million and/or net investment or unearned annual income exceeding $250,000 or 30% of your regular income?

This includes assets you either have an ownership interest in or control over (directly or indirectly) including those held in your spouse's name, in trusts or other entities owned by trusts or any other entity that you have had control over.

☐ Yes ☐ No

If **YES**, please provide further information on what this includes, the amount for each asset and whether they are personal or business related:

TO BE COMPLETED FOR ALL COVER

Please complete if the total industry Life cover exceeds $2,000,000 and / or the total industry Critical Illness cover exceeds $500,000 and for TPD and Income Support / Income Protection of all amounts.

5.16 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

5.17 Do your occupation duties include any manual work or hazardous duties?

☐ Yes ☐ No

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

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 Support, whereas the hazardous duties question will be asked for all benefits.

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

5.18 Do your occupation duties include working at heights above 10 meters, 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.

6. Purpose of cover

6.1 What is your purpose for applying for life insurance with NEOS?

☐ Personal ☐ Business / key person 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.

7. Personal details

7.1 What is your height?

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

7.2 What is your weight?

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

8. Tobacco usage history

8.1 Which of the following are you?

☐ Non-smoker (Life-long)
☐ Ex-smoker (please complete 8.2)
☐ Smoker (please complete 8.3)
☐ Very occasional smoker (please complete 8.3)
☐ User of e-cigarettes or vape pens in the last year (please complete 8.3)
☐ User of other nicotine replacement products in the last year (please complete 8.3)

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

☐☐ / ☐☐ / ☐☐☐☐

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

9. Family history

9.1 Have your biological parents, brothers or sisters 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
- ☐ Diabetes (If **YES**, have you ever had a routine blood test for this condition and if so, results?)

- ☐ Bowel cancer or familial bowel polyps
  (If **YES**, have you been advised to have a colonoscopy, if so how often, date of last test and results if known)

- ☐ Cancer of the breast or ovaries
- ☐ Other cancer
- ☐ Muscular dystrophy, Huntington's disease or motor neurone disease
- ☐ Polycystic kidney disease
- ☐ Cardiomyopathy
- ☐ Parkinson's disease, Alzheimer's disease or multiple sclerosis
- ☐ Any other neurological or inherited disorder not already listed above
- ☐ 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:

10. Medical history

LAST FIVE YEARS

10.1 In the last five years have you had any of these? Please tick all applicable boxes.

- ☐ Raised blood pressure or cholesterol
- ☐ Diabetes or raised blood sugar
- ☐ Stress, anxiety, depression, insomnia, ADHD / ADD, behavioural disorder or any other symptoms related to mental ill-health
- ☐ Anaemia, thrombosis or anything else affecting your blood
- ☐ None of the above

10.2 In the last five years have you had any of these? Please tick all applicable boxes.

- ☐ Asthma, sleep apnoea or anything else affecting your lungs or breathing
- ☐ Crohn's, colitis, IBS or anything else affecting your stomach, bowel or digestive system
- ☐ Kidney stones, urinary infection or anything else affecting your kidneys, bladder or urine (or prostate for males)
- ☐ Anything affecting your liver or pancreas
- ☐ Hypothyroidism, hyperthyroidism or any symptoms or condition related to your thyroid or glands
- ☐ None of the above

10.3 In the last five years have you had any of these? Please tick all applicable boxes.

- ☐ Tinnitus, labyrinthitis or anything else affecting your ears or balance
- ☐ Impaired vision, optic neuritis or anything else affecting your eyes (you do not need to disclose short-sightedness or long-sightedness corrected by glasses or contact lenses)
- ☐ Numbness, pins and needles, nerve pain, tremor, muscle weakness, difficulty with balance or coordination or any other similar symptoms
- ☐ Persistent or recurrent migraines or headaches, or any migraine with aura
- ☐ Growths, lumps or cysts
- ☐ Mole(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

10.4 In the last five years have you had any of these? Please tick all applicable boxes.

- ☐ Any pain, symptoms or condition affecting your back or neck
- ☐ Any pain, symptoms or condition affecting your bones, joints, ligaments, tendons or muscles
- ☐ Persistent or recurrent fatigue or tiredness, chronic fatigue syndrome, myalgic encephalomyelitis, or fibromyalgia
- ☐ None of the above

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

Section 10.1–10.4	Condition/symptoms	Date started	Date of last symptoms	Time off work	Please provide full details

LIFETIME

10.5 Have you ever had any of these? Please tick all applicable boxes.

- ☐ Cancer, melanoma, leukaemia, Hodgkin's disease or any other tumour
- ☐ Heart attack, heart disease, irregular heartbeat, heart surgery or anything else affecting your heart
- ☐ A stroke, TIA, brain haemorrhage or damage or surgery to your brain
- ☐ Multiple sclerosis, epilepsy or any other neurological condition
- ☐ An abnormal mammogram or abnormal pap smear (females only)
- ☐ A positive test for HIV/AIDS, hepatitis screening, or are you awaiting results or considering having such a test
- ☐ None of the above

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

Section 10.5	Condition/symptoms	Date started	Date of last symptoms	Time off work	Please provide full details

Please only complete question 10.6 if your total industry cover including this increase exceeds any of the following amounts: Life or TPD over $500,000, Critical Illness (Trauma) over $200,000 or Income Protection (Disability Income Insurance) over $4,000 per month.

10.6 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, INCOME SUPPORT AND INCOME PROTECTION COVER ONLY

10.7 Have you ever had any of these? Please tick all applicable boxes.

- ☐ Any back, neck or joint replacement surgery
- ☐ Any other musculoskeletal condition requiring more than one 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 10.7	Condition/symptoms	Date started	Date of last symptoms	Time off work	Please provide full details

RECENT HEALTH

10.8 Have any of these applied to you in the last two years? Please tick all applicable boxes.

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*
- *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
(Please also provide any contact information for the treating practitioner)

☐ I've been asked to attend follow-ups with a medical practice, specialist, hospital or clinic

☐ I've been referred to a specialist or advised to have tests or investigations

☐ None of the above

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

Section 10.8	Condition/symptoms	Date started	Date of last symptoms	Time off work	Please provide full details

10.9 Have you had any of these in the last three months? Please tick all applicable boxes.

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

☐ Symptoms of COVID-19 which are current/ongoing

☐ Onset of fits or seizures

☐ A mole or skin lesion/blemish which has changed in appearance

☐ Bleeding from the bowels or change in bowel habits

☐ A lump or growth including swelling or hardening of any kind

☐ None of the above

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

Section 10.9	Condition/symptoms	Date started	Date of last symptoms	Time off work	Please provide full details

TO BE COMPLETED FOR ALL COVER

10.10 Are you currently 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:

11. Insurance and claims history

11.1 Have you ever had an application for Life, TPD, Critical Illness (Trauma) or Income Protection (Disability Income 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, INCOME SUPPORT AND INCOME PROTECTION COVER ONLY

11.2 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):

12. Lifestyle details

TRAVEL AND RESIDENCY

12.1 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:

12.2 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.

12.3 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

12.4 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 '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 etc
- ☐ Motor car or motorcycle sport
- ☐ Sailing at sea or powerboat racing
- ☐ Martial arts or combat sports
- ☐ Competitive horse riding
- ☐ Football (any code)
- ☐ Professional or semi-professional sport
- ☐ Extreme sports such as base jumping, rock climbing or mountaineering etc
- ☐ None of the above

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

12.5 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

12.6 Have you used recreational drugs in the last 10 years?

Recreational drugs include: cannabis, ecstasy, cocaine, ice, heroin, amphetamines and anabolic steroids

☐ 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.

If you smoke cannabis, please also confirm whether you use tobacco products.

12.7 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:

13. General practitioner details

Name of general practitioner:

Street address:

Suburb: State: Postcode:

Telephone number:

14. Any other practitioner details

Name of practitioner:

Street address:

Suburb: State: Postcode:

Telephone number:

15. Plan declaration

Declaration and Authority for the plan owner (where they are an individual) and the insured person (if they are not the plan 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 have been provided with a copy of the NEOS Protection Product Disclosure Statement (PDS) by my adviser and I/we have read and understood the important information about the product contained in the PDS, including the privacy information, and situations when the insurer won't pay claims. My/our decision to increase/alter my/our plan is based on the information in the PDS. I/we understand that subject to specific terms and conditions, changes to my/our plan will not commence until my/our increase/alteration application is accepted and a Plan Schedule is issued.
- I/we have read and understood the duty to take reasonable care and understand the consequences of misrepresentation.
- 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 understand that the email address(es) provided is for the purpose of receiving communication from NEOS. 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.

Additional Declaration and Authority for the Plan Owner

- I understand that my financial adviser is my agent and is not the agent of the insurer.
- I understand that NEOS, on behalf of the insurer, may accept information from my financial adviser, or their representative, and that NEOS 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 NEOS, on behalf of the insurer, 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 such as doctors and accountants, or otherwise discovered as part of the assessment process. NEOS will not provide copies of medical 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 plan owner).
- In the event my increase/alteration application is not accepted on standard terms:
  - I authorise NEOS to inform my financial adviser, or their representative, of the reasons for that decision.
  - I understand that NEOS 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 plan owner); and
  - I authorise my financial adviser, or their representative, to communicate to NEOS 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 information from this increase/alteration application.

☐ Yes, I agree as insured person

Insured person

Signature

Date ☐☐ / ☐☐ / ☐☐☐☐

☐ Yes, I agree as plan owner

Plan owner

Signature

Date ☐☐ / ☐☐ / ☐☐☐☐

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