

Application for Group Salary Continuance Insurance

This form should be completed by Participating Employers (or employers applying as Participating Employers) in the Seafarers or Maritime Super divisions who would like to provide Salary Continuance insurance as a basic benefit for employee members.

Please complete and sign this form and return to: Maritime Super, Locked Bag 2001, QVB Post Office NSW 1230.

Employer Details

Employer Name (Business Name)

Employer Trading Name (if different)

Type

Company OR Other (please specify)

ABN or ACN

Parent Company's Name (if applicable)

Registered Address

Contact Name

Position

Email address

Phone Number

Employee Details

You must have at least ten (10) employees who are eligible and become members of Maritime Super to apply for group Salary Continuance insurance cover.

To assess your application, the Insurer requires the name, date of birth, occupation and salary for each eligible employee who you will be nominating for membership. You may provide this information electronically (in something as simple as a spreadsheet or text file). Alternatively, provide the details for each employee below. If you have more than 10 employees, you may attach a list or use a separate sheet of paper for additional employees.

Name of electronic file

OR

Name	Gender	Salary	Date of Birth	Occupation
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

Declarations and Authorisation

The employer wishes to apply to Maritime Super Pty Limited ('the Trustee') and AIA Australia Limited ('the Insurer') to provide group Salary Continuance insurance through Maritime Super to employees who become members of Maritime Super.

I/We confirm, on behalf of the employer, that the details on this form are true and correct and that I/we understand that:

- the insurance will be subject to the terms and conditions in the Insurance Policy held by Maritime Super Pty Limited in respect of the Seafarers division and the Maritime Super division of the Fund; and
- insurance premiums will be payable by the employer (monthly)

I/We confirm that the employees nominated for Basic Salary Continuance insurance:

- a. will have SG contributions made to Maritime Super on their behalf
- b. Maritime Super has been/will be nominated by us as the default fund for contributions under Choice of Fund; **OR**
- c. the employer has an obligation to provide replacement income insurance under an award or workplace agreement for the employee.

Name	Signature	Date
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text" value=" / /"/>

Capacity				<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Sole Director	<input type="checkbox"/> Director	<input type="checkbox"/> Company Secretary	<input type="checkbox"/> Other (specify)	

Name	Signature	Date
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text" value=" / /"/>

Capacity				<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Director	<input type="checkbox"/> Company Secretary	<input type="checkbox"/> Other (specify)		

This form must be signed by:

- a. two Directors
- b. a Director and the Company Secretary
- c. the Sole Director of the Company; or
- d. under a Power of Attorney (a copy of the Power of Attorney should be provided).

Privacy information and consents

Personal information is collected from or in respect of you to enable Maritime Super to administer your (or your employees') benefits. If you do not supply the required information, we may not be able to do so (and may be unable to action your requests). We may disclose this personal information to a number of parties, such as the administrator of the Fund, Maritime Super's professional advisers, insurer(s) and service providers, as required by law and/or as authorised by you. You may be entitled to gain access to personal information we may have on file in respect of you. If you wish to obtain access or have a complaint, please contact Member Services on 1800 757 607.