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 duty of disclosure. 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:

- Section 6-10
- Section 14 (Medical questionnaires)

Adviser administration

Client name:

Client reference number (if applicable):

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

NEOS Life 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.

F003_1220

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?

*Answer **YES** if you're applying for similar cover (e.g. Life, TPD, Critical Illness or Income Protection Cover) with NEOS and you intend to keep your existing cover in addition to any new NEOS cover.*

*Answer **NO** if you intend to cancel your existing cover if cover with NEOS is approved.*

☐ 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)*
Life Cover	**$**
TPD Cover	**$**
Critical Illness Cover	**$**
Income Protection Cover	**$**

4. Occupation and income

Occupation:

Employer name / business name / industry type:

Depending on the information entered, this second field may or may not be asked online.

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

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

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

*For **EMPLOYED** individuals (those who have no direct or indirect ownership in the business they're employed in) – this is your **earned income** before tax, including regular monthly overtime payments and the average of any commission and bonus payments received over the last two years.*

*For **SELF-EMPLOYED** individuals – your **insurable income** can be broadly taken as your personal exertional income less any applicable business expenses.*

$

TO BE COMPLETED FOR INCOME PROTECTION COVER ONLY

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

$

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

4.4 Do you expect to earn at least as much in this financial year as you did last year? (i.e. the amount your entered into question 4.2)?

*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:

4.5 Has your normal / regular income or hours reduced or have they been / or are they expected to be affected by the Coronavirus outbreak?

Please answer yes if work has or will be reduced, you are unable to perform parts of your job now or work has been limited due to government restrictions.

☐ YES ☐ NO

Employee

Please provide further details to enable us to consider your cover. In particular please try to provide details of any reduction in income and provide an estimated % reduction of income over the next 3 - 6 months. Please describe how the Coronavirus is affecting you for example: You have been stood down or been advised this could be the case in next 3-6 months as business has/could temporarily cease trading, income reduction due to reduced hours or likely reduced hours or you are receiving job keeper allowance.

Self-employed

Please provide further details to enable us to consider your cover. In particular please try to provide details of any reduction in your income after expenses. Please estimate the % reduction of income after expenses over the next 3 - 6 months. Please describe how the Coronavirus is affecting you for example: Long term contracts have ceased, regular short term projects have ceased due to government restrictions or no new contracts or estimates are taking place.

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

If you work more than 60 hours per week, please provide full details of your working pattern and hours worked over the last four weeks:

4.7 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:

4.8 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:

4.9 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

If **YES**, please provide full details of your second occupation and your duties:

TO BE COMPLETED FOR INCOME PROTECTION COVER ONLY

4.10 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

4.11 If you could no longer work due to illness or injury would you receive sick leave payments from any source?

☐ Yes ☐ No

If **YES**, how many sick leave days do you have?

Please tell us about any sick leave arrangements or entitlements you may have.

Complete only if you're self-employed

4.12 How many employees are there in your business (not including yourself)?

Please answer only in whole numbers (and round up or down). For example, if you have two full-time employees and one part-time employee working three days a week (0.6 FTE), the answer would be '3'.

4.13 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:

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

☐ Yes ☐ No

If **YES**, would your income continue for more than 90 days in the event you were unable to work?

☐ Yes ☐ No

If **YES**, then please provide full details:

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

4.15 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:

5. Purpose of cover

If your purpose for applying for life insurance with NEOS includes business reasons, please provide full details of your reasons if you're applying for more than $1,000,000 of Life and/or TPD Cover, or more than $750,000 of Critical Illness Cover.

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

☐ Personal ☐ Business / keyman 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
- ☐ User of e-cigarettes or other nicotine replacement products

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

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 14 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 or any other mental illness
- ☐ 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 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
- ☐ None of the above

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

- ☐ Tinnitus, labrynthitis or anything else affecting your ears or balance
- ☐ Impaired vision, optic neuritis or anything else affecting your eyes
- ☐ Persistent headaches, migraines, numbness, pins and needles, muscle weakness or any other neurological symptoms
- ☐ Growths, lumps, moles or cysts
- ☐ None of the above

TO BE COMPLETED FOR TPD AND INCOME PROTECTION COVER ONLY

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

- ☐ Sciatica, whiplash or anything else affecting your back or neck
- ☐ Arthritis, gout or anything else affecting your bones, joints, ligaments, tendons or muscles
- ☐ 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 14 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, 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 Protection 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 PROTECTION 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 14 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 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 (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 TPD AND INCOME PROTECTION COVER ONLY

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 PROTECTION 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**, due to the current government restrictions for overseas travel please advise which of the following applies to you;

☐ My travel/trip has been cancelled and I no longer have definite plans to travel outside of Australia within the next 12 months

☐ I have definite plans to travel outside of Australia within the next 12 months but will only travel if government advice states it is safe to do so. I will not travel if the Department of Foreign Affairs and Trade travel advisory is level 3 – "Reconsider Your Need to travel" or level 4 – "Do not travel"

☐ I need or intend to travel regardless of government advice

☐ Other

Please list the countries/regions you intend to travel to 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 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.

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*

- ☐ Australian defence force reserve
- ☐ Scuba diving
- ☐ Private flying, gliding, parachuting or ballooning
- ☐ Motor car or motorcycle sport
- ☐ Mountaineering or rock climbing
- ☐ Sailing at sea or powerboat racing
- ☐ Martial arts or combat sports
- ☐ Competitive horse riding
- ☐ Football (any code)
- ☐ Professional or semi-professional sport
- ☐ Extreme sports including base jumping, ice climbing and free soloing
- ☐ 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. General practitioner details

Name of general practitioner:

Street address:

Suburb: | State: | Postcode:

Telephone number:

13. 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				

14. 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?

15. 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.neoslife.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.neoslife.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:

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

NEOS Life 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.