

# Application Form

INSURED PERSON DETAILS to be completed by the person to be insured by this Policy



## WageCover Outside Working Hours Accident & 24 Hour Sickness Income Protection Plan – Application

Full name of Applicant (Person to be Insured) Please print clearly

Mr/Mrs/Miss: .....

Full postal address: .....

State: ..... Postcode: .....

Date of Birth: / / Sex: (Please Tick) Male:  Female:  Accident Plan:  Accident & Sickness Plan:

Home Phone: ( ) ..... Work Phone: ( ) ..... Mobile Phone: ( ) .....

Employer/Company/Name: ..... E-mail address: .....

Occupation/Classification: .....

**1. MEDICAL HISTORY DETAILS:** Have you **ever** consulted a doctor or other health professional or ever received any treatment or advice for (please tick): **YES** **NO**  
1.) Hypertension, High/Elevated blood pressure or Heart Disease of any kind?    
2.) Diabetes?

If you have answered YES to question number 1 the following exclusion will apply to your cover:

Your Policy will not cover any Loss or Event directly or indirectly arising from, traceable to or accelerated by any disease or disorder of the Heart, Cardiovascular system, Peripheral vascular or Renal systems, Coronary Arteries, any form of Cerebrovascular accident, Hypertension or any complications thereof.

If you have answered YES to question number 2 the following exclusion will apply to your cover:

Your Policy will not cover any Loss or Event directly or indirectly arising from, traceable to or accelerated by Diabetes and any complication thereof. This also excludes any condition that Diabetes is a risk factor for, including but not limited to any disease or disorder of the Cardiovascular, Cerebrovascular, Peripheral vascular or Renal systems. Examples of condition which may arise as a result of Diabetes and are excluded by this clause are: coronary artery disease, myocardial infraction, atherosclerosis, retinopathy, neuropathy, nephropathy, cerebrovascular accident or any complications thereof.

**2. COOLING OFF PERIOD:** You may return this Policy to us within 14 Days of the date we enter into it provided that no right or power under your Policy has been exercised. (e.g. No claim has been made). Where You return it within the above 14 day period we will cancel the Policy and give you a full refund of premium. Please note You still have cancellation rights that You can use after this period expires.

**3. DECLARATION:** I am the Insured Person and my signature is below. I have read and understood the WageCover Product Disclosure Statement (PDS) and my decision to apply for this insurance is based upon my understanding of the information contained in the PDS.


I have read and understood the questions in this application form; in particular I understand the Duty of Disclosure as outlined on pages 6 & 7 of the PDS.

I acknowledge that the insurer will have no liability whatsoever, until it accepts this application by issuing a Policy Schedule and that I have a duty to disclose any matter material to the Insurer's decision whether to issue a Policy and if so on what terms, I understand my duty continues until the Insurer has issued the Policy Schedule.

I authorise my medical practitioner or other professional to disclose any information they may possess about me to the Insurer in relation to this Insurance.

I declare that each statement that I make to the Insurer in relation to this insurance and this Application Form is true and correct.

I declare that on the date shown below with my signature I am actively performing my occupation duties with.....

Date: / / Signature of Insured Person:  .....




## Authority to Deduct

I, Surname: ..... Given Name: .....

Staff N°:                      Pay Group:

Authorise my employer: ..... to deduct an amount of: \$  per week/fortnight

from my wages and remit this amount to WageCover Australia Pty Limited (ABN 31 070 231 748) PO Box 590 Newport NSW 2106. The Plan will be subject to an annual review, which may or may not result in a change to the weekly/fortnightly premium. 30 days written notice of any such change will be advised.

Employee Signature:  .....

**PLEASE RETURN SIGNED APPLICATION FORM TO:** WageCover Australia Pty Limited PO Box 590 NEWPORT NSW 2106

**T: 02 9970 8411 F: 02 9970 7290 E: admin@wagecover.com.au**

ABN 31 070 231 748 AFSL 246276 Underwritten by certain underwriters at Lloyd's

Date of issue: 1/4/2010

# Application Form (Continued)

INSURED PERSON DETAILS to be completed by the person to be insured by this Policy



## WageCover Outside Working Hours Accident & 24 Hour Sickness Income Protection Plan – Direct Debit Request Schedule

I/We:

Surname: ..... Given Name: .....

request WageCover Australia Pty Ltd ABN 31 070 231 748

### Account to be Debited

Note: direct debiting is not available on the full range of financial institutional accounts. If in doubt, please refer to your financial institution before completing the schedule.

Name of financial institution: .....

Name of account to be debited: .....

BSB: ..... Account N°: .....

### Payment Details

AFA/Policy No: .....

I/We acknowledge that this direct debit request schedule is governed by the terms of the direct debit request service agreement and the terms and conditions of my AFA Policy. I have read and agree to the terms and conditions.

If possible I/We would prefer the direct debits to take place on the: (please tick)  7th day of the month, OR  22nd day of the month

Name(s) of financial institution account holder(s): .....

Customer Address: .....

Signature of financial institution account holder(s): Signature(s):  ..... Date: \_\_\_/\_\_\_/\_\_\_

 ..... Date: \_\_\_/\_\_\_/\_\_\_  
(Are both signatures required for a joint account?)

Business telephone: ( ) ..... Home telephone: ( ) .....

WageCover Australia Pty Ltd ABN 31 070 231 748 Direct Debit Request User ID No: 227472

### DIRECT DEBIT REQUEST

#### Service Agreement with WageCover

This Direct Debit Request (DDR) Service Agreement is used by WageCover User ID 227472. This Service Agreement and the Schedule contain the terms and conditions on which you authorise WageCover to debit money from your account and the obligations of WageCover and you under this agreement. You should read through the Service Agreement and Schedule carefully to ensure you understand these terms and conditions before signing the Schedule.

#### Our commitment to you

WageCover will give you at least 14 days notice in writing if there are any changes to the drawing arrangements (except where you have nominated automatic increases for WageCover). WageCover will not disclose any details of your direct debit request to any person or corporation unless required to do so by law or unless the information is required in relation to a disputed transaction.

Where our direct debit falls due on a weekend or a public holiday WageCover will process it on the next business day in accordance with the terms and conditions of your Insurance Policy.

#### Your commitment to us

It is your responsibility to:  
Ensure your nominated account can accept direct debits.  
Ensure there are sufficient funds available in the nominated account to meet each drawing on the due date.  
Advise us if the nominated account is transferred or closed or the account details change.  
Arrange an alternative payment method acceptable to WageCover if WageCover cancels the drawing arrangements.  
Ensure that all account holders on the nominated financial institution account sign the DDR schedule.

#### Your rights

You may defer, alter, stop or cancel Your direct debit at any time by providing at least (10) ten

business days notice in writing to Us at:

WageCover Australia Pty Ltd, PO Box 590 Newport NSW 2106.

All requests to vary the details of the account to be debited must be in writing and in terms of the operating authority for the account.

If you wish to dispute a direct debit transaction, You should first contact WageCover on (02) 9970 8411, who will arrange for Your complaint to be investigated and a correction made where appropriate. If You are not satisfied with the response, please write to Us. Your letter should be marked "Notice of Complaint" and addressed to:

WageCover Australia Pty Ltd, PO Box 590 Newport NSW 2106

WageCover will respond within 7 days of receiving your letter. WageCover has formal procedures for dealing with a complaint but if We are unable to resolve the dispute to your satisfaction You should contact Your financial institution and lodge a direct debit customer claim form.

#### Other information

The details of your drawing arrangements are contained in the DDR schedule.

WageCover reserves the right to cancel drawing arrangements if drawings are dishonoured by your financial institution.

If your account dishonours, your financial institution may charge you a fee.

Your drawing arrangements are also governed by the terms and conditions of your AFA Policy. You should be aware that there are some financial institutions that may not allow direct debit transactions on specified accounts. It is Your responsibility to check Your account details against Your statements or to check with Your financial institution to ensure that the direct debit facility is available for Your nominated account.

You cannot claim under this Policy if at any time the Injury occurred or the Sickness manifested itself if any instalment of premium remained unpaid for 14 days or more.

We may cancel this policy by giving notice if any instalment of premium has remained unpaid for 1 month or more. Other than in the above circumstances, We may deduct from any claim paid or payable any unpaid premium or instalment of premium.

You should direct all enquiries about your direct debit to:

WageCover on (02) 9970 8411.