FirstChoice Employer Super Plan number:_____
Investor Account number: _____
Request to reduce or remove Employer Selected Insurance Cover

Investor Declaration

I hereby request that my Employer Selected Cover be reduced as follows:

- ☐ Death only cover be reduced to an amount of $ _____
- ☐ Death and Total & Permanent Disablement*, cover be reduced to an amount of $_____
- ☐ Salary Continuance be reduced to an amount of $ _____ per month

***If your plan has Death and Total & Permanent Disablement Cover, changes to Death cover cannot be made without corresponding changes to Total and Permanent Disablement cover.**

Or:

I wish to remove the following Employer Selected Cover from my account:

- ☐ Death only
- ☐ Death and Total & Permanent Disablement
- ☐ Salary Continuance

I acknowledge that by signing this declaration that neither my dependants nor myself will have any claim in excess of my account balance, or my account balance plus the amount detailed above, against the Trustee should I die or become totally and permanently disabled. I also acknowledge that if I subsequently wish to reinstate this cover the entire benefit will be treated as Investor Selected Cover and full underwriting will be required.

……
Signature of Investor

Print Name

		/			/				

Date