

Diversa Group Life Pool - Choice of Fund Insurance Transfer Form

How to use this form

Use this form to apply to transfer your existing insurance cover into the Diversa Group Life Pool (Pool), via your super fund. You can transfer cover from any other commercially insured policy regardless of whether it is part of a superannuation arrangement or not.

Complete all sections of the attached Form and return it to Diversa Superannuation Services Limited ('we' or 'us') together with copies of the *Supporting Documentation* within 30 days of the date the insured person signed this form.

Insured Person's Details

Please provide the personal details of the insured person who is requesting the insurance transfer.

Diversa Group Life Pool Member Details

This section should be completed by the appropriate contact person for the super fund that is a member of the Pool ('Member Fund').

Eligibility to Transfer Cover

To be eligible, an insured person must satisfy all of the following criteria:

- (a) They must be eligible for insurance within the Member Fund; and
- (b) Their cover in the existing fund (or policy) must cease on acceptance of cover via the Pool; and
- (c) The insured person must transfer their entire superannuation account balance into the Member Fund; and
- (d) The maximum amount of cover that can be transferred for death and TPD is \$1.5 million; and
- (e) The insured person's total cover (obtained under automatic acceptance and choice of fund transfer arrangements) must not exceed \$1.5 million for death and TPD; and
- (f) The insured person must cancel the transferred cover and not continue it under any other insurance arrangement, reinstate that cover or effect a continuation option for it with any other insurance arrangement; and
- (g) The insured person must provide a copy of their most recent benefit statement (or similar document) as evidence of their current cover held; and
- (h) They must satisfactorily complete the choice of fund insurance transfer form and return it to us within 30 days of the date that they signed the form.

Statement of Good Health

You **must** complete the Statement of Good Health section of this form. If you are unable to answer "no" to each of the questions asked, you will not be eligible to transfer your insurance.

Cancellation of Previous Cover

Once your transfer request has been accepted you are required to cancel the previous cover. **If you do not, no claim will be payable** from the Pool or by the Insurer.

Please do not cancel your previous cover until you have received written notice from us that your transfer has been accepted.

Supporting Documentation

To support your transfer request you will need to provide a copy of either:

- A recent benefit statement from a super fund evidencing the type and level of insurance cover you have; or
- Your current insurance policy; or
- Another document acceptable to the Insurer.

The document must show the type and level of cover you have as well as any loadings or exclusions imposed. The document must be dated within 30 days of the date you sign this form.

Privacy

By completing this form you consent to us collecting, disclosing and using your personal information. We protect the personal information we collect about you by maintaining physical, electronic, and procedural safeguards that meet or exceed applicable law. We only permit personnel associated with the Pool and its service providers to have access to your personal information. We require third parties that process personal information on our behalf to follow stringent standards of security and confidentiality. We will not disclose your personal information for marketing purposes to other entities unless you agree. If you would like more information, please contact us.

Declarations & Signature

Both the insured person and the nominated fund contact person must sign and date this form.

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Insured Person's Details

Title: Mr Mrs Miss Ms Other: _____

Given Names(s): _____ Surname: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone : _____ Email: _____

Diversa Group Life Pool Reference number (if known): _____

Membership Details

Super Fund Name: _____

Contact Person: _____

Position Held: _____ Phone: _____

Email: _____

Details of Existing Insurance to be Transferred

Existing Cover

Name of Insurer: _____

Insured Amount: \$ _____

Type of insurance: Death Only Death & TPD

Is this cover subject to any loadings or exclusions? Yes No Don't Know

If Yes, exclusion details: _____
(please also attach a copy of the wording of the exclusions)

Is this cover provided via a superannuation fund? Yes No

Fund Name: _____

Super Fund Member Number (if applicable): _____

Policy number (non-super cover only): _____

Cover to be transferred

(Note that the maximum cover that can be transferred is \$1,500,000)

I would like to transfer (Select one only from each line):

All of my existing cover \$1,500,000 (maximum)

Death Only Death & TPD Cover

Statement of Good Health

Please tick the appropriate box for all 5 questions:

In order to be eligible to transfer your insurance cover, you must be able to answer 'No' to each of the questions below:

1. Do you have any injury or illness which restricts you or is likely to restrict you in the future from carrying out, on a full-time basis, all the identifiable duties of your current employment? (Full-time means more than 30 hours a week on an ongoing basis. It is not necessary that you work full-time, but only that you have the physical and mental capacity to do so)

Yes No
2. Have you ever submitted a Total and Permanent Disablement (TPD) claim, or are you eligible for or entitled to a claim from any superannuation fund or any insurance policy?

Yes No
3. Have you been diagnosed with an illness that reduces your life expectancy to less than 12 months from today?

Yes No
4. Do you have, or have you ever had, any disease, illness or injury, or any other conditions (other than colds, flu or mild asthma) which:
 - a. Has required more than a total of 2 consecutive weeks off work during the last 12 months, or
 - b. Has recurred more than twice in the last two years, and/or is currently causing you symptoms or requiring treatment?

Yes No
5. Is your existing insurance cover subject to any premium loading in regards to medical or other conditions?

Yes No

If you answer 'Yes' to any of the above questions, you will not be eligible to transfer your insurance cover.

Duty of Disclosure

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

You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate a contract of life insurance. Your duty, however, does not require disclosure of a matter that diminishes the risk to be undertaken by the Insurer; that is of common knowledge; that the Insurer knows, or in the ordinary course of its business ought to know; as to which compliance with your duty is waived by the Insurer.

If you fail to comply with your duty of disclosure and the Insurer would not have entered into the contract on any terms if the failure had not occurred, the Insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract at any time. An Insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

Declarations & Signatures

I declare that:

- The information I have given on this form and any accompanying information is true and correct; and
- I consent to the collection and disclosure of my personal information for the purposes outlined on this form; and
- I satisfy the eligibility criteria for a Choice of Fund transfer; and
- I have read and understood the Duty of Disclosure above, and I have not withheld any information that may affect the Insurer's decision as to whether or not to accept my application for cover; and
- My existing insurance cover will be cancelled from the date that cover commences and I will not transfer my existing cover to any other policy or reinstate cover. Should it become apparent to the Insurer that I have not cancelled my previous insurance cover, no claim will be payable under this policy.

Furthermore, I acknowledge and agree that:

- If I do not fully complete this form, or I do not sign and date it, I will not be eligible to transfer my insurance cover to the Pool; and
- My insurance cover will not commence until the Insurer has accepted my application. Cover will commence from the date advised in writing, subject to the payment of premiums; and
- If my transferred cover is subject to exclusions, the same exclusion(s) apply to my transferred cover in the Pool, and
- The Insurer may undertake appropriate inquiry and investigation to verify the answers that I have provided. These inquiries and investigations may be made at any time including, but not limited to, when the Insurer is considering this application or at the time of the claim.

I have attached the required supporting documents.

Insured person's Signature: _____

Date: ___ / ___ / ___

I confirm that:

- the insured person named in this form has requested that their insurance be transferred to our fund;
- the super fund has been selected by the Insured person under "Choice of Fund" arrangements;
- I understand that if the insured person does not cancel their existing cover following acceptance of this transfer OR has not selected our super fund under a "Choice" arrangement that the Pool's Insurer may decline to provide cover or pay any benefit in accordance with the terms of the Policy.

Super Fund Contact's Signature: _____

Date: ___ / ___ / ___

Please return the completed form to:

Diversa Superannuation Services Limited, PO Box A2499, Sydney South NSW 1235

If you have any questions regarding this form or your membership, please contact us on 1300 734 359 or by email insurance@diversa.com.au.

DO NOT CANCEL ANY EXISTING INSURANCE COVER UNTIL AFTER YOU HAVE RECEIVED WRITTEN NOTICE OF ACCEPTANCE OF THE TRANSFER OF COVER FROM US.