

Insurance Application Form

To join the Fonterra Welfare Fund insurance plan, complete this form and send it to welfarefund.nz@mercermarshbenefits.com

1: PERSONAL DETAILS

Surname:	<input type="text"/>	Given Names:	<input type="text"/>
Email (work):	<input type="text"/>	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:	<input type="text"/>		
Telephone (home):	<input type="text"/>	Telephone (work):	<input type="text"/>
Company:	<input type="text"/>	Location:	<input type="text"/>
Date of Birth (DD/MM/YYYY):	<input type="text"/> / <input type="text"/> / <input type="text"/>	Annual Salary (without incentive loading):	\$ <input type="text"/>
Employee Number:	<input type="text"/>	Do you work more than 15 hours per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I require:	<input type="checkbox"/> Life Insurance <input type="checkbox"/> OR <input type="checkbox"/> Life + Income Protection <input type="checkbox"/> Critical Illness Insurance		

2: CONTRIBUTIONS

My employer is hereby authorised as my agent and I hereby request my employer to deduct from my salary on each day the contributions payable to secure my benefits in the Fund and to pay the contributions to the Trustees of the Fund for the purposes of the Fund. All payments made on my behalf in accordance with this authority shall be deemed to be payments by me personally to the Trustees of the Fund.

3: AGREEMENT TO COMPLY WITH THE TRUST DEED AND SUPPLY INFORMATION

I have received a copy of the Member Information Booklet and am aware of the terms and conditions of the Fonterra Welfare Fund. I agree to be bound by the Trust Deed of the Fonterra Welfare Fund and any subsequent modifications. I agree to supply any other information, including personal medical details, as may be requested by the Trustees or the Insurer.

4: MEMBERSHIP ACCEPTANCE

I acknowledge that if I join during the period when first eligible i.e. within 90 days of commencing employment, then insurance is usually automatic within acceptance limits agreed with the insurer. The automatic acceptance benefit limits are **\$1,000,000** for life insurance, **\$75,000** for Critical Illness Insurance and **\$132,000** for income protection insurance. If I elect to join at some other date outside of the first 90 days of employment, or apply for insurance above the automatic acceptance level, then insurance will be subject to my medical declaration and acceptance by the Insurer.

5: PRIVACY STATEMENT

I hereby authorise my employer, the Trustees of the Fund, the Insurer(s) and any Administration Manager or other person involved in the administration of the Fund to provide and disclose to any person the personal information held about me for any purpose relating to the operation and administration of the Fund and the payment of my benefits there from.

I hereby apply for membership to the Fonterra Welfare Fund ("the Fund"):

Your signature:	<input type="text"/>	Date (DD/MM/YYYY):	<input type="text"/> / <input type="text"/> / <input type="text"/>
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PAYROLL USE ONLY

Verified details above (please initial):	<input type="text"/>	Date commenced employment:	<input type="text"/> / <input type="text"/> / <input type="text"/>
Current remuneration for the purposes of the fund:	<input type="text"/>	Date (DD/MM/YYYY):	<input type="text"/> / <input type="text"/> / <input type="text"/>
Application accepted on behalf of the Trustees by (elected person as agreed by the Trustees):	<input type="text"/>		
Salaried Agreement:	<input type="text"/>	Pay cycle Frequency:	<input type="text"/>

An employee on a collective employment agreement is not eligible to join.

MARSH USE ONLY

Contribution / Premium:	<input type="text"/>	Date Effective (DD/MM/YYYY):	<input type="text"/> / <input type="text"/> / <input type="text"/>
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