Personal Life Insurance Fact Find

Issue Number 3 – April 2020

Prepared for client:

Date completed:

Adviser name

Business name

Business address

Contents

Personal Details

Please complete this section.

	Client 1	Client 2
Is English your first language? If not, are you fluent in English?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
Do you require the assistance of an interpreter?	☐ Yes ☐ No	☐ Yes ☐ No
Title (eg Mr, Mrs)		
Surname		
Given name		
Preferred name		
Gender		
Marital status		
Date of Birth	DD/MM/YYYY	DD/MM/YYYY
Are you a smoker?	☐ Yes ☐ No Have you quit within the last 12 months? ☐ Yes ☐ No	☐ Yes ☐ No Have you quit within the last 12 months? ☐ Yes ☐ No
Preferred retirement age		
Relationship between clients 1 and 2		
Are you a permanent resident of Australia?	☐ Yes ☐ No	☐ Yes ☐ No
Residential address	State Postcode	State Postcode
Postal address *(write 'as above' if same as residential address)*	State Postcode	State Postcode
Home telephone		
Business telephone		
Mobile		
Email address		
Preferred contact method		

Employment

	Client 1	Client 2
Occupation		
Breakdown of occupation duties (administration, manual, travel etc)		
Employment status	☐ Full time ☐ Retired ☐ Unemployed ☐ Part time ☐ Casual ☐ Homemaker	☐ Full time ☐ Retired ☐ Unemployed ☐ Part time ☐ Casual ☐ Homemaker
Employer name		
Employer address	State Postcode	State Postcode
Date commenced with employer	DD/MM/YYYY	DD/MM/YYYY
If self-employed, what is the business structure?	☐ Sole Trader ☐ Company ☐ Partnership split %	☐ Sole Trader ☐ Company ☐ Partnership split %
Accrued sick leave days		
Accrued annual leave days		
Accrued long service leave days		

Pre-assessment Process

	Client 1	Client 2
Do you know of, or have you been made aware of, any issues which may be relevant to the assessment of a life insurance application? For example: known medical conditions; occupational hazards; planned overseas travel; engagement in hazardous pursuits; and/or immediate family medical history concerns. If yes, please provide details or alternatively complete the 'Life Insurance Pre-Assessment Request' and attach as an addendum to this document.	☐ Yes ☐ No ☐ Not disclosed	☐ Yes ☐ No ☐ Not disclosed

Dependants

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Name	Date of Birth (DD/MM/YYYY)	Age	Gender	Relationship	When would you expect dependency to cease?
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

Are you planning to grow your family? ☐ Yes ☐ No If yes, when?

What health issues, if any, need to be considered for your dependants?

Family Trust Details

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Name of Family Trust

Australian Company Number (ACN)

Trustees

Trustee 1:

Trustee 2:

Trustee 3:

Trustee 4:

Beneficiaries

Beneficiary 1:

Beneficiary 2:

Beneficiary 3:

Beneficiary 4:

Professional Advisers

Company name	Contact name	Phone number
Accountant:		
Solicitor:		
Doctor:		
Other:		

Income/Expenditure Analysis

Please complete this section or tick box below.

☐ Alternate income and expenses data collection used, refer to Budget Tool.

Select Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly

Source of Income (Before Tax)	Client 1 ($)	Client 2 ($)	Joint ($)
Salary and wages (exclude Super Guarantee contributions)			0
Other			0
Total combined income (before tax)			0
Less: Estimated tax and/or other deductions (eg salary sacrifice, salary packaging)			
Net combined income			0

Expenses

Select Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly

	Client 1 ($)	Client 2 ($)	Joint ($)
Living expenses			0
Rent/home mortgage			0
Health insurance			0
Other	0	0	
Subtotal expenses			0
Total combined expenses			0
Surplus/deficit (total net combined income less total combined expenses)			

Assets and Liabilities

Please complete this section or tick box below.

☐ Alternate assets and liabilities data collection used, refer to Budget Tool.

Lifestyle, Investment and/or Superannuation Assets

	Client 1 Amount ($)	Client 2 Amount ($)	Joint Amount ($)	To be sold in the event of Death/ TPD/Trauma?
Principal residence			0	☐ Yes ☐ No
Home contents			0	☐ Yes ☐ No
Motor vehicle			0	☐ Yes ☐ No
Caravan, boat, etc.			0	☐ Yes ☐ No
Holiday house			0	☐ Yes ☐ No
Investment property			0	☐ Yes ☐ No
Cash and fixed interest			0	☐ Yes ☐ No
Managed funds			0	☐ Yes ☐ No
Direct shares			0	☐ Yes ☐ No
Superannuation 1			0	☐ Yes ☐ No
Superannuation 2			0	☐ Yes ☐ No
Other			0	☐ Yes ☐ No
Other			0	☐ Yes ☐ No
Total	0	0	0	

Liabilities

	Lender	Client 1 Balance ($)	Client 2 Balance ($)	Joint Balance ($)
Mortgage				0
What is the mortgage duration? Is there a fixed interest component? If yes, what is the duration			☐ Yes ☐ No	☐ Yes ☐ No
Credit cards				0
Investment loan				0
What is the investment loan duration?				
Personal loan				0
What is the personal loan duration?				
Other				0
Other				0
Total		0	0	0

Goals

Life Insurance Goals

Please complete this section.

I/We require advice in relation to personal insurance only.

☐ Yes ☐ No ▶ DO NOT PROCEED – a full Financial Planning Fact Find should be completed to ensure all necessary information is collected in order to provide appropriate advice.

What you want to achieve	Client 1	Client 2
You would like to protect your income. If yes, would you want to protect it for a defined timeframe? Specify:	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
In the event of your death you would like to provide financial protection to your family/estate	☐ Yes ☐ No	☐ Yes ☐ No
In the event of permanent disablement you would like to provide financial protection for you and your family	☐ Yes ☐ No	☐ Yes ☐ No
In the event of serious illness you would like to provide financial protection for you and your family	☐ Yes ☐ No	☐ Yes ☐ No
Review existing levels of cover	☐ Yes ☐ No	☐ Yes ☐ No
Reduce existing insurance premiums	☐ Yes ☐ No	☐ Yes ☐ No
You would like to protect your mortgage and/or loan(s) for a defined timeframe If yes, specify timeframe:	☐ Yes ☐ No	☐ Yes ☐ No

Please describe any other insurance objectives you want to achieve:

Health Insurance Goals

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

	Client 1	Client 2
Do you have private health insurance?	☐ Yes ☐ No	☐ Yes ☐ No
When was the last time you reviewed your health insurance?	☐ The last 12 months ☐ The last 5 years ☐ Longer	☐ The last 12 months ☐ The last 5 years ☐ Longer
Have your circumstances changed since you last reviewed your cover?	☐ Yes ☐ No	☐ Yes ☐ No
Are you comfortable with the value currently received from your health fund?	☐ Yes ☐ No	☐ Yes ☐ No

Health and Wellbeing Goals

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

	Client 1	Client 2
I require advice as to how my health and wellbeing can benefit my personal insurance.	☐ Yes ☐ No	☐ Yes ☐ No
When it comes to your health and wellbeing how would you best describe yourself?	☐ I'm actively trying to maintain or improve my health ☐ I have tried to establish some routines and disciplines but wish I could be more persistent and do more ☐ I pay attention to my health but don't have any particular goals and disciplines ☐ I don't really pay any attention to it	☐ I'm actively trying to maintain or improve my health ☐ I have tried to establish some routines and disciplines but wish I could be more persistent and do more ☐ I pay attention to my health but don't have any particular goals and disciplines ☐ I don't really pay any attention to it
Would you like to be rewarded for your health and wellbeing efforts?	☐ Yes ☐ No	☐ Yes ☐ No

Estate Planning

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

	Client 1	Client 2
Power of Attorney		
Do you have a current Power of Attorney?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please tick type:	☐ Enduring ☐ Medical ☐ General ☐ Other	☐ Enduring ☐ Medical ☐ General ☐ Other
Who is the Power of Attorney?		
Will		
Do you have a Will?	☐ Yes ☐ No	☐ Yes ☐ No
What is the date of your Will?	DD/MM/YYYY	DD/MM/YYYY
Is your Will current? If yes, does it reflect current wishes?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
Who is the executor?		
Testamentary Trust		
Do you have a testamentary trust?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a letter of wishes?	☐ Yes ☐ No	☐ Yes ☐ No

Estate Planning Goals

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

What you want to achieve	Client 1	Client 2
You would like your current Will, PoA's, and Testamentary trust reviewed	☐ Yes ☐ No	☐ Yes ☐ No
You do not have a full estate plan in place and would like to implement one	☐ Yes ☐ No	☐ Yes ☐ No
You have components of your estate plan that need to be implemented: If yes, please state:	☐ Yes ☐ No	☐ Yes ☐ No

Please describe any other estate planning goals you would like to achieve:

Current Insurance Details

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Please attach an addendum to the back of this document if you are unable to fit all existing policies below.

Client 1

Protection Need	Policy Number	Insurer	Policy Owner	Insured Benefits	Amount of Cover	Total Premium	Premium Frequency
Lifestyle protection				☐ Death ☐ TPD (own) ☐ TPD (any) ☐ Trauma	$ $ $ $	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly
Personal Super				☐ Death ☐ TPD	$ $	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly

Protection Need	Policy Number	Insurer	Policy Owner	Benefit Period	Waiting Period	Monthly Benefit	Premium	Premium Frequency
Income protection						$	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly
Salary Continuance						$	$	☐ Monthly ☐ Half yearly ☐ Yearly

Do you have loadings or exclusions on your existing benefits? ☐ Yes ☐ No ☐ Not disclosed

If yes, please provide details:

Employer Sponsored Super

Fund	Insured Benefits	Sum Insured/ Monthly Benefit	Benefit Period (SCI only)	Waiting Period (SCI only)	Nominated Beneficiaries
	☐ Death ☐ TPD ☐ Salary Continuance	$ $ $			

Notes:

Current Insurance Details (continued)

Client 2

Protection Need	Policy Number	Insurer	Policy Owner	Insured Benefits	Amount of Cover	Total Premium	Premium Frequency
Lifestyle protection				☐ Death ☐ TPD (own) ☐ TPD (any) ☐ Trauma	$ $ $ $	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly
Personal Super				☐ Death ☐ TPD	$ $	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly

Protection Need	Policy Number	Insurer	Policy Owner	Benefit Period	Waiting Period	Monthly Benefit	Premium	Premium Frequency
Income protection						$	$ ☐ Stepped ☐ Level	☐ Monthly ☐ Half yearly ☐ Yearly
Salary Continuance						$	$	☐ Monthly ☐ Half yearly ☐ Yearly

Do you have loadings or exclusions on your existing benefits? ☐ Yes ☐ No ☐ Not disclosed

If yes, please provide details:

Employer Sponsored Super

Fund	Insured Benefits	Sum Insured/ Monthly Benefit	Benefit Period (SCI only)	Waiting Period (SCI only)	Nominated Beneficiaries
	☐ Death ☐ TPD ☐ Salary Continuance	$ $ $			

Notes:

Income Protection Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of income protection is to replace income lost through your inability to work due to injury or sickness.

	Client 1	Client 2
For how long would you continue to receive an income if you were unable to work due to an illness or accident?		
After that period of time, what would happen to your income if you were still unable to work?		
Is that what you would want to have happen?	☐ Yes ☐ No	☐ Yes ☐ No

Income Protection Analysis	Client 1	Client 2
% of annual income (before tax)*	$	$
Plus: % super contributions	$	$
Maximum level of cover available (per annum)	$	$
Less: Existing cover to be retained with:	$	$
Level of cover required (per annum)	$	$
Level of cover recommended (per month)	$	$
How long could you go without your regular income?	☐ 14 days ☐ 12 months ☐ 1 month ☐ 2 years ☐ 3 months	☐ 14 days ☐ 12 months ☐ 1 month ☐ 2 years ☐ 3 months
How long should the monthly benefit be paid for?	☐ 2 years ☐ 5 years ☐ To age 65	☐ 2 years ☐ 5 years ☐ To age 65

* Where the life insured:
- directly or indirectly owns part or all of a business or practice – the business or practice income generated by the life insured's personal exertion after deduction of their share of business or practice expenses in generating that income. Self-employed individuals may be required to produce supporting P&L statements, tax returns and/or group statements.
- is an employee – the total remuneration paid by the employer including salary, superannuation, commissions, fees, regular bonuses, regular overtime and fringe benefits.
- financial evidence supporting the calculations and inclusions is likely to be required at time of underwriting.

Life Cover Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of life cover is to provide a sufficient lump sum amount to your family in the event of your death to help maintain their lifestyle.

	Client 1	Client 2
If we could replace your income stream, how much of it would you want replaced?	%	%
For how many years would this income replacement need to continue?	years	years
Would you want your debts fully paid off?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, specify timeframe:		
If no, specify amount:	$	$
Would you want to include funds to cover your final costs and funeral expenses?	☐ Yes ☐ No	☐ Yes ☐ No
Would your partner continue to work or return to work in the event of your death?	☐ Yes ☐ No	☐ Yes ☐ No

Life Capital Needs Analysis	Client 1	Client 2
Final and funeral expenses	$	$
Eliminate debt or portion of debt	$	$
Mortgage	$	$
Outstanding debts	$	$
Personal guarantees	$	$
If applicable: Capital Gains Tax	$	$
Other	$	$
(A) Subtotal	$ 0	$ 0
Life Income Needs Analysis		
Income replacement x years	$	$
(B) Subtotal	$ 0	$ 0
Less Existing Resources		
Existing life cover with:	$	$
Superannuation (insured benefit)	$	$
Financial assets realised in the event of death	$	$
Lifestyle assets realised in the event of death	$	$
(D) Subtotal	$ 0	$ 0
Summary of Needs		
(C) Level of cover required before resources (A+B)	$ 0	$ 0
(D) Less total existing resources	$ 0	$ 0
(E) Level of cover required (C – D)	$ 0	$ 0

Total and Permanent Disability (TPD) Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of TPD cover is to provide a sufficient lump sum amount should you become totally and permanently disabled to help pay medical costs and maintain your lifestyle.

	Client 1	Client 2
In the event of prolonged or serious illness or accident, where between 0% and 100% would you want your income to be replaced?	%	%
For how many years would this income replacement need to continue?	years	years
Would you want your debts fully paid off?	☐ Yes ☐ No If no, specify amount: $	☐ Yes ☐ No If no, specify amount: $
Would you want an additional lump sum to cover possible rehabilitation/medical expenses?	☐ Yes ☐ No	☐ Yes ☐ No
Would your partner continue to work or return to work in the event of your TPD event?	☐ Yes ☐ No	☐ Yes ☐ No

TPD Capital Needs Analysis	Client 1	Client 2
Eliminate debt or portion of debt	$	$
Mortgage	$	$
Outstanding debts	$	$
Personal guarantees	$	$
Medical/rehabilitation costs	$	$
If applicable: Capital Gains Tax	$	$
Other	$	$
(A) Subtotal	$ 0	$ 0
TPD Income Needs Analysis		
Income replacement x years	$	$
(B) Subtotal	$ 0	$ 0
Less Existing Resources		
Existing TPD cover with:	$	$
Superannuation (insured benefit)	$	$
Financial assets realised in the event of TPD	$	$
Lifestyle assets realised in the event of TPD	$	$
(D) Subtotal	$ 0	$ 0
Summary of Needs		
(C) Level of cover required before resources (A+B)	$ 0	$ 0
(D) Less total existing resources	$ 0	$ 0
(E) Level of cover required (C – D)	$ 0	$ 0

Trauma Cover Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of trauma cover is to ease financial stress during the recovery period following diagnosis and/or treatment of a critical illness.

	Client 1	Client 2
In the event of prolonged or serious illness, where between 0% and 100% would you want your income to be replaced?	%	%
Specify how many years you would want it replaced.	years	years
Would you want your debts fully paid off?	☐ Yes ☐ No	☐ Yes ☐ No
Would you want an additional lump sum to cover possible capital/medical expenses?	☐ Yes ☐ No	☐ Yes ☐ No
In the event of a prolonged or serious illness, would you want your partner to be off work to support you?	☐ Yes ☐ No	☐ Yes ☐ No

Critical Illness Analysis	**Client 1**	**Client 2**
Eliminate debt or portion of debt	$	$
Income replacement x years	$	$
Income replacement for partner off work	$	$
Medical/rehabilitation costs	$	$
Other	$	$
(A) Subtotal	$ 0	$ 0
Less Existing Resources		
Existing trauma cover with:	$	$
Financial assets realised in the event of trauma	$	$
Lifestyle assets realised in the event of trauma	$	$
(B) Subtotal	$ 0	$ 0
Summary of Needs		
(A) Total level of cover required before resources	$ 0	$ 0
(B) Less total existing resources	$ 0	$ 0
(C) Level of cover required (A – B)	$ 0	$ 0

Subject matter

At our meeting, we discussed the goals you are seeking to achieve and the strategy for reaching these goals. As part of the process we discussed your needs, objectives and financial situation and agreed on the following:

Scope of advice

After identifying the subject matter above we agreed to cover the following areas of advice, as relevant to your circumstances, within an appropriate advice document:

Where the advice is limited, please state reasons for the limitation:

The following matters will not be included as part of the advice document preparation at this time:

Client Acknowledgement and Engagement Authority continued >

Client Acknowledgment and Engagement Authority (continued)

I/We request that you provide insurance advice based on the information disclosed and acknowledge that you will rely on the information contained in this document.

I/We acknowledge that if I/we provided any incomplete or inaccurate information that I/we will carefully consider the appropriateness of the advice according to our personal objective, before acting on any advice provided.

I/We acknowledge that you will charge a plan preparation fee of $ _____ (GST inclusive) for the written advice.

I/We have received a copy of the Financial Services Guide and have read and understood it, including the section titled 'Privacy Statement'.

I/We agree to our adviser collecting, using and disclosing my/our personal information in accordance with the Privacy Policy.

I/We will only provide information about other individuals, such as dependants, spouse/partner, guarantors, if those individuals have agreed that I can share that information with you and I will inform them that I/we have provided information about them and make them aware of the information provided in the Privacy Policy.

Where applicable, the personal and sensitive information you provide to your adviser as part of the pre-assessment process may be disclosed to third parties, including the adviser's business, authorising Australian financial services licensee and insurers participating in this process. It will be handled in accordance with the privacy policy of the adviser and those other entities. Please ensure that the adviser gives copies of the relevant privacy policies to you before you disclose personal or sensitive information as part of this pre-assessment process.

If you decline to provide the required information but you proceed to apply for insurance with a particular insurer, that insurer will conduct its own investigations regarding the information it requires to consider your application and you may be required to provide additional information to the insurer, including, for example, a Personal Statement regarding your medical history and other personal information.

Signature of Client 1	✗	Date	DD/MM/YYYY
Signature of Client 2	✗	Date	DD/MM/YYYY
Signature of Financial Adviser	✗	Date	DD/MM/YYYY

The following documents have been supplied:

- ☐ Insurance policy details/Superannuation statements
- ☐ Tax returns
- ☐ PAYG summaries
- ☐ 'Option to Quote Tax File Number' obtained from your Financial Adviser
- ☐ Other

Identification procedure

GUIDE TO COMPLETING THIS FORM

- Complete all applicable sections of this form in BLOCK LETTERS. Provision of this information is required by law.
- The individual's identity must be verified before the product/service can be provided.
- Complete one form for each individual.

SECTION 1: PERSONAL DETAILS

Surname: Date of Birth: DD/MM/YYYY

Full Given Name(s)

Residential address

Street

Suburb State Postcode

COMPLETE THIS PART IF INDIVIDUAL IS A SOLE TRADER

Full Business Name ABN

Principal place of business

Street

Suburb State Postcode

ID RECORD	Document 1	Document 2
Verified from	☐ Original ☐ Certified copy	☐ Original ☐ Certified copy
Copy of ID document (copy must be legible)	☐ Attached (go to Section 2) ☐ Alternative agreed (complete ID document details below)	☐ Attached (go to Section 2) ☐ Alternative agreed (complete ID document details below)

ID DOCUMENT DETAILS	Document 1	Document 2
Document issuer		
Issued date		
Expiry date		
Document number		
English translation	☐ N/A ☐ Attached	☐ N/A ☐ Attached

SECTION 2: FINANCIAL ADVISER DETAILS – Identification and verification

Conducted by: Date verified: DD/MM/YYYY

Financial adviser's name: Phone no.

AFS licensee name: AFSL No.

Identification procedure (continued)

- Verify the individual's full name, and **EITHER** their date of birth or residential address.
- Complete either **Part A or Part B** (Note: **Part B** should only be completed if the individual does not own a document from Part A).

PART A – ACCEPTABLE PRIMARY ID DOCUMENTS

Tick **Select ONE** valid option from this section only

- ☐ Australian State/Territory driver's licence containing a photograph of the person
- ☐ Australian passport (a passport that has expired within the preceding 2 years is acceptable)
- ☐ Card issued under a State or Territory for the purpose of proving a person's age containing a photograph of the person
- ☐ Foreign passport or similar travel document containing a photograph and the signature of the person*

PART B – ACCEPTABLE SECONDARY ID DOCUMENTS

Tick **Select ONE** valid option from this section

- ☐ Australian birth certificate
- ☐ Australian citizenship certificate
- ☐ Pension card issued by Centrelink
- ☐ Health card issued by Centrelink
- ☐ National identity card issued by a foreign government containing a photograph of the person in whose name the card was issued*

AND ONE valid option from this section

- ☐ A document issued by the Commonwealth or a State or territory within the preceding 12 months that records the provision of financial benefits and contains the individuals name and residential address
- ☐ A document issued by the Australian Taxation Office within the preceding 12 months which contains the individuals name and residential address
- ☐ A document issued by a local government body or utilities provider within the preceding 3 months which records the provision of services to that address or to that person (the document must contain the individuals name and residential address)
- ☐ Foreign driver's licence that contains a photograph of the person in whose name its issued and the individuals date of birth*
- ☐ If under the age of 18, a notice that:
  - was issued to the customer by a school principal within the preceding 3 months; and
  - contains the customers name and residential address; and
  - records the period of time that the customer attended at that school

*Documents that are written in a language that is not English, must be accompanied by an English translation prepared by an accredited translator

Client Authorisation

Client authorisation (for financial adviser to request additional information from other institutions)

To whom it may concern:

I, _____ whose date of birth is DD/MM/YYYY

I, _____ whose date of birth is DD/MM/YYYY

Of (insert full address)

_____

_____

Request that all relevant information on my investments, insurances, superannuation, bank accounts or other financial information be released to _____

Authorised Representative of _____ on request.

_____ is an Australian Financial Services Licensee

whose Australian Financial Services License number is _____ whose ABN is _____

and address is _____

Please accept a photocopy or facsimile copy of this letter as authority, as the original will stay on file.

Your faithfully,

Client signature _____ Client signature _____

Date DD/MM/YYYY Date DD/MM/YYYY