PROTECTION PLANS

Non-Lapsing Nomination of Beneficiaries

TERM LIFE AS SUPERANNUATION

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GENERAL NOTICE

- Use this form to nominate who receives your superannuation benefit in the event of your death.
- You can use this form to make a new nomination, or amend an existing nomination.
- If you would like to nominate more than five beneficiaries, please photocopy page 2 of this form. You must sign the photocopied form as well as the original. Please ensure that the percentages nominated total 100%.
- We recommend you seek professional advice before making a nomination.
- Complete all sections of this form and return to us.

DETAILS OF INSURED MEMBER

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Mx ☐ Other

Given name(s)

Surname

Postal address

Suburb State Postcode

Country, if not Australia

Date of birth DD / MM / YYYY

Email address

Home phone

Mobile phone

Work phone

Please provide the following information (as applicable)

Policy Number

Adviser Number

Portfolio Number

NON-LAPSING NOMINATION OF BENEFICIARIES GUIDELINES

WHO YOU CAN NOMINATE

- **Who can receive your benefit in the event of your death?**

  You can pay your benefit to:

  - your estate, or
  - nominated beneficiary(ies).

  Any beneficiary you nominate must be either your Legal Personal Representative (i.e. executor or administrator of your estate) or a dependant at the date of your death.

- **Who qualifies as a dependant?**

  Your dependants include:

  - your spouse,
  - your children,
  - a person with whom you have an interdependency relationship (see below for definition), and
  - a person who is financially dependent on you.

- **What is an interdependency relationship?**

  An interdependency relationship is a close personal relationship between two people who live together, where one or both of them provide for the financial and domestic support and personal care of the other.

  An interdependency relationship may still exist if there is a close personal relationship but the other requirements are not satisfied because of some physical, intellectual or psychiatric disability.

WHO WOULD YOU LIKE YOUR BENEFIT TO BE PAID TO IN THE EVENT OF YOUR DEATH?

☐ Pay to my Legal Personal Representative (my estate) OR

☐ Pay to my nominated beneficiary(ies)

If any nominated beneficiary is no longer your dependant or Legal Personal Representative at the date of death, they will not be entitled to receive a share of your benefit. You direct the Trustee to pay the share to the remaining nominees based on their proportional entitlement to your benefit.

Please use whole figures when specifying the '% of benefit'. Your total nomination must equal 100%.

NAME OF BENEFICIARY	DATE OF BIRTH	RELATIONSHIP	GENDER	% OF BENEFIT
	DD / MM / YYYY			%
	DD / MM / YYYY			%
	DD / MM / YYYY			%
	DD / MM / YYYY			%
	DD / MM / YYYY			%
			Must total 100%	0 **%**

DECLARATION

INSURED MEMBER'S DECLARATION

I declare and agree that:

- I have read and understood this completed form and declare that the statements made and the information completed therein is true and correct as at the date I signed this form;
- I have read and understood the section NON-LAPSING NOMINATION OF BENEFICIARIES GUIDLINES above;
- I have read and understood the TAL Privacy Policy available on the website at tal.com.au/privacy-policy and I agree to the various uses and disclosures of my personal information set out in that document. I also agree to make any beneficiary nominated by me aware of the matters set out in the Privacy Policy;
- this application and any related documents (including the Product Disclosure Statement (PDS)) shall form the basis of any contract issued;
- the email address(es) provided in this application may be used to electronically communicate with me, including information in relation to my application and my insurance; and
- my nomination will not become effective until it is confirmed by the Insurer in writing.

Name of Insured Member

Signature ✗

Date DD / MM / YYYY

WITNESS DECLARATION

I declare that I am 18 years or over, I am not a named beneficiary on this form and the Insured Member's signature was signed and dated by the Insured Member in the presence of us both.

Name of Witness

Signature ✗

Date DD / MM / YYYY

SUBMITTING THIS FORM

Please return your completed form and any supporting documents by either:

TAL Life
GPO Box 5467
Sydney NSW 2001

PPUWAlterations@tal.com.au for new applications

PPInsurance@tal.com.au for existing policy/ies

CONTACTING TAL

PPInsurance@tal.com.au

1300 553 764

tal.com.au

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