

Life and/or disability income protection insurance benefits

Use this form: To change your life and/or disability income protection insurance benefits. If you are a Member through your employer, any change will be subject to the rules of your company's arrangements. Send completed form to SuperLife at superlife@superlife.co.nz or post to us at P.O. Box 105262, Auckland City 1143.

SL00133 – 01.07.2020

Your details

Name:		SuperLife number: <input type="text"/>	
Email:		Date of birth: / / (dd/mm/yyyy)	
Home address:		Phone: ()	
		Post code:	

Life insurance cover

	Current cover	New cover wanted	
I want death cover of	\$ _____	\$ _____	You should also update your beneficiaries
and total & permanent disablement cover of <i>(can't be more than the amount of death cover)</i>	\$ _____	\$ _____	

Premium basis

I want the calculation of the premium to change *(tick one)*

each 1 April
 each 5 years
 each 10 years

Smoker status

Do you smoke or have you smoked in the 12 months before this application? *(tick one)*

Yes **No**

Disability income protection cover

	Current cover	New cover wanted
I want total disability income cover of:	\$ _____ p.a.	\$ _____ p.a.
<i>(Minimum is \$5,200 each year, maximum is 55% of gross pay)</i>		

Waiting period

I want the waiting period to be *(tick one)*

1 month
 3 months
 6 months

Benefit period

I want the benefit period to be *(tick one)*

2 years
 5 years
 to age 65

Employer information (for Disability income protection cover)

SuperLife needs your employer to confirm details of your occupation and pay level as outlined in the attached standard letter. You should ask your employer to complete it and attach this to your application form when you send it to SuperLife.

Health questions

You must complete the following health questions. If you are unsure, it is better to answer 'yes'. If you answer 'no' and your answer isn't right, the insurance company can refuse to pay out your insurance.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you been away from work for five (or more) days in a row because of sickness or injury in the past month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been told by your doctor that you have a terminal illness which means that you have 12 months or less to live? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you sought medical advice in the month before completing this application? | <input type="checkbox"/> | <input type="checkbox"/> |

Other questions

Please answer if either of the following apply to you, as it may affect the medical free cover available.

- | | Yes | No | | <i>(dd/mm/ccyy)</i> |
|---------------------------------------|--------------------------|--------------------------|----------------------------|---------------------|
| 1. Have you recently got married? | <input type="checkbox"/> | <input type="checkbox"/> | Marriage date | / / |
| 2. Have you recently had a new child? | <input type="checkbox"/> | <input type="checkbox"/> | Date of birth, or adoption | / / |
- (tick one)*

Signature

I understand that any new covers only start when I am notified by SuperLife, but not before the date the new premium is paid. I understand that I will be charged each year an administration fee of \$33 for each type of cover (Life and Total and Permanent Disablement, or Income Protection) and 8.8% of the premium which will be deducted by, and payable to, Smartshares Limited. I authorise the deduction of the required contributions for the new premium from my bank account, or from my pay or from my SuperLife Accounts as appropriate.

Your signature: _____ **Date:** / / *(dd/mm/yyyy)*

Employment details confirmation

To: **SuperLife**

PO Box 105262
Auckland City 1143

I confirm the occupation and income details of the employee as detailed below, for the purposes of his/her application under SuperLife for disability income protection insurance. I also confirm that the employee has been at work for the full month prior to completing this confirmation.

Details

Employee's name:

Occupation:

Gross annual income:

Employer's name:

Contact name:

Contact phone number: ()

Signed on behalf of employer

Signature: _____

Date: / / _____