

SERIES 28 APPLICATION | TOWER PROTECTION POLICY |

BPAY NO:

Before you sign this Application Form, be aware that TOWER or a financial adviser must have provided you with a Product Disclosure Statement (PDS) dated 17 November 2008. This PDS contains important information in relation to the TOWER Protection Policy. This information will help you to understand the product and to decide whether it is appropriate to your financial situation, objectives and needs.

YOUR DUTY OF DISCLOSURE

Before you enter into or become insured under a contract of insurance with TOWER Australia Limited (ABN 70 050 109 450) (TOWER), you and any life to be insured have a duty, under the Insurance Contracts Act 1984, to inform TOWER of every matter that you or any life to be insured know, or could reasonably be expected to know, is relevant to TOWER's decision whether to accept the risk of insurance and, if so, on what terms. You have the same duty to disclose those matters to TOWER before you extend, vary or reinstate a contract of insurance. Your duty however does not require disclosure of a matter that reduces TOWER's risk, is common knowledge, that TOWER knows or ought to know in the ordinary course of business, or as to which compliance with your duty is waived.

Your duty of disclosure applies even after this Application is completed until TOWER advises acceptance of insurance.

If you or any life to be insured fail to comply with your duty of disclosure and, if the failure had not occurred, TOWER would not have entered into the contract on any terms, TOWER may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, TOWER may avoid the contract at any time. Instead of avoiding the contract TOWER may, within three years of entering into it, reduce the sum insured in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to TOWER.

HOW TO APPLY

1. When completing the Application Form please:
 - use a black pen
 - use BLOCK LETTERS only
 - use ✓ in boxes
 - if you make a mistake, do not use correction fluid, instead cross out the error, initial the change and be sure to date it.
2. Complete any additional questionnaires if requested, on pages 10, 14, 15 & 17, or as supplied by your financial adviser.
3. If you intend to have your payments:
 - debited directly from your bank credit card, complete the Authority by Credit Card on page 21.
 - debited directly to your bank account, complete the Direct Debit Request on page 21.
4. If you are making your first payment by cheque, please make it payable to TOWER Australia.
5. Please ensure that all parties have signed and dated the Policy Declaration on page 18.
6. The Application Form, copy of your quotation, Direct Debit Request or Authority by Credit Card and cheque (where applicable) should be handed to your financial adviser.

1. APPLICATION DETAILS

<input type="checkbox"/> New Application	<input type="checkbox"/> Alteration/Addition to PDS 28	Policy No. <input type="text"/>
<input type="checkbox"/> Non Super	<input type="checkbox"/> TOWER Super	<input type="checkbox"/> External Super (Please provide Super Fund's name in 2(B))
<input type="checkbox"/> Continuation Option	Group Name <input type="text"/>	Fund/Member No: <input type="text"/>
<input type="checkbox"/> Conversion Option	Policy No. <input type="text"/>	I am applying for this product in the capacity of: <input type="checkbox"/> An individual <input type="checkbox"/> A company <input type="checkbox"/> A trustee <input type="checkbox"/> A partnership <input type="checkbox"/> An incorporated or unincorporated association <input type="checkbox"/> A registered co-operative <input type="checkbox"/> A Government Body
<input type="checkbox"/> Buy Back Option	Policy No. <input type="text"/>	
<input type="checkbox"/> Business Insurance Option		
<input type="checkbox"/> Modified Underwriting/Transfer Terms		
Number of lives to be insured under this application	<input type="text"/>	
Policy Ownership	<input type="checkbox"/> Single Life <input type="checkbox"/> Joint Life*	

* Please note that if this policy is jointly owned, BOTH policy owners must sign where the policy owner's signature is requested.

Reasons for Insurance

LIFE TO BE INSURED NO.1	<input type="checkbox"/> Family/Personal Protection	<input type="checkbox"/> Loan Protection	<input type="checkbox"/> Keyperson
	<input type="checkbox"/> Share Purchase/Partnership	<input type="checkbox"/> Disability Protection	
LIFE TO BE INSURED NO.2	<input type="checkbox"/> Family/Personal Protection	<input type="checkbox"/> Loan Protection	<input type="checkbox"/> Keyperson
	<input type="checkbox"/> Share Purchase/Partnership	<input type="checkbox"/> Disability Protection	

2. POLICY OWNER DETAILS (ONLY COMPLETE IF DIFFERENT FROM THE LIFE TO BE INSURED IN SECTION 3.)

(A) POLICY OWNER 1	Title	<input type="text"/>	Surname	<input type="text"/>
	Given Names	<input type="text"/>		
POLICY OWNER 2 (IF APPLICABLE)	Title	<input type="text"/>	Surname	<input type="text"/>
	Given Names	<input type="text"/>		
OR	Company Name (please advise ABN)	<input type="text"/>		
POSTAL ADDRESS OF POLICY OWNER FOR NOTICES	Street Address	<input type="text"/>		
	Suburb	<input type="text"/>	State	<input type="text"/>
			Postcode	<input type="text"/>
PHONE NO.	Home	<input type="text"/>		
	Business	<input type="text"/>		
	Mobile	<input type="text"/>		
	Email	<input type="text"/>		
	Contact Name if the policy owner is a company	<input type="text"/>		

(B) Are all the addresses provided in this application form within Australia?

Yes
 No

(C) If applying for the TOWER Protection Policy as superannuation, please tick one of the following fund options:

Trustee of the TOWER Superannuation Fund
 The Trustee of a superannuation fund other than the TOWER Superannuation Fund (please specify)

Trustee Details:

Superannuation Fund:

3. LIFE INSURED DETAILS

Life to be insured No. 1

PERSONAL DETAILS Title Surname

Given Names

Previous Surname

Gender Male Female Date of Birth / /

Marital Status Married Single Defacto

Has the life to be insured smoked tobacco or other substances in the last 12 months? No Yes

ADDRESS Unit No. Street No. Street Name

Suburb State Postcode

If life to be insured is also the policy owner, please provide address for notices (if different to the address above)

ADDRESS Street Address

Suburb State Postcode

Your relationship to policy owner Self Spouse/Partner Business Partner Employee

Member of the Superannuation Fund Other

Life to be insured No. 2 (if applicable) Please note that a separate Personal Statement will be required (Form T3034)

PERSONAL DETAILS Title Surname

Given Names

Previous Surname

Gender Male Female Date of Birth / /

Marital Status Married Single Defacto

Has the life to be insured smoked tobacco or other substances in the last 12 months? No Yes

ADDRESS Unit No. Street No. Street Name

Suburb State Postcode

If life to be insured is also the policy owner, please provide address for notices (if different to the address above)

ADDRESS Street Address

Suburb State Postcode

Your relationship to policy owner Self Spouse/Partner Business Partner Employee

Member of the Superannuation Fund Other

Where there are more than 2 lives to be insured under this policy please list details of other lives and complete a further Application Form:

First Name	Surname	Submitted with this Application	Barcode No. of Application
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

PERSONAL STATEMENT - LIFE TO BE INSURED NO. 1 (THIS SECTION MUST BE COMPLETED BY THE LIFE TO BE INSURED)

CONTACT DETAILS

Home Phone () Business Phone () ext:
 Mobile Email

TELEPHONE UNDERWRITING

At times there are aspects of the Application Form that we may need to clarify with you, and a TOWER underwriter may contact you in connection with the answers you have provided on this form. If you do NOT agree to being contacted directly by a TOWER underwriter, please tick this box.

Please advise a convenient time and place to phone.

Most convenient place to call Home Business Monday to Friday 9:00 am to 5:00 pm OR
 From am to pm Monday Tuesday Wednesday Thursday Friday

1. RESIDENCE

Are you an Australian or New Zealand Citizen or do you have an Australian Permanent Resident's Visa? No Complete the following Yes **Go to 2**
 How long have you lived in Australia? Years Months
 Will you be applying for Permanent Residency? No Yes
 If 'Yes', please state proposed date. If 'No', please clarify your plans to stay in Australia (including duration and purpose of stay).
 Visa Type Expiry Date / /
 Country of Birth Nationality

2. TRAVEL PLANS

Do you have any plans to travel overseas in the immediate future (ie. next 2 years), or are you required to travel on a regular basis for business? No **Go to 3** Yes Complete the following
 Reasons for Trip Holiday Business Study Other (specify)

COUNTRY					
DURATION OF STAY					
FREQUENCY					

 Dates of next Trip Date Leaving / / Date Returning / /

3. INSURANCE DECLINED OR MODIFIED

Has any insurer ever indicated they would not insure you, or would modify your insurance terms in any way? No **Go to 4** Yes Complete the following
 Declined Deferred Loading/Extra Premium Benefits Reduced Term of Plan Limited Exclusion
 Give details:

DATE	COMPANY	REASON
/ /		
/ /		

4. CLAIMS

Have you ever claimed or received, or are you currently receiving, benefits from any source? No **Go to 5** Yes Give details below
 Insurance Plan Workers' Compensation Veterans Affairs Social Security (eg: unemployment/disability or sickness)
 Other (specify)
 Give details:

DATE	COMPANY	REASON	CLAIM FINALISED
/ /			
/ /			

5. OTHER INSURANCE DETAILS

(A) Are you a life insured under any existing insurance with TOWER or any other insurers?

No **Go to B** Yes Give details in table below and include any TPD benefits under Crisis/Trauma and Group/Employer Insurance. Also indicate if the Crisis/Trauma includes a buy-back of Crisis/Trauma Cover.

NAME OF INSURER	TYPE OF PLAN/POLICY (EG. DEATH/TPD/CRISIS/INCOME COVER)	POLICY OWNER/PURPOSE (EG. SELF/KEYMAN)	INSURED AMOUNT	TO BE REPLACED BY THIS COVER?
			\$	<input type="checkbox"/> No <input type="checkbox"/> Yes
			\$	<input type="checkbox"/> No <input type="checkbox"/> Yes
			\$	<input type="checkbox"/> No <input type="checkbox"/> Yes

(B) Are you also applying for insurance with any other insurer?

No **Go to 6** Yes Give details in table below

NAME OF INSURER	TYPE OF PLAN/POLICY (EG. DEATH/ TPD/ CRISIS/ INCOME COVER)	INSURED AMOUNT
		\$
		\$

(C) Will that insurance be additional to the TOWER insurance currently being applied for?

No Yes

Important Note: If you have indicated that the cover being applied for with TOWER is to replace existing cover with either TOWER or another Life Office, you must cancel that existing cover. No claim will be paid in respect of the new TOWER policy unless the previous cover has been cancelled. If the previous policy is not cancelled and a claim occurs, any premiums paid to TOWER will be refunded, and no benefit will be paid.

6. OCCUPATION

(A) What is your occupation?

(B) Employment Status Full-time ie. ≥ 30 hrs/week Permanent part-time Casual

(C) What industry do you work in?

(D) Does your occupation involve:

- Contact with explosives, acid, corrosives, poisons, or other dangerous substances? No Yes
- Working underground or off shore? No Yes
- Lifting or moving objects or equipment weighing more than 15kgs? No Yes
- Working at heights over 10 metres? No Yes
- Being more than 2 hours from medical care? No Yes
- Any other hazards? No Yes

If 'Yes' to any of the above, please provide details.

(E) What was your income for the last 12 months? (after deducting business expenses if self employed) \$ per year

If you are applying for cover where we will need financial information from your Accountant, do you give us permission to contact your Accountant to clarify any particular issues? No Yes

Accountant's Name Phone Number ()

(F) Do you have any definite plans to change your occupation, activities or employment status (ie employed to self-employed to employed) or to take extended leave (eg parental or study leave) in the immediate future?

No **Go to 7**
 Yes Give details:

DATE	DETAILS
/ /	
/ /	

IF YOU ARE APPLYING FOR TPD PLEASE COMPLETE SECTIONS 7 & 8.
 IF YOU ARE APPLYING FOR INCOME PROTECTION PLEASE COMPLETE SECTIONS 7, 8 & 9.
 IF YOU ARE APPLYING FOR BUSINESS EXPENSES COVER PLEASE COMPLETE SECTIONS 7, 8, 9 & 10.

7. EMPLOYMENT DETAILS

(A) Name of your employer

(B) Address of your employer

(C) How long have you been in your current occupation? Years Months

(D) Are you self employed? (this means shareholder or employee of own company, sole trader or partner)

No **Go to 8** Yes, give details:

i) How long? Years Months % of business you own

ii) Name of your business/company

iii) How many employees do you have? (excluding yourself)

iv) Business Address

v) Do you work at home?

No **Go to 8**

Yes Give details of the home/office setup (**Adviser Note:** refer to Adviser Manual for information required)

8. CAREER DETAILS

(A) What are the main duties of your occupation?

DUTIES (EG. OFFICE WORK, SALES, SUPERVISION, MANUAL)	% OF TIME
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
	100%

(B) In what location do you perform your duties?

LOCATION (EG. OFFICE, ON-SITE, AT HOME)	% OF TIME
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
	100%

(C) Do you hold any professional/trade qualifications?

No

Yes Give details: Type Institution where obtained

(D) How many weeks per year and hours/days per week do you work in your main occupation? hours per week days per week weeks per year

(E) Has your main occupation, employer or employment status changed in the last 3 years?

No **Go to F** Yes Give details in table below:

PREVIOUS OCCUPATION	EMPLOYER	EMPLOYMENT STATUS (I.E. UNEMPLOYED, EMPLOYED, EMPLOYED BY OWN COMPANY, SELF EMPLOYED, PARTNERSHIP)	Date From	Date To
<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"/>

(F) Do you have any other occupation?

No **Go to 9** Yes Complete the following:

i) Type of occupation ii) Name of your employer

iii) How many hours per week do you work in this other occupation?

iv) How long have you been doing this other occupation? Years Months

v) What is your monthly income from this other occupation? \$

NOTE: DO NOT INCLUDE THIS INCOME IN SECTION 9

9. INCOME DETAILS (PLEASE COMPLETE SECTIONS (A) AND (B))

(A) If you were to become disabled, would any part of your income continue?

No **Go to B** Yes If yes, advise the amount of income that would continue, for how long, and also the source. (e.g. sick pay, pension, group salary continuance, company profits, trail commission, investment etc) then **go to (B)**.

i) Source			
ii) Amount			
iii) Duration			

BANKRUPTCY

(B) Have you been declared bankrupt, placed into receivership or liquidation within the last 5 years?

No Yes Give details: i) When? ii) Date of discharge. / /

(C) For self-employed persons (i.e. shareholder or employee of own company, sole trader or partner)

As an alternative to completing (C), you may attach the last 2 years Profit & Loss accounts.

Adviser Note: for large sums insured, other requirements will be necessary. Please refer to Adviser Manual.

	LAST YEAR TAX	PREVIOUS TAX YEAR
Gross Income (your share of Gross Income) before business expenses or tax	\$	\$
Less Business Expenses (your share)	- \$	- \$
Net Income before tax (after deducting expenses)	= \$	= \$
Please also provide the following income details as per your Profit & Loss accounts:		
i) Your share of the net income/(loss) above	\$	\$
ii) Your Wage or Salary	\$	\$
iii) Your Director's Fees	\$	\$
iv) Your superannuation contribution	\$	\$
TOTAL (I + II + III + IV)	\$	\$

(D) For employed persons (i.e. no ownership interest in the business in which you are employed)

	CURRENT INCOME	PREVIOUS TAX YEAR
Gross annual salary (include all salary packaged items)	\$	\$
Plus bonuses and/or commissions	+ \$	+ \$
Total income	= \$	= \$

(E) For Income Protection Benefits over \$20, 000 per month (total cover)

Important Note: Top-up income protection where the total benefit exceeds \$20,000 per month is only available where the existing cover is insured with TOWER.

Do you have either an ownership interest in or control over assets (directly or indirectly including those held in your spouse's name, in trusts or other entities owned by trusts or any other entity that you have control over) where:

(i) the net assets (excluding the personal residence/family home) exceed \$5.0 million?

No Yes

(ii) the investment or unearned income exceeds \$250,000 per annum?

No Yes

10. BUSINESS EXPENSES (PLEASE ONLY COMPLETE IF APPLYING FOR BUSINESS EXPENSE COVER)

If you want to insure for more than \$10,000 per month business expense cover for AAA, AA+ or AA occupation classes, or \$4,000 per month for A or BBB occupation classes, ALWAYS complete the Business Expenses Questionnaire below. For smaller amounts, use the questionnaire to assist you if you are not sure which expenses to include.

Important Note: Only include business overheads (expenses) not included as your earnings for which you are personally responsible and
 • which are paid using business income generated by your own activity; and
 • which will still have to be paid if you are not at work.

(A) BUSINESS	\$ PER MONTH
Premises rent	\$
Rates and property taxes	\$
Loan interest repayments including business property (NOT repayment of principal)	\$
Electricity/water/gas/heating	\$
Fire & general insurance premiums	\$
Cleaning	\$
Telephone (exclude calls which won't be made while you are not at work)	\$
Lease of equipment/vehicles	\$
Dues/membership fees to professional and industry bodies	\$
Accounting fees	\$
Salaries and other costs (e.g. superannuation) for staff (Refer to schedule (F) below)	\$
Locum Fees (if applicable)	\$

(B) Other fixed expenses of non-business income generating activities, i.e. costs 'just to open the doors'. Do NOT include expenses which will stop if you are not working, or will continue because of other people's income generating activities eg buying stock for resale, one-off expenses, petrol, stationery.

DESCRIPTION OF EXPENSES	\$ PER MONTH
	\$
	\$
	\$
	\$
	\$
	\$

(C) Total business overheads. All of (A) plus all of (B) \$ _____ per year

(D) What is your % share of these overheads (usually your % share of the business)? _____

(E) Describe what would happen to the business if you became disabled. **Note:** Where Locum Fees are included in Part A as an eligible Business Expense, you will need to take this into account when answering this question.

(F) Schedule of all employees and/or partners

NAME OF EMPLOYEE OR PARTNER	% OF INCOME GENERATED	OCCUPATION	DUTIES	ANNUAL SALARY	% INTEREST IN THE BUSINESS (IF ANY)

11. SMOKING

Have you smoked any substance(s) in the last 12 months? No **Go to 12**

Yes Give details

Substances smoked Cigarettes Cigars Pipe Other (specify)

Number/Amount For years

Status Still smoking Stopped smoking on (specify date) / /

12. DRINKING

(A) Do you drink alcohol? No **Go to 13**
 Yes Give details below and **go to 13**

Number of standard drinks* Per Day Per Week Per Month

*A standard drink = 1 nip spirits, 1 wine glass of wine, glass of port/sherry, 10oz/285ml glass of beer

13. HAZARDOUS OR SPORTING ACTIVITIES (PLEASE COMPLETE SECTIONS (A) AND (B))

Do you currently engage in or do you have any intention of engaging in:

(A) Aviation other than as a fare paying passenger on a recognised airline:

No **Go to B** Yes Complete the following

1. Please state type of licence and date issued: Type Date Issued / /

2. Purpose for Flying: Private Agricultural Aerobatics Charter Other

If private or other, please give details:

3. What type of aircraft do you fly?

4. Please indicate the number of hours flown:

Last 12 months: Crew hrs Passenger hrs

Future Annual Average: Crew hrs Passenger hrs

5. Total number of hours you have flown as a pilot: hrs

6. Do you intend to change your present licence? No Yes Give details

(B) Any other hazardous activity or sport:

No **Go to 16** Yes Complete the following

Diving* Hang Gliding Ballooning Bungy Jumping
 Football (any code) Paragliding Parachuting Horse Riding
 Boxing Abseiling Whitewater Rafting Mountain/Rock Climbing
 Martial Arts Caving Motor Sports (on land or water)* Other Please specify:

* Please complete the questionnaire on the following page. If any of the other above boxes have been ticked please provide details as follows:

Specific activity?		
How long have you been doing this?		
Qualifications?		
Professional or amateur?		
How often do you do this?		
Geographic location?		

14. DIVING QUESTIONNAIRE

1. Do you hold a current diving certificate? No Yes Qualifications

2. Status Amateur Professional

3. Type of diving Scuba Surface Demand eg. Hooka Saturation or Clearance
 Other, (specify)

4. Location: Deep Sea Close to Shore Inland Water Caves
 Potholes Dams Wrecks

5. How many years have you been diving?

6. Maximum No. of dives per day

7. Average number of dives per year

8. Average depth attained metres

9. Do you dive below 30 metres? No Yes

10. Please provide details of any diving accidents

15. MOTOR SPORTS QUESTIONNAIRE

1. Status Amateur Professional

2. Location of Events

3. Type of vehicle

4. Engine Size

5. Type of events

6. Maximum speeds attained

7. Number of vehicles engaged in each event

8. Competition Licence Type

9. Issuing Body (eg. CAMS)

10. Years Held

11. Number of events entered in last 12 months

12. Number of events you anticipate entering in the coming 12 months

13. Do you intend to change the scope of your present activities? No Yes If 'Yes' please provide details

14. Have you ever had a motor sport accident, or has your competition licence ever been suspended? No Yes If 'Yes' please provide details

16. GENERAL FAMILY HISTORY

Has any of your immediate family had any of the following: diabetes, heart problem, stroke, high cholesterol, haemochromatosis, familial polyposis, cancer (breast, cervical, ovarian, colon or other), cystic fibrosis, depression or other mental disorder, polycystic kidney disease, or Huntington's chorea?

No **Go to 17** Yes Complete the table below

RELATIONSHIP	AGE AT DIAGNOSIS	AGE NOW IF ALIVE	AGE AT DEATH	LIST ALL CONDITIONS AND CAUSE OF DEATH IF APPLICABLE (IF CANCER GIVE TYPE AND SITE IF KNOWN)
MOTHER				
FATHER				
BROTHER(S)				
SISTER(S)				

17. DOCTOR INFORMATION

(A) Name of your current doctor

Address of your current doctor

Suburb

State

Postcode

Phone number

 ()

How long have you been a patient of this doctor?

 Years

 Months

Date, reason and result of last consultation.

(B) If you have been a patient of this doctor for **less than 2 years** or consult more than one doctor, please provide the name and address of your previous or concurrent doctor.

Name

Address

Suburb

State

Postcode

Phone number

 ()

How long were you, or have you been, a patient of this doctor?

 Years

 Months

Date, reason and result of last consultation.

18. HEALTH DETAILS

If a medical examination is required, only complete the AIDS questions (H), (I) and (J).

(A) What is your height? cm ft/ins (B) What is your weight? kg st/lbs

(C) Have you EVER had or received medical advice or treatment for any of the following? If 'Yes', please complete details within the Additional Medical Statement on page 13. If Back/Neck or Asthma/Bronchitis, also complete the questionnaire(s) on pages 14 and/or 15.	NO	YES
1. High blood pressure, raised cholesterol, stroke or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
3. Asthma, bronchitis or other lung complaint, or sleep apnoea?	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
6. Hepatitis or any other liver or gall bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. Back, neck or knee complaint or any disorder of the joints, bones or muscles (eg gout, arthritis)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Kidney or bladder disease, renal colic, stones or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
9. Depression, anxiety, stress, mental or nervous condition or chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
10. Any congenital or neurological abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
11. Cancer, tumour, melanoma, sunspots, mole or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
12. Eczema, dermatitis, psoriasis or any other skin condition?	<input type="checkbox"/>	<input type="checkbox"/>
13. Tinnitus, hearing loss or any defect in hearing, sight or speech?	<input type="checkbox"/>	<input type="checkbox"/>
14. Anaemia, leukaemia, haemophilia or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
15. Thyroid or prostate disorder or any disorder of the reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
16. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
17. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
18. Epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks?	<input type="checkbox"/>	<input type="checkbox"/>
19. Other physical impairment, deformity or symptoms of ill health, illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
(D) During the LAST THREE YEARS have you, other than advised above:	NO	YES
1. Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellors, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation?	<input type="checkbox"/>	<input type="checkbox"/>
2. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection?	<input type="checkbox"/>	<input type="checkbox"/>
(E) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation (including a genetic test)?	<input type="checkbox"/>	<input type="checkbox"/>
(F) Have you EVER had any blood tests which revealed an abnormality eg. raised blood sugar, liver function or renal function results, or anaemia etc?	<input type="checkbox"/>	<input type="checkbox"/>
(G) Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future?	<input type="checkbox"/>	<input type="checkbox"/>

If questions C, D, E, F or G answered 'Yes', please complete details in the Additional Medical Statement on page 13.

AIDS QUESTIONS	NO	YES
(H) Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus), had an AIDS related condition or are you carrying antibodies for that virus?	<input type="checkbox"/>	<input type="checkbox"/>
(I) Have you EVER sought or are you expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV?	<input type="checkbox"/>	<input type="checkbox"/>
(J) Have you EVER shared a needle or syringe for the injection of any drug, engaged in anal activity or worked as or engaged in sexual activity with a prostitute or someone you know or suspect to be HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>

If questions H, I or J answered 'Yes', we will send you a separate questionnaire.

FEMALES ONLY		NO	YES
(K) Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)?		<input type="checkbox"/>	<input type="checkbox"/>
(L) Have you ever had any complications of pregnancy or childbirth?		<input type="checkbox"/>	<input type="checkbox"/>
(M) Are you currently pregnant? If 'Yes', what is expected delivery date?	/ /	<input type="checkbox"/>	<input type="checkbox"/>
(N) Have you ever had a breast lump (even if you have not seen a doctor about it)?		<input type="checkbox"/>	<input type="checkbox"/>

If questions K, L, M or N answered 'Yes', please complete details in the following Additional Medical Statement.

19. ADDITIONAL MEDICAL STATEMENT

(A) QUESTION NO	Q	Q	Q
(B) What was the condition and which part of the body was affected?			
(C) Date symptoms first started and description of symptoms?			
(D) What was the medical diagnosis including results of x-rays and investigations?			
(E) What was the frequency (daily, weekly, etc) of attacks or symptoms?			
(F) What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
(G) How long were you unable to work or perform your normal duties/activities?			
(H) If a hospital visit was required, please provide date and duration of your stay.			
(I) What advice/treatment did you receive?			
(J) Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
(K) When did you last suffer from any symptoms?			
(L) Degree of recovery (%)			
(M) Please supply the name and address of all doctors or hospitals consulted for this specific condition.			
(N) Does your current GP have records for this condition?			

20. BACK/NECK DISORDER QUESTIONNAIRE

(A) Which area(s) of your back were affected?

- Lower back Middle/upper back Neck The whole back

(B) Which of these symptoms did you experience?

- Pain in the leg Numbness/pins and needles Pain in the arm Stiffness/restriction of movement

(C) When did you first experience these symptoms and how long did they last?

Commenced Lasted

(D) What was the cause of these symptoms?

(E) Have you had an X-ray, CT Scan, MRI or any other investigation? No Yes If 'Yes', please advise type, date and result

(F) Which of these treatments were recommended/undertaken?

- Rest Exercise Program Physiotherapy Surgery Chiropractic Tablets

Other

(G) Have you experienced any recurrence of the symptoms?

- No Yes

If 'Yes', date recurred and how long they lasted:

(H) Have you continued to consult a health professional (doctor, physiotherapist, chiropractor, etc) for your back/neck?

- No Yes

(I) Are you restricted in any way from pursuing your usual activities (eg avoid lifting, manual work, gardening, etc)?

- No Yes

If 'Yes', provide details:

(J) Due to your symptoms were you:

Unable to work

- No Yes

On restricted/light duties

- No Yes

If 'Yes', provide details, including dates and durations of these:

(K) Are you still experiencing any symptoms?

- No Yes

If 'No', when did they cease?

(L) Have you claimed any compensation or insurance benefits in regard to this disorder/s?

- No Yes

Type of claim

(eg worker's comp., insurance policy, etc)

With whom lodged

(eg employer, insurance company, etc)

Status

- Settled On-going - Awaiting finalisation

(M) Please advise the name and address of ALL health professionals (doctors, physiotherapists, chiropractors, etc) consulted and the date of the last visit to each.

21. ASTHMA/BRONCHITIS QUESTIONNAIRE

(A) When did you first experience the symptoms of wheezing, chest tightness, breathlessness or cough?

(B) What is the frequency of the symptoms? (eg daily, 2 x per week, etc)?

(C) Has the severity of the symptoms changed?

No - remained constant Yes

If 'Yes' did it:

Increase OR Decrease

(D) When did you last experience any symptoms?

(E) What treatment do you use and how often?

Name (eg ventolin, becotide, etc)

Type (eg inhaler/aerosol, nebuliser, etc)

Frequency (eg daily, 2 x per week, etc)

(F) During the last 5 years has your treatment included steroids (eg prednisone, cortisone, prednisolone) or any other similar treatment?

No Yes

If 'Yes', please advise the name of the treatment and when used

(G) During the last 5 years have you required emergency treatment or admission to a hospital because of your symptoms?

No Yes

If 'Yes', please advise the name of hospital and attendance date(s)

(H) Do you measure your peak flow?

No Yes

If 'Yes', please advise for last 12 months

Highest

Recorded on

Lowest

Recorded on

(I) When did you last consult a doctor for your condition?

(J) Are your usual activities limited in any way by this condition?

No Yes If 'Yes', details

(K) During the last 5 years have you ever missed work or school because of your symptoms?

No Yes If 'Yes', number of days and year

(L) Please advise the name and address of ALL doctors consulted for this condition in the past 5 years and the date of the last visit to each:

23. CHILD'S QUESTIONNAIRE

This should be completed if the Child's Crisis Option is required

CHILD 1 First Names Surname
 Date of Birth / / Place of Birth Sex
 Relationship to life to be insured

CHILD 2 First Names Surname
 Date of Birth / / Place of Birth Sex
 Relationship to life to be insured

(A) Has this child ever had:	CHILD1		CHILD2	
	NO	YES	NO	YES
1. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Rheumatic fever or any heart complaint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Asthma, tuberculosis or any other lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cancer, cyst, or tumour of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Indigestion, gastric or duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Epilepsy, fainting attacks or fits of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A physical defect, impaired sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Anaemia, leukaemia, haemophilia or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Kidney, bowel, liver or gall bladder problems, including hepatitis, of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(B) Has this child:				
1. Ever been advised to have an operation or surgery in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Suffered from AIDS or an AIDS related disease or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Been injected with, or used any drug not prescribed by a medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Received a blood transfusion or treatment with human blood products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(C) Has the child's mother, father or any brother or sister suffered from diabetes, heart disease, cancer, stroke, mental disorder or breakdown, kidney disorder, Huntington's chorea or any hereditary disease?				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For any 'Yes' answer above, please advise name of condition, dates of treatment, name and address of doctors or hospitals.

CHILD 1

CHILD 2

24. CHILD'S CRISIS OPTION DECLARATION

This should be completed if the Child's Crisis Option is required.

I/We have read the Duty of Disclosure and declare that the information in the Application Form concerning the child/children to be insured is true to the best of my/our knowledge and belief. I/We consent to the information provided being used for the insurance purpose described.

Signature (Policy owner) _____ Date / / Parent Guardian

* Please note that if this policy is jointly owned, BOTH policy owners must sign.

25. PRIVACY

Personal information is collected from or in respect of you to enable TOWER to provide or arrange for the provision of the product or service requested. Further personal information may be requested from you at a later time, such as if you want to make alterations to the policy or at claim time. If you do not supply the required information, we may not be able to provide the product or service requested or pay the claim.

In processing and administering your insurance (including at the time of claim) we may disclose your personal information (excluding health information) to a number of parties or such organisations to whom we outsource our mailing and information technology, the Insurance Reference Service, Government regulatory bodies, and other companies within the TOWER group and accountants (if applicable).

We may also disclose your personal information (including health information) to other bodies such as the reinsurers, your adviser, health professionals, investigators, the administrator, lawyers, the trustee of any superannuation fund through which the policy is effected, external complaints resolution bodies and as required by law.

By signing the Application Form you are agreeing to our collection, use and disclosure of your personal information.

We would also like to provide you with information about other products and services that we or other companies within the TOWER group offer. To do so we need to disclose personal information (excluding health information) to companies within the TOWER group, authorised TOWER advisers or financial planners and the distributors and suppliers who are commissioned by us to perform certain tasks such as market research.

If you do not want to be informed of other products or services, please notify our Customer Service Centre on 1800 226 364.

You may also be entitled to gain access to personal information we may have on file in respect of you. If you wish to obtain access please make your request to our Customer Service Centre on 1800 226 364.

26. POLICY DECLARATION — PLEASE COMPLETE IN ALL INSTANCES

- I/We have received a copy of and read and understood the Product Disclosure Statement dated 17 November 2008, and relevant Supplementary PDS (SPDS) which accompany this Application Form relating to the insurance for which I/We am/are applying and my/our decision to apply for this insurance is based on my/our understanding of the content of the PDS and relevant SPDS;
- I/We have read all questions contained in the Application Form and all other forms, including questionnaires submitted to TOWER in relation to this Application, including but not limited to any quotation form submitted with or attached to this Application Form and to the best of my/our knowledge the answers and other information provided to TOWER are true, correct and complete;
- I/We have made no statement to the financial adviser or any other person connected with the financial adviser which in any way alters, qualifies or modifies the answers given in the Application Form and other documents relevant to this Application;
- If I/We have not completed the answers to these questions myself/ourselves, I/We have checked its contents to ensure they are true, correct and complete;
- In relation to any tax returns submitted in support of this Application I/We confirm that these are the tax returns submitted to the Australian Tax Office and no subsequent adjustments have been made or are expected;
- I/We have read and understood the Duty of Disclosure and have not knowingly withheld any information which might affect my/our eligibility for this insurance;
- I/We understand the consequences of non - disclosure;
- I/We understand that the Duty of Disclosure also applies to Interim Cover;
- If TOWER fails to issue a notice of acceptance for the Plans applied for in the Application Form within 90 days of the date shown below, the Application shall be deemed to be declined;
- If circumstances alter after completing the Application Form and before a policy has been issued I/we will advise TOWER immediately;
- I/We have read and understand the Privacy Section in this document which sets out important details of how TOWER may use my/our information; and
- I/We understand that by signing this form, I/We consent to TOWER's collection, use and disclosure of my/our personal information.

Signature of life to be insured _____ Date / /

Signature of Policy owner 1 _____ Date / /

Signature of Policy owner 2 _____ Date / /

* Please note that if this policy is jointly owned, BOTH policy owners must sign.

27. NOMINATED BENEFICIARIES — NON-SUPERANNUATION (OPTIONAL)

Section 48A of the Insurance Contracts Act 1984 allows you to nominate an individual or company to receive benefits under this policy. The following restrictions apply to such a nomination under this policy:

- you may only nominate up to five beneficiaries to receive the benefit payable as a result of a death claim (but not Terminal Illness claim) on the Life Protection Plan;
- you must be both the only policy owner and the only life insured in order to make a valid nomination;
- you may change a nominated beneficiary or revoke a previous nomination at any time prior to a claim event, but the change does not take effect until TOWER receives the new nomination form;
- payment of Death Benefits will be made on the basis of the latest nomination received, unless it has been revoked;
- if a nominated beneficiary predeceases you, the portion of the Death Benefit nominated in respect of that beneficiary will be paid to your personal representative;
- your nomination will be automatically revoked on the assignment (transfer) of the policy; and
- a nominated beneficiary has no rights under the policy, other than to receive the Death Benefit after the claim has been admitted by TOWER. The nominated beneficiary cannot authorise or initiate any policy transaction.

NAME OF BENEFICIARY	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO POLICY OWNER	% OF DEATH BENEFIT
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

28. THIRD PARTY OWNERSHIP DECLARATION

THIS MUST BE COMPLETED IF THE INCOME PROTECTION PLAN OR THE BUSINESS EXPENSE PLAN ARE TO HAVE A POLICY OWNER OTHER THAN THE LIFE INSURED.

I request that the following special provision should apply to my policy:

"If a claim becomes payable under the Income Protection Plan or the Business Expense Plan, I (the policy owner) request that the payment be made to the life insured on my behalf."

Signature of life to be insured

X

Date

X / /

Signature of Policy owner

X

Date

X / /

29. AUTHORITY TO DISCLOSE INFORMATION TO FINANCIAL ADVISER

In the event that TOWER determines not to accept my application at standard rates, I hereby authorise TOWER to inform my financial adviser of the reasons for that decision, including disclosing personal medical information and "sensitive information" (as defined in the Privacy Act). I understand that TOWER will not provide copies of medical or other reports to my financial adviser without first obtaining my specific consent.

No Yes

I understand that TOWER may accept information by telephone, facsimile or e-mail from me and that TOWER will rely on any such information in deciding whether or not to accept my application. I also understand that TOWER may accept information by telephone, facsimile or e-mail from me or my financial adviser in relation to matters of administration once this application has been accepted by TOWER. I hereby appoint my financial adviser as my agent for the purpose of providing any such information to TOWER by telephone, facsimile or e-mail. Matters of administration will include such examples as notifying a change of address or altering the frequency payment.

No Yes

Signature of life to be insured

X

Date

X / /

30. MEDICAL EVIDENCE AUTHORITY (TO BE COMPLETED IN ALL INSTANCES)

Barcode No.

R

Name

Date of Birth

/ /

Dear Doctor,

I have applied to TOWER Australia Limited (TOWER) for insurance and a medical report from your practice is required. Until this report is received by TOWER my application for insurance cannot proceed. I have agreed that any Medical Practitioner or any other person who has been or may be consulted by me at any time in the future whether named by me or not shall be and is hereby authorised and directed by me to divulge to TOWER, any legal tribunal or any third party engaged by TOWER all medical or surgical information acquired with regard to myself. A photocopy or facsimile of this authority shall be considered as valid as the original. I would be grateful if you could attend to this matter as soon as possible.

Signature of life to be insured

X

Date

X / /



TOWER Australia Limited
ABN 70 050 109 450
AFSL Number 237848
TOWER Australian Superannuation Limited
AFSL Number 237851
RSE Lic. Number L0000642
PO Box 142, Milsons Point NSW 1565
80 Alfred Street, Milsons Point NSW 2061
Telephone 02 9448 9000
Facsimile 02 9448 9100

31. BENEFIT INFORMATION**ATTACH QUOTE TO THIS PAGE**

Tick this box to confirm that a copy of the full TOWER Protection Policy premium quotation has been attached to this Application Form. The quotation provides the details of the insurance benefits and options being applied for. We need this so we can assess your application.

32. METHOD OF PAYMENT (PLEASE TICK THE APPROPRIATE BOX FOR INITIAL AND ON-GOING)

METHOD	DDR	C/CARD	CHEQUE	BPAY (Biller Code: 7955)
INITIAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ON-GOING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> *	<input type="checkbox"/> *

* NOT APPLICABLE FOR MONTHLY.

33. DIRECT DEBIT PAYMENT AUTHORITY BY CREDIT CARD

Cardholder's Name

I hereby authorise TOWER to regularly charge my: (tick one) Visa Mastercard

Card Number Expiry Date / /

Cardholder's Signature Date / /

34. DIRECT DEBIT REQUEST

Important Notes: By filling out this form, you will be deemed to have agreed to the terms and conditions appearing in the PDS. This form and those terms and conditions will be deemed to be the Direct Request Service Agreement between you and TOWER Australia Limited ("TOWER") for the purposes of the Direct Debit System. Please fill out this form in capital letters using a black pen.

PERSONAL DETAILS Surname

Given Names

ADDRESS Street Address

Suburb State Postcode

YOUR ACCOUNT DETAILS Name of Bank

Branch

BSB Number Account Number

Account Name

Note: Direct debit may not be available with all banks. If in doubt, refer to your bank.

AUTHORISATION

I/We request and authorise TOWER Australia Limited ABN 70 050 109 450 (Direct Debit System User Identification Number 245397), until further notice in writing from me/us, to instruct the Bank to debit my/our account (details of which appear above), with all amounts payable by me/us periodically under the policy/policies issued by TOWER on the day on which each payment is due through the Direct Debit System. I/We understand and acknowledge the terms and conditions included in this brochure relating to the Direct Debit System, and agree that this Direct Debit Request and those terms and conditions will be deemed to be the Direct Debit Request Service Agreement between me/us and TOWER for the purposes of the Direct Debit Systems. I/We also understand and acknowledge that TOWER may, in its absolute discretion, by notice in writing to me/us of no less than 14 calendar days terminate this Direct Debit Request as to future debits or vary the amount of frequency of future debits.

Your Signature Date / /

Additional Signature (if required) Date / /

PLEASE NOTE: DEDUCTIONS ARE MADE ON OR AROUND THE 15TH OF THE MONTH.

Please ensure that if there is more than one signatory to the account that each signs this authority and/or that if a company account, that signature is of an authorised signatory.

TOWER Australian Superannuation Limited
ABN 69 003 059 407 AFSL Number 237851
80 Alfred Street Milsons Point NSW 2061

THIS SHOULD ONLY BE COMPLETED WHERE THE POLICY IS TO BE OWNED BY THE TRUSTEE OF THE TOWER SUPERANNUATION FUND

1. PERSONAL DETAILS

PERSONAL DETAILS	Surname	<input type="text"/>		
	Given Names	<input type="text"/>		
ADDRESS RESIDENTIAL	Unit No.	<input type="text"/>	Street No.	<input type="text"/>
		Street Name <input type="text"/>		
	Suburb	<input type="text"/>		State <input type="text"/>
				Postcode <input type="text"/>
OR				
ADDRESS BUSINESS	Unit No.	<input type="text"/>	Street No.	<input type="text"/>
		Street Name <input type="text"/>		
	Suburb	<input type="text"/>		State <input type="text"/>
				Postcode <input type="text"/>
TAX FILE NUMBER		<input type="text"/>	<input type="text"/>	<input type="text"/>
		<input type="text"/>	<input type="text"/>	<input type="text"/>

Please read the Tax File Number section on page 76 of the Product Disclosure Statement before completing

2. ELIGIBILITY TO CONTRIBUTE

Please tick any of the following statements that apply:

I am under age 65

The contributions to meet the premiums are employer award or superannuation guarantee contributions

None of the above statements apply to me but I am still eligible to make or receive superannuation contributions for the following reason:

Please see the contribution rules section on page 63 of the Product Disclosure Statement for details

3. CONTRIBUTIONS TO MEET PREMIUMS

Employer Contributions	<input type="checkbox"/>		
Personal Contributions:	I intend to apply for a tax deduction for the contributions	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Spouse Contributions:	Has the spouse in respect of whom the contributions are made ever worked in paid employment (including self-employment)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If 'Yes', state period	<input type="text"/>		

4. DEATH BENEFIT NOMINATION

SECTION A – SELECT A CATEGORY OF MEMBERSHIP OR A BINDING DEATH BENEFIT NOMINATION

I wish to select the following **CATEGORY OF MEMBERSHIP**

RULES OF CATEGORY – Death Benefits are payable in accordance with the category information. Category rules can be found on page 63 of the Product Disclosure Statement. Payment of benefits is subject to superannuation law.

INSTRUCTIONS: Select **ONE** category only, then state the percentage to be paid as a lump sum to the person noted in the first column; any remaining benefit will be paid as an Allocated Pension to the person noted in the second column. If you do not define a percentage, 100% of your death benefit will be paid as a lump sum to the person defined in the first column. For category 6 you can suggest the percentage you would like paid to any dependant(s) you nominate for consideration by the Trustee in the table opposite.

(Section 4 continued next page)

TICK OPTION	CAT	DEATH BENEFIT PAYABLE AS A LUMP SUM (DEFINE % FOR CATEGORY)*	DEATH BENEFIT PAYABLE AS AN ALLOCATED PENSION (FOR REMAINING BENEFIT)
<input type="checkbox"/>	1	Spouse	Eligible Children ⁺
<input type="checkbox"/>	2	Eligible Children	Spouse
<input type="checkbox"/>	3	Personal representative	Spouse
<input type="checkbox"/>	4	Person with whom you have an Interdependency Relationship	Eligible Children ⁺
<input type="checkbox"/>	5	Personal representative	Person with whom you have an Interdependency Relationship
<input type="checkbox"/>	6	At the Trustee's discretion	

* I would like % of the death benefit to be paid as a lump sum to the person(s) in the first column of my selected category (not applicable for category 6.)

⁺ You can select the age at which you would like any Allocated Pension payable to your eligible children to be commuted to a lump sum. If no age is selected, any Allocated Pension payable to your children will be commuted to a lump sum at age 18. Age 18 Age 21 Age 25

OR

I wish to make a **BINDING DEATH BENEFIT NOMINATION**

Please note that your binding death benefit nomination remains valid for 3 years and should be reviewed regularly, particularly if circumstances change as in the case of marriage or divorce. If you are making a binding death benefit nomination you must sign this application in the presence of two witnesses, who are at least aged eighteen and who are not nominated as beneficiaries. All signatures should be affixed using the same pen.

SECTION B - BENEFICIARY DETAILS

CATEGORY OF MEMBERSHIP - Please provide details for any person who would currently qualify to receive your benefit in the event of your death under your Category Nomination or whom you would like the Trustee to consider if you have nominated category 6. Please note, providing this information does not mean the Trustee will be able to pay the named person(s) if your circumstances have changed at the time of your death. **BINDING DEATH BENEFIT NOMINATION** – Provide full details for the nominee(s) you wish the Trustee to pay.

NAME OF DEPENDANT	ADDRESS	DATE OF BIRTH	RELATIONSHIP	BENEFIT %*
		/ /		
		/ /		
		/ /		
		/ /		
PERSONAL REPRESENTATIVE				
TOTAL				

* Provide benefit percentage for category 6 or Binding Death Benefit Nomination Only.

5. DECLARATION

Applicant - I wish to apply to become a member of the TOWER Superannuation Fund. If a binding death benefit nomination has been made in Section 4, you must sign this application in the presence of two witnesses.

Signature Date

Witnesses - Signed by the applicant in the presence of both at the same time attested and signed by us as witnesses in the presence of the applicant and each other.

Witness 1 Signature	<input type="text" value="X"/>	Witness 2 Signature	<input type="text" value="X"/>
Date	<input type="text" value="X / /"/>	Date	<input type="text" value="X / /"/>
Witness 1 Name	<input type="text"/>	Witness 2 Name	<input type="text"/>
Witness 1 Date of Birth	<input type="text" value="/ /"/>	Witness 2 Date of Birth	<input type="text" value="/ /"/>
Witness 1 Address	<input type="text"/>	Witness 2 Address	<input type="text"/>
	<input type="text"/>		<input type="text"/>

35. AUTHORISED REPRESENTATIVE DETAILS

PRINCIPAL AUTHORISED REP	TOWER Adviser No./Authorised Rep No.	<input type="text"/>
	Authorised Rep Name	<input type="text"/>
	Dealer Group	<input type="text"/>
	Commission Split (whole nos.)	New Business % <input type="text"/> Servicing % <input type="text"/>
	Business Phone / Mobile Phone	<input type="text"/>
	Email	<input type="text"/>
SHARED AUTHORISED REP	TOWER Adviser No./Authorised Rep No.	<input type="text"/>
	Authorised Rep Name	<input type="text"/>
	Dealer Group	<input type="text"/>
	Commission Split (whole nos.)	New Business % <input type="text"/> Servicing % <input type="text"/>

Note: New business and servicing commission must each total 100%

LIFE INSURED NO. 1 COMMISSION DETAILS

	UPFRONT	HYBRID 1	HYBRID 2	LEVEL	A	B	C	D	E
LPP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IPP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please complete commission details section on stand alone personal statement for any subsequent life insured.

Is a concurrent application being submitted to TOWER for this applicant/life to be insured? No Yes

If required, have you arranged: Medical Exam Blood Tests ECG Fast-Check Other

If arranged, who have these been organised through, and when will they be done?

If this case has already been pre-assessed by TOWER, please provide details including the name of the underwriter involved.

CHECKLIST

- Application fully completed and signed where required
- Initial Deposit Premium attached
- Client contact details completed so they can be contacted if required
- PREMIUM QUOTE ATTACHED**
- Faxscan used - 1800 300 072

Adviser Comments - additional space is available on page 16.

DECLARATION

I am an Authorised Representative of Dealer No.

and am authorised by them to deal and give advice on the type of product submitted.

Authorised Representative Signature Date / /