

# Insurance alteration form

Complete this form in pen using CAPITAL letters. Where applicable complete boxes with an **X**

## SECTION 1 - YOUR PERSONAL DETAILS

Client number

Last name

Mr

☐

Mrs

☐

Miss

☐

Ms

☐

Dr

☐

First name/s

Male

☐

Female

☐

Date of birth (DD/MM/YYYY)

Postal address

Suburb/town

State

Postcode

Street address (if different to postal address)

Suburb/town

State

Postcode

Home phone

Day time phone

Mobile

Email

## SECTION 2 - INSURANCE CANCELLATION

Please indicate which insurance option/s you would like to cancel:

☐ Income Protection ☐ Death and TPD ☐ Death only ☐ TPD only\*

**\*You cannot cancel TPD only if you have Basic Cover and TPD cover cannot be more than your Death cover.**

## SECTION 3 - INSURANCE DECREASE

Please indicate which insurance type you would like to decrease, and your new nominated sum insured.

☐ Income Protection

a) Select your waiting period:

☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 1 year ☐ 2 years

b) Select your benefit period:

☐ 2 year ☐ 5 year

☐ Death and TPD

\$

☐ Death only

\$

## SECTION 4 - YOUR PRIVACY

Your privacy is important to us. Details on how your personal information is collected, managed and used is contained in our Privacy Policy which includes our Privacy Collection Statement and is available at [www.wasuper.com.au/privacy/](http://www.wasuper.com.au/privacy/).

## SECTION 5 - ACKNOWLEDGEMENT AND DECLARATION

- I understand that in completing and signing this form that any previous details will be replaced by the new details on this form.
- I have read and understood the Fund's Product Disclosure Statement.
- In signing this form I acknowledge that I will continue to be bound by the Fund Trust Deed and Rules in all respects.
- I understand that by cancelling my insurance, if I wish to apply again in the future, full underwriting including a medical examination may be required and I may be subject to different terms and conditions, levels of cover or premium loadings.
- If at a later date I wish to increase my cover I will be required to provide health and personal information.
- My request to alter my insurance will take effect from the date the form is received by the Fund.

Signature

Date