NEOS PROTECTION DATA CAPTURE FORM

This form has been designed to help you capture the information required to submit an online application for a NEOS Protection plan.

All questions in this data capture form should be answered, unless it's indicated that the question is only applicable for clients applying for a particular cover type.

As the online application is dynamic, with several thousand rules designed to maximise automatic acceptance rates, the questions asked in this form are not exhaustive for all medical conditions. However, they've been designed to assist you in completing the questions required for the most commonly suffered conditions.

When entering the data collected in this form into the online application, you'll be prompted if further information is required. Our online application allows you to save the application at any point, and resume it as soon as you've gathered the additional information from your client.

Important notes

NEOS doesn't accept paper applications; all data collected in this form will need to be entered into our online application system – **please don't mail this form to us.**

The answers you enter into the online application, including your client's plan declaration, form part of your client's contract of insurance with the insurer.

Once the online application has been completed and submitted, the responses entered will be immediately emailed to your client, in the form of an application summary PDF. Your client must check the application summary and inform NEOS of any errors or omissions within five working days.

Before you use this data capture form, we recommend that you explain its purpose to your client, that their application will be submitted electronically and the importance of completing all questions honestly in line with their obligation not to make a misrepresentation. We also recommend that you explain the importance of reviewing their application summary to ensure the answers they've provided have been recorded correctly.

If you're utilising our tele-interview services, please skip the following:

- Sections 6-11
- Section 15 (Medical questionnaires)

Adviser administration

Client name:

Client reference number (if applicable):

neosprotect.com.au
GPO Box 239, Sydney NSW 2001
e: adviser@neoslife.com.au **t:** 1300 881 756

NEOS Life (NEOS) is a registered business name of Australian Life Development Pty Ltd ABN 96 617 129 914 AFSL 502759. NEOS Protection is issued by NobleOak Life Limited (NobleOak) ABN 85 087 648 708 AFSL 247302. NEOS Life provides administration services in relation to NEOS Protection on behalf of NobleOak.

1. Insured person details

First name:

Middle name:

Last name:

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

Gender: ☐ Male ☐ Female

2. Contact details

2.1 Phone and email address

Mobile number:

Landline number:

Email address: (mandatory)

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

2.2 Residential address

Street address:

Suburb: | State: | Postcode:

2.3 Postal address

Street/PO Box address:

Suburb: | State: | Postcode:

3. Existing insurance details

3.1 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 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

4. Occupation and income

4.1 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 2 years? ☐ Yes ☐ No

☐ Retired or unemployed

Complete only if you're self-employed

4.2 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

4.3 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 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).*

$

TO BE COMPLETED FOR INCOME SUPPORT COVER ONLY

Complete only if you're self-employed

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

$

Complete only if you're an employee

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

$

TO BE COMPLETED FOR TPD AND INCOME SUPPORT COVER ONLY

4.6 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 4.2 or 4.3)?

*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:

4.7 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:

4.8 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:

4.9 Do you have any definite plans to change your occupation, work duties, working hours or employment status?

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:

4.10 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

4.11 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 SUPPORT COVER ONLY

4.12 Have you been continuously working in your occupation, trade or profession for at least 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

4.13 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:

Only required where the total monthly benefit is over $10,000

4.14 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.

4.15 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.

4.16 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

4.17 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 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

4.18 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.

5. Purpose of cover

5.1 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.

6. Personal details

6.1 What is your height?

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

6.2 What is your weight?

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

7. Tobacco usage history

7.1 Which of the following are you?

☐ Non-smoker (Life-long)
☐ Ex-smoker (please complete 7.2)
☐ Smoker (please complete 7.3)
☐ Very occasional smoker (please complete 7.3)
☐ User of e-cigarettes or vape pens in the last year (please complete 7.3)
☐ User of other nicotine replacement products in the last year (please complete 7.3)

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

☐☐ / ☐☐ / ☐☐☐☐

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

8. Family history

8.1 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 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:

9. Medical history

Important: Please be aware that we may not pay a claim and could cancel your plans 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.

LAST FIVE YEARS

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 16 of this form) for each condition you have or have previously suffered.

9.1 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

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

- ☐ Asthma, sleep apnoea, COVID-19 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

9.3 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 SUPPORT COVER ONLY

9.4 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

LIFETIME

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 16 of this form) for each condition you have or have previously suffered.

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

- ☐ Cancer, melanoma, leukaemia, Hodgkin's disease or any other tumour
- ☐ Heart attack, irregular heart beat or any other heart condition or heart surgery
- ☐ 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

Please only complete question 9.6 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 Support over $4,000 per month.

9.6 Have you ever had a genetic test of any kind?

☐ Yes ☐ No

TO BE COMPLETED FOR TPD AND INCOME SUPPORT COVER ONLY

9.7 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

RECENT HEALTH

If you tick **YES** to having suffered from any of the conditions listed in the below questions, please complete a medical questionnaire (found on page 16 of this form) for each condition you have or have suffered.

9.8 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 <u>not</u> 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 (answer only if applying for IP/TPD cover + 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

9.9 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
- ☐ 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

TO BE COMPLETED FOR ALL COVER

9.10 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:

10. Insurance and claims history

10.1 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 SUPPORT COVER ONLY

10.2 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):

11. Lifestyle details

TRAVEL AND RESIDENCY

11.1 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:

11.2 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 Support 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.

11.3 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

11.4 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*
- *volunteer firefighting work which doesn't include any aviation activities*

- ☐ 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

11.5 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

11.6 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.

11.7 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:

12. Final acknowledgement

Important: Please be aware your plan and/or cover could be cancelled and/or avoided (treated as if it never existed), or its terms may be changed if you do not answer the following questions truthfully and accurately.

This may also result in a claim being declined or a benefit being reduced.

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

13. General practitioner details

Name of general practitioner:

Street address:

Suburb: State: Postcode:

Telephone number:

14. Child Cover

Please complete this section only if you're applying for Child Cover.

Please note:

- *Each insured child must be a financial dependant of an adult insured person.*
- *Child Cover is not underwritten.*

	Child 1	Child 2	Child 3	Child 4
First name				
Middle name				
Last name				
Date of birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender				

15. Medical questionnaires

CONDITION ONE

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling? If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type and the frequency.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings. If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

CONDITION TWO

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling? If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type and the frequency.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings. If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

CONDITION THREE

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling? If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type and the frequency.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings. If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

CONDITION FOUR

1. What condition has been diagnosed?

2. When did this condition or symptoms first occur?

3. When did you last have symptoms?

4. Have your symptoms been continuous? If no, how many episodes have you suffered?

5. Please confirm what symptoms you're suffering or have suffered and the severity.

6. Are you currently receiving treatment, for example medication, surgery, physiotherapy or counselling? If yes, please confirm the type of treatment being received and the frequency.

7. If you've had previous treatment, please confirm the type and the frequency.

8. Have you had any tests or investigations? For example, scans, x-rays, blood pressure or cholesterol readings. If yes, what were they and what were the results?

9. Have you been admitted to hospital with this condition? If yes, how many times and when?

10. Are you awaiting any investigations, an operation or the results of tests or investigations? If yes, please provide details.

11. How much time off work have you taken in relation to this condition and when was this? If you've had time off work, have you now fully returned to work?

12. Are you fully recovered?

16. Plan details
NON-SUPER

PLAN OWNER

Owner name:	
Contact number:	
Email address:	
Street address:	
	Suburb: / State: / Postcode:

BENEFICIARIES (LIFE COVER ONLY)

Section 48A of the Insurance Contracts Act 1984 allows you to nominate a person, persons or certain legal entities to receive the **death benefits** available under Life Cover.

The following restrictions apply to such a nomination under this cover type:

1. you may only nominate up to five beneficiaries to receive the benefit payable as a result of a death claim (but not a terminal illness claim) under **Life Cover**; and
2. you must be both the plan owner and the insured person in order to make a valid nomination.

Please ensure percentages are entered as whole numbers and that the total percentage share is equal to 100%.

Full name of beneficiary	Address	Date of birth	Relationship to insured person*	% of death benefit
		DD/MM/YYYY		%
		DD/MM/YYYY		%
		DD/MM/YYYY		%
		DD/MM/YYYY		%
		DD/MM/YYYY		%

*Options available spouse, de facto, child, interdependency relationship, financial dependant, legal personal representative, not applicable.

PAYMENT DETAILS

NEOS accepts premium payments via credit card (MasterCard and Visa only) or via direct debit from your nominated bank account.

By providing your details below, you're requesting that NEOS debit your credit card/bank account for all future premium payments. This request is governed by the Direct Debit Service Agreement outlined in the NEOS Protection Product Disclosure Statement, available at www.neosprotect.com.au/pds

Credit card details

Name on card:	
Credit card number:	
Expiry date:	M M / Y Y Y Y

Bank account details

BSB number: ☐☐☐-☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐

Bank name:

Account name:

SUPER

PLAN OWNER

Owner name:

Contact number:

Email address:

Street address:

Suburb: State: Postcode:

Fund Name:

Fund ABN:

Fund USI:

Member Account No:

PAYMENT DETAILS

NEOS accepts premium payments via credit card (MasterCard and Visa only) or via direct debit from your nominated bank account.

By providing your details below, you're requesting that NEOS debit your credit card/bank account for all future premium payments. This request is governed by the Direct Debit Service Agreement outlined in NEOS Protection Product Disclosure Statement, available at www.neosprotect.com.au/pds

Credit card details

Name on card:

Credit card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry date: M M / Y Y Y Y

Bank account details

BSB number: ☐☐☐-☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐

Bank name:

Account name:

neosprotect.com.au
GPO Box 239, Sydney NSW 2001
e: adviser@neoslife.com.au **t:** 1300 881 756

NEOS Life (NEOS) is a registered business name of Australian Life Development Pty Ltd ABN 96 617 129 914 AFSL 502759. NEOS Protection is issued by NobleOak Life Limited (NobleOak) ABN 85 087 648 708 AFSL 247302. NEOS Life provides administration services in relation to NEOS Protection on behalf of NobleOak.