# ALTERATION OF RESPONSE

## IMPORTANT INFORMATION

Please complete in ENGLISH and BLOCK CAPITALS.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

Please select the specific form for which an alteration of response is required.

The signatures below must match the signatures provided on the form that is being altered.
A completed Declaration of Good Health form must be submitted together with this form.

| | | | |
|---|---|---|---|
| Proposed Insured | Given Name(s) | Surname | |
| Date of Birth | (dd/mm/yyyy) | | |
| Proposed Policy Owner (Full Name) | | | |
| Producer Name | | Producer ID | |
| Distributor Name | | | |

☑ Select the box that applies

| | | |
|---|---|---|
| ☐ | Information Disclosure and Authorisation (Completed by the proposed insured) | Signed on (dd/mm/yyyy) |
| ☐ | Application for Policy (Completed by the proposed policy owner) | Signed on (dd/mm/yyyy) |
| ☐ | Other Form Please specify: _____ | Signed on (dd/mm/yyyy) |

The company is hereby requested by the undersigned, to accept the following answers in lieu of the answers to the corresponding questions in the form indicated above (please specify question number from the relevant form):

1189BME AOR(GM) 0325

By signing below, the undersigned represents that the answers and statements provided above are true, accurate and complete. The undersigned acknowledges and understands that this information may be used by any insurance company to assess the insurability of the proposed insured indicated above. This completed Alteration of Response shall form part of the said Information Disclosure and Authorisation, Application for Policy, or other form indicated above, and will be incorporated as part of the life insurance policy issued on the basis thereof. Any misrepresentation or failure to provide all relevant information may render the insurance coverage void.

To be completed by: ☐ Proposed Insured or ☐ Proposed Policy Owner

☑ Select the box that applies

| Name of Proposed Insured or Proposed Policy Owner | |
|---|---|
| Signature | Date |
| X | (dd/mm/yyyy) |

| Producer Name | |
|---|---|
| Signature | Date |
| X | (dd/mm/yyyy) |

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