



APPLICATION | PARTNER INSURANCE PORTFOLIO |

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 28 May 2007. This PDS contains important information in relation to the Partner Insurance Portfolio. 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

- 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.
- Complete any additional questionnaires if requested, or as supplied by your financial adviser.
- IMPORTANT** Please note if you are applying for Disability Income, Optimal Income or Business Expense insurance in addition to any Term, Medical Catastrophe or Total and Permanent Disability cover then you will be issued with a 2nd policy for your Disability Benefit.
- If you intend to have your payments:
 - debited directly from your bank credit card, complete the Payment Authorisation form on page 26.
 - debited directly to your bank account, complete the Payment Authorisation form on page 26.
- If you are making your first payment by cheque, please make it payable to TOWER Australia.
- Please ensure that all parties have signed and dated the Policy Declaration on page 23.
- The Application Form, copy of your quotation, Payment Authorisation should be handed to your financial adviser.

In order to be eligible to apply for cover under a Superannuation Term Insurance Policy owned by the Partner Superannuation Fund, you must be prepared to quote your Tax File Number to the Trustee. This can be done at page 25 (Section 34) of this Application.

1. APPLICATION DETAILS

<input type="checkbox"/> New Application	<input type="checkbox"/> Alteration/Addition to PDS issued 28 May 2007	Policy No.	<input type="text"/>
<input type="checkbox"/> Continuation Option	Group Name	Fund/Member No.	<input type="text"/>
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 under a First To structure, 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

(A) If applying for Ordinary Term, Stand Alone Medical Catastrophe or Stand Alone TPD please complete the following

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 / PO Box	<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"/>		
	Contact Name if the policy owner is a company	<input type="text"/>		

(B) Term through Superannuation

<input type="checkbox"/> Trustee of the Partner Superannuation Fund	
<input type="checkbox"/> The Trustee of a superannuation fund other than the Partner Superannuation Fund (please specify)	
Trustee Details:	<input type="text"/>
Superannuation Fund:	<input type="text"/>

(C) Disability Income, Optimal Income and Business Expense Insurance (ONLY COMPLETE IF DIFFERENT FROM THE LIFE TO BE INSURED IN SECTION 7)

POLICY OWNER	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 / PO Box	<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"/>		
	Contact Name if the policy owner is a company	<input type="text"/>		

(D) Please complete this section if any of the following benefits are to be linked to a Term Policy issued through Superannuation.

Stand Alone Medical Catastrophe

POLICY OWNER Title Surname
 Given Names

OR Company Name (please advise ABN)

POSTAL ADDRESS OF POLICY OWNER FOR NOTICES Street Address / PO Box
 Suburb State Postcode

PHONE NO. Home ()
 Business ()
 Mobile

Contact Name if the policy owner is a company

Stand Alone Total and Permanent Disability

POLICY OWNER Title Surname
 Given Names

OR Company Name (please advise ABN)

POSTAL ADDRESS OF POLICY OWNER FOR NOTICES Street Address / PO Box
 Suburb State Postcode

PHONE NO. Home ()
 Business ()
 Mobile

Contact Name if the policy owner is a company

3. ADVISER'S DETAILS

By signing below, I/We confirm that the information shown on this application accurately and completely records information given by the Policyowner and Life Insured.

Commission type		Pay structure		Premium discount
<input type="checkbox"/> Upfront <input type="checkbox"/> Hybrid <input type="checkbox"/> Balanced <input type="checkbox"/> Level		<input type="checkbox"/> Drip <input type="checkbox"/> Upfront		%

Adviser company name

Adviser code Percentage %

AFSL number Phone number ()

Name of Adviser/ contact person

Email address

Signature

Adviser company name

Adviser code Percentage %

AFSL number Phone number ()

Name of Adviser/ contact person

Email address

Signature

4. LIFE INSURED DETAILS (LIFE 1)

Title(s)	<input type="text"/>	Surname	<input type="text"/>
Given names(s)	<input type="text"/>		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/> Age next birthday <input type="text"/>
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Permanent resident of Australia?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Place of birth	<input type="text"/>		
Occupation	<input type="text"/>	Occupation class	<input type="text"/>
Time in occupation	<input type="text"/> yrs <input type="text"/> mths	Main duties of occupation	<input type="text"/>
Hours worked per week	<input type="text"/>	Annual income/salary	<input type="text"/> \$
Email address	<input type="text"/>		
Street Address / PO Box	<input type="text"/>		
Suburb	<input type="text"/>	State	<input type="text"/> Postcode <input type="text"/>
Home phone number	<input type="text"/> ()	Mobile phone number	<input type="text"/> ()
Work phone number	<input type="text"/> ()	Fax Number	<input type="text"/> ()
May TOWER contact you directly to clarify or gather information in relation to this application?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Specify daytime contact no.	<input type="text"/> ()	Best time of day to call	<input type="text"/> am <input type="text"/> pm

5. ADDITIONAL LIFE INSURED (LIFE 2) *Please note a separate Personal Statement (Form T3782) will be required for Life 2 if applicable*

Title(s)	<input type="text"/>	Surname	<input type="text"/>
Given names(s)	<input type="text"/>		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/> Age next birthday <input type="text"/>
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Permanent resident of Australia?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Place of birth	<input type="text"/>		
Occupation	<input type="text"/>	Occupation class	<input type="text"/>
Time in occupation	<input type="text"/> yrs <input type="text"/> mths	Main duties of occupation	<input type="text"/>
Hours worked per week	<input type="text"/>	Annual income/salary	<input type="text"/> \$
Email address	<input type="text"/>		
Street Address / PO Box	<input type="text"/>		
Suburb	<input type="text"/>	State	<input type="text"/> Postcode <input type="text"/>
Home phone number	<input type="text"/> ()	Mobile phone number	<input type="text"/> ()
Work phone number	<input type="text"/> ()	Fax Number	<input type="text"/> ()
May TOWER contact you directly to clarify or gather information in relation to this application?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Specify daytime contact no.	<input type="text"/> ()	Best time of day to call	<input type="text"/> am <input type="text"/> pm

6. 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
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

7(A). DISABILITY INCOME INSURANCE DETAILS

Name of Life to be insured Date of Birth / /

Cover type	Waiting period (days)
<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver	<input type="checkbox"/> 14 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 360 <input type="checkbox"/> 720
Premium type	Benefit period
<input type="checkbox"/> Stepped <input type="checkbox"/> Level	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> 10 years <input type="checkbox"/> Age 60 <input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70
Additional benefits required (please ✓ if required)	
<input type="checkbox"/> Accident Benefit <input type="checkbox"/> Increasing Claim <input type="checkbox"/> Medical Catastrophe <input type="checkbox"/> Indemnity	
Annual Benefit \$ <input type="text"/>	Instalment premium \$ <input type="text"/>

7(B). OPTIMAL INCOME INSURANCE DETAILS

Annual Benefit \$ **Instalment premium** \$

7(C). BUSINESS EXPENSES INSURANCE DETAILS

Cover type	Waiting period (days)	Additional benefits required (please ✓ if required)
<input type="checkbox"/> Platinum <input type="checkbox"/> Gold	<input type="checkbox"/> 14 <input type="checkbox"/> 30	<input type="checkbox"/> Accident Benefit <input type="checkbox"/> Leasepay Benefit
Address of premises <input type="text"/>	Postcode <input type="text"/>	
Annual Benefit \$ <input type="text"/>	Instalment premium \$ <input type="text"/>	
Leasepay sum insured \$ <input type="text"/>	Term of lease <input type="text"/> years	

8. TERM INSURANCE (ORDINARY PRODUCT AVAILABLE FOR PERSONAL, BUSINESS AND SELF MANAGED SUPER FUNDS)

Please enter the sum insured for the type of policy and tick ✓ the additional benefits that you require.

Type of Policy/Benefit	Life 1	Life 2
Term Insurance	\$ <input type="text"/>	\$ <input type="text"/>
Line of Cover(s)	<input type="checkbox"/>	<i>NOTE: Line of cover is not available under 'First To'</i>
Waiver of Premium on Total Disability	<input type="checkbox"/>	<input type="checkbox"/>
Guaranteed Future Insurability	<input type="checkbox"/>	<i>NOTE: Guaranteed Future Insurability is not available under 'First To'</i>
Children's Future Insurability <i>(Indicate no. of children and attach a personal statement for each child)</i>		
Total and Permanent Disability	\$ <input type="text"/>	\$ <input type="text"/>
Line of Cover	<input type="checkbox"/>	<i>NOTE: Line of cover is not available under 'First To'</i>
Double TPD	<input type="checkbox"/>	<input type="checkbox"/>
Own Occupation	<input type="checkbox"/>	<input type="checkbox"/>
Medical Catastrophe	\$ <input type="text"/>	\$ <input type="text"/>
Advance Payment for Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Medical Catastrophe Buy-back Option	<input type="checkbox"/>	<input type="checkbox"/>
Children's Medical Catastrophe Benefit	<input type="checkbox"/>	<input type="checkbox"/>

Disability Income discount *Please select if you are applying for or have an existing TOWER Partner Insurance Portfolio or earlier PrefSure Disability Income Policy.*

Premium Type Stepped Level **Instalment premium** \$

9. PARTNER SUPERANNUATION TERM INSURANCE (OWNED BY THE TRUSTEE OF THE PARTNER SUPERANNUATION FUND)

PARTNER SUPERANNUATION TERM INSURANCE IS NOT AVAILABLE UNDER A FIRST TO POLICY STRUCTURE.

Please enter the sum insured for the type of policy and tick the additional benefits that you require.

Type of Policy/Benefit	Life to be insured
Term Insurance	\$
<i>In order to be eligible to apply for cover under a Superannuation Term Insurance Policy owned by the Partner Superannuation Fund, you must be prepared to quote your Tax File Number to the Trustee. This can be done at page 25 (Section 34) of this Application.</i>	
Waiver of Premium on Total Disability	<input type="checkbox"/>
Guaranteed Future Insurability	<input type="checkbox"/>
Total and Permanent Disability	\$
Double TPD	<input type="checkbox"/>

Disability Income discount Please select if you are applying for or have an existing TOWER Partner Insurance Portfolio or earlier PrefSure Disability Income Policy.

Premium Type Stepped Level

Instalment premium \$

10. STAND ALONE MEDICAL CATASTROPHE INSURANCE

Please enter the sum insured for the type of policy and tick the additional benefits that you require.

Type of Policy/Benefit	Life 1	Life 2
Medical Catastrophe Insurance	\$	\$
Children's Medical Catastrophe Benefit <i>(Indicate no. of children and attach a personal statement for each child)</i>		
Advance Payment for Cancer Option	<input type="checkbox"/>	<input type="checkbox"/>
Medical Catastrophe Buy-back Option	<input type="checkbox"/>	<input type="checkbox"/>
Waiver of Premium on Total Disability	<input type="checkbox"/>	<input type="checkbox"/>
Linking <i>(reduces benefit payable under Partner Superannuation Term and Partner Term policy if applicable)</i>	<input type="checkbox"/>	NOTE: Linking is not available under 'First To'
Total and Permanent Disability	\$	\$
Own Occupation	<input type="checkbox"/>	<input type="checkbox"/>

Premium Type Stepped Level

Instalment premium \$

11. STAND ALONE TPD

Please enter the sum insured for the type of policy and tick the additional benefits that you require.

Type of Policy/Benefit	Life 1	Life 2
Total and Permanent Disability	\$	\$
Waiver of Premium on Total Disability	<input type="checkbox"/>	<input type="checkbox"/>
Linking <i>(reduces benefit payable under Partner Superannuation Term and Partner Term policy if applicable)</i>	<input type="checkbox"/>	NOTE: Linking is not available under 'First To'
Own Occupation	<input type="checkbox"/>	<input type="checkbox"/>

Premium Type Stepped Level

Instalment premium \$

12. SUPERANNUATION

(THIS SECTION IS ONLY TO BE COMPLETED FOR APPLICATIONS FOR MEMBERSHIP TO THE PARTNER SUPERANNUATION FUND)

LINKED POLICIES (if applicable)

I hereby agree that my benefits in respect of my membership of the Partner Superannuation Fund may be reduced by any benefit amounts paid under a linked Medical Catastrophe Insurance Policy and/or a linked Stand Alone Total and Permanent Disablement Policy.

Agree Not relevant to this application

DECLARATION

I hereby apply for membership of the Partner Superannuation Fund and agree to be bound by the provisions of the Trust Deed and Rules of the Fund.

- At the date of this application, I am an Eligible Person. In the Trust Deed, "Eligible Persons" is defined to mean a person who: "is engaged in any gainful business, trade, profession, vocation, calling, occupation or employment."
- I will notify the Trustee in writing immediately if, at any time, I cease to be an "Eligible Person".
- I understand that the absolute owner of the Policy on my life is TOWER Australia Superannuation Limited: the Trustee of the Fund and that I cannot deal with the Policy in any way (except in special approved circumstances).

	Signature of life (lives) to be insured	Date	Signature of witness(es)	Date
1	X	/ /	X	/ /
2	X	/ /	X	/ /

ELECTION OF NOMINATED BENEFICIARY

I hereby apply that the benefit payable on my death under this Policy shall be paid as specified below:

	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
Life 1		/ /		
	Address			
		/ /		
	Address			
		/ /		
	Address			

BINDING NOMINATIONS DECLARATION BY WITNESSES

If you want the above nominations to be legally binding, please have 2 witnesses sign below.

In accordance with superannuation legislation, two witnesses must sign to validate a binding nomination.

I hereby declare that this Application was signed by the member in the presence of both witnesses. I declare that I am at least 18 years old and I am not a person nominated on page 7.

	Signature of witness(es)	Name of witness(es)	Date
1	X		/ /
2	X		/ /

NOTES ON NOMINATION OF BENEFICIARY

The Nominated Beneficiary must be a Dependant of the Nominator within the meaning of the Trust Deed. Dependant means: The spouse or child of the Member; or any other person, who in the opinion of the Trustee, is or was wholly or in part dependant on the Member at the time of the happening of the event and any person defined as a "dependant" under Superannuation Law. In making this nomination, I am aware that if no valid binding nomination exists, the decision as to which dependant is to receive any benefit on my death is at the sole discretion of the Trustee and that this nomination is in no way binding upon the Trustee.

13. SUPERANNUATION

(TO BE COMPLETED BY THE TRUSTEE OF A SUPERANNUATION FUND OTHER THAN THE PARTNER SUPERANNUATION FUND)

DECLARATION

It is agreed and declared that the Trustee shall be bound by the terms and conditions of the Policy issued pursuant to this application and that the Trustee is empowered under the Trust Deed to enter into an insurance contract with TOWER Australia Limited. It is further declared that the most recent statutory compliance notice confirms the Fund's complying status and that the Fund will be administered to ensure its continued compliance with superannuation legislation.

Signed by (insert name of company Trustee and ACN)

Pursuant to s127(1) of the Corporations Act 2001

Signature of applicant (Director)

Date

Signature of applicant (Director/Secretary)

Date

OR INDIVIDUAL TRUSTEES

Signature of Trustee

Date

Signature of Trustee

Date

14. BENEFICIARY NOMINATION

(NON-SUPERANNUATION - NOT APPLICABLE FOR FIRST TO POLICIES AND POLICIES OWNED BY A SELF MANAGED SUPER FUND)

I hereby nominate the following individual(s) or entities to receive the specified proportion(s) of the death benefit. I understand that I can revoke or change any nomination at any time by notice in writing to TOWER Australia Limited.

Life 1	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
		/ /		
	Address			
	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
		/ /		
Life 2	Address			
	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
		/ /		
	Address			
Life 2	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
		/ /		
	Address			
	Full Name of nominated Beneficiary	Date of Birth	Relationship to member	Proportion of Benefit
		/ /		
Address				

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PERSONAL STATEMENT - LIFE TO BE INSURED NO.1

(THIS SECTION MUST BE COMPLETED BY THE LIFE TO BE INSURED)

15. OCCUPATION DETAILS (FOR DISABILITY INCOME INSURANCE ONLY)

(A) What is your Occupation?

(B) Hours worked per week (C) Number of years in industry

(D) Qualifications (relevant in your occupation)

(E) Specify the duties of your occupation including any manual duties, lifting, driving, etc.

Duty	Time
	%
	%
	%
	%
	%
	%

(F) Name of present employer or business

(G) Nature of business or industry

Business address Postcode

(H) Date commenced current employment /business venture / /

(I) Are you self employed?

No Yes Specify number of employees

Income producing Non-income producing

If you are self employed, what percentage of the business do you own? %

(J) Please give details of previous occupations or jobs that you have had over the last 5 years.

Date from	Date to	Occupation	Industry	Name of employer
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			

(K) Does your occupation include any hazardous duties such as working at heights or with explosives? No Yes Please give details

(L) Do you intend to change your occupation? No Yes Please give details

Type of new occupation Date of intended change / /

(M) Do you have a second occupation? No Yes Please give details about your second occupation below

Details of second occupation including duties

Annual income \$ Hours per week

16. INCOME DETAILS (FOR DISABILITY INCOME INSURANCE ONLY)

(A) What is your annual earned income (*net of business expenses, but before tax*) from your **main occupation**?

Current year	\$	Last year ended 30/06/	YY	\$	
Previous year ended 30/06/	YY	\$	Prior year ended 30/06/	YY	\$

(B) Give details of any "packaged" items e.g. superannuation, group salary continuance, telephone, motor vehicle leasing/running costs, income splitting, regular bonuses

Item	Amount
	\$
	\$
	\$
	\$
Total	\$

(C) Will your income continue if you are disabled?

No Yes Please give details below including the amount, type of income and for how long
e.g. sick leave 35 days; GSC \$3,000 per month for 2 years

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(D) Have you ever been declared bankrupt or entered into an arrangement under the Bankruptcy Act?

No Yes Please also complete the separate Bankruptcy Statement. **Proof of income may be required.**

17. BUSINESS EXPENSES INSURANCE DETAILS

(A) List your share of total ANNUAL BUSINESS expenses

Accounting and audit fees	\$
Business insurance premiums (<i>fire, liability, professional indemnity etc</i>)	\$
Council rates and taxes	\$
Depreciation of business equipment	\$
Leasing - specify e.g. MV, business equipment	\$
Locum - net cost	\$
Mortgage interest repayments	\$
Rent (business premises)	\$
Salaries including payroll tax, etc (<i>non-income producing employees only</i>)	\$
Subscriptions to professional organisations	\$
Telephone	\$
Utilities (<i>e.g. electricity, gas, water, cleaning</i>)	\$
Other expenses (specify)	\$
	\$
Total	

(B) What proportion of total business income is derived from your personal exertion?	%
(C) What amount of total business expenses are you responsible for?	\$
(D) What was the profit before tax in the last financial year of the business?	\$

18. OTHER INSURANCE DETAILS

Tell us about your other insurance. If you answer "Yes" to any of these questions, give details in the table below.

(A) Have you ever held or applied for any life, disability or trauma insurance that has been refused, postponed, loaded, restricted or dealt with adversely in any way?	<input type="checkbox"/> No <input type="checkbox"/> Yes
(B) Have you ever claimed on any type of trauma, sickness, accident or workers' compensation insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes
(C) Do you have any existing, or are you currently applying for life, disability or trauma insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes

If you answer "Yes" to any of questions (A) - (C), give details in the table below.

No.	Name of company	Cover type	Sum insured	Comments	To be replaced?
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> 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.

19. PASTIMES AND TRAVEL

(A) Do you engage in any hazardous activities or sports e.g. football, scuba diving, motor racing, rock climbing or aviation other than as a fare paying passenger travelling over recognised routes?

No Yes Please make sure you also complete the separate "Sports and Pastimes" or "Aviation" statement on pages 19 and 20.

(B) Do you intend to travel, reside or work overseas **in the future**?

No Yes Please give details about your travels below

Destination(s)	<input type="text"/>	
When	<input type="text"/>	For how long? <input type="text"/>
Reason for travel	<input type="text"/>	

20. DOCTOR'S DETAILS

(A) Please give details of your **usual doctor OR of the last doctor you attended** if you do not have a regular G.P.

Name of doctor	<input type="text"/>		
Address of doctor	<input type="text"/>		
Doctor's phone number	(<input type="text"/>) <input type="text"/>	Doctor's fax number	(<input type="text"/>) <input type="text"/>
How long have you been a patient of this doctor?	<input type="text"/> yrs	mths	Date of last consultation <input type="text"/> / <input type="text"/> / <input type="text"/>

Specify the reason for, and the result of, your last consultation

<input type="text"/>
<input type="text"/>
<input type="text"/>

(B) If you have attended this doctor for less than 12 months, specify the name and address of your previous doctor

<input type="text"/>
<input type="text"/>
<input type="text"/>

21. DETAILS OF YOUR HABITS

(A) Please give details of your alcohol consumption habits

I drink alcohol <input type="checkbox"/> I do not drink alcohol, but I used to <input type="checkbox"/>	Type <i>(e.g. wine, beer)</i>	
I have never drunk alcohol <input type="checkbox"/>	Specify quantity <i>(e.g. 3 glasses, 1 bottle)</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly

(B) Please give details of your smoking habits (including tobacco and other substances)

I smoke <input type="checkbox"/> I do not smoke, but I used to <input type="checkbox"/>	Type	
I have never smoked <input type="checkbox"/>	Daily quantity smoked	
	Date stopped smoking <i>(if applicable)</i>	/ /

(C) Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs?

No Yes Please give details

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22. FAMILY HISTORY

Has any of your **immediate family** (living or deceased) suffered from ANY of the following:

- Diabetes
- Stroke
- Kidney disease
- Haemophilia
- Heart Disease
- Cancer
- Haemochromatosis
- Familial Adenomatous Polyposis
- High blood pressure
- Mental disorder
- Huntington's disease
- Muscular dystrophy

Or from any other hereditary disease?

No Yes Please give details in the table below

Relationship	Condition <i>(for cancer and heart disease specify type/site)</i>	Approximate age when diagnosed	Age at death <i>(if applicable)</i>

23. 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 15. If Back/Neck or Asthma/Bronchitis, also complete the questionnaire(s) on pages 16 and/or 18.	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?	<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 15.

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.

(Section 23 continues on page 15)

25. BACK/NECK PAIN STATEMENT

(A) When did you first experience symptoms? /

(B) What was the reason for the onset of symptoms? (e.g. injury, degenerative disease, etc)

(C) Describe the location and severity of the pain (e.g. lower back; dull ache, sharp pain, severe pain, etc)

(D) Please advise all dates, lengths of time and the cause of any recurrences of symptoms.

(E) Are you currently experiencing any type of symptoms? (e.g. discomfort, pain, restriction of movement, etc)

No Date symptoms last experienced /

Yes Please give details

(F) Is your condition deteriorating?

No Yes Please give details

(G) Please list all treatment(s) received (e.g. physiotherapy, medication, exercises, etc), dates of treatment, and all tests carried out (e.g. X-rays). Include results if known.

(H) Has any surgery been planned or suggested?


No Yes Please give details

(I) Have you lost any time from work due to your back/neck problem?

No Yes Specify the number of times you have been off work, when and for how long?

(J) Please provide names and addresses of all people who have treated you for this condition. Advise if they are doctors, physiotherapists, chiropractors, etc.

(K) Please tick on the diagram, the area of your neck and/or back that is affected.

<input type="checkbox"/> Cervical Curve (7 vertebrae)	
<input type="checkbox"/> Thoracic Curve (12 vertebrae)	
<input type="checkbox"/> Lumbar Curve (5 vertebrae)	
<input type="checkbox"/> Sacrum (5 fused vertebrae)	
<input type="checkbox"/> Coccyx (4 fused vertebrae)	

26. ASTHMA STATEMENT

(A) When did you have your first episode of asthma?

(B) When did your most recent symptoms of asthma occur?

(C) How often do you experience symptoms (*e.g. daily, weekly*)?

(D) Do you use any form of medication?

No Yes Specify the type of medication and how often it is used.

(E) Has your peak flow been monitored?

No Yes Specify dates and results of your recent readings

(F) In the last 5 years, have you required steroid treatment (*e.g. prednisone, prednisolone*) for this condition?

No Yes Specify name of medication, dates and duration of treatment for all occurrences.

(G) Have you ever required hospital admission or emergency treatment for asthma?

No Yes Give full details including dates, names, and addresses of hospitals attended

(H) In the last 5 years, have you lost any time from work due to asthma?

No Yes Give details

(I) Please specify the name, address and approximate date(s) of consultation for any doctors that you have consulted.

27. AVIATION STATEMENT

(A) Please specify the type of Civil Aviation Safety Authority Licence you hold

(B) Do you land at **unauthorised** aerodromes, airports or landing areas?

No Yes Please give details

(C) Indicate the type of aircraft that you fly (tick all that apply)

Fixed wing Helicopter Ultralight/Microlight Glider Balloon Hang-glider/Paraglider

(D) Specify the number of hours flown in the following categories

Activity		Last 12 months		Next 12 months	
		Crew	Passenger	Crew	Passenger
Fixed Wing	Commercial airline				
	Charter				
	Private				
	Aero club/flying school				
	Agricultural				
Helicopter	Commercial airline				
	Charter				
	Private				
	Aero club/flying school				
	Agricultural				
	Ultralight/Microlight				
	Glider				
	Balloon				
	Hang-glider/Paraglider				

(E) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

(F) Have you ever had an accident or been charged with a violation of Department of Transport regulations?

No Yes Please give details

(G) Do you intend to change the scope of your present licence?

No Yes Please give details

28. SPORTS AND PASTIMES STATEMENT

SCUBA OR SKIN DIVING

(A) Specify diving qualifications held

Dive History	Depth in metres	Number of times per annum
Average Depth		
Maximum Depth		

(B) Do you use explosives while diving?

No Yes Give details

(C) Do you intend to change the scope of your diving activities?

No Yes Give details

(D) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

MOTORSPORTS (CAR, BIKE, BOAT)

(A) Specify type of motorsport and type of vehicle

Engine Size Maximum Speed

Times per annum Period

Type of competition Amateur Professional

(B) Specify type of events, categories of racing

(C) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

FOOTBALL

(A) Code of game played
e.g. rugby union/league, soccer

(B) Times per Annum

(C) Type of competition Amateur Professional

(D) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

MOUNTAIN CLIMBING/ABSEILING/CAVING

(A) Specify type of activity

(B) Times per Annum

(C) Location where activity is conducted Indoor Outdoor

(D) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

OTHER ACTIVITIES (E.G. BOXING, SKIING, BUNGY JUMPING, SKY DIVING)

(A) Specify type of activity

(B) Times per Annum

(C) Type of competition Amateur Professional

(D) Please specify additional information you think we may need to know. Include details of any injuries you have suffered.

30. DECLARATION BY POLICYOWNER AND LIFE TO BE INSURED

POLICY DECLARATION — PLEASE COMPLETE IN ALL INSTANCES

- I/We have received a copy of and read and understood the Product Disclosure Statement dated 28 May 2007, 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;
- 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.
- In the circumstances where I/we have applied for Stand Alone Medical Catastrophe Cover, benefits are only payable if the Life Insured survives for fourteen days after the Medical Catastrophe event (as defined). If the Life Insured dies within the fourteen day period, the policy will provide a death benefit of \$5,000 only.
- Medical Catastrophe Insurance is subject to specific definitions of medical conditions defined in the Policy Document. Some of these conditions require a degree of severity before a benefit is payable.
- I/We acknowledge and understand that where a Death Benefit or Terminal Illness Benefit becomes payable under a policy with multiple lives insured, then the payment will be made to the surviving policyowner(s).

Signature of Life to be insured 1	X	Date	/	/
Signature of Life to be insured 2	X	Date	/	/
Signature of Policy Owner 1	X	Date	/	/
Signature of Policy Owner 2	X	Date	/	/

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



TOWER Australia Limited
 ABN 70 050 109 450
 AFSL Number 237848
 TOWER Australian Superannuation Limited
 AFSL Number 237851
 RSE Licence Number L0000642
 PO Box 142, Milsons Point NSW 1565
 80 Alfred Street, Milsons Point NSW 2061
 Telephone 02 9448 9000
 Facsimile 1300 133 260

31. 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 221 142.

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 221 142.

32. 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. No Yes

I 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 of payment. No Yes

Signature of life to be insured Date

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

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 Date

34. TAX FILE NUMBER NOTIFICATION - LIFE TO BE INSURED NO.1 VIA FUND TRUSTEE OR EMPLOYER

IMPORTANT INFORMATION

Collection of tax file numbers is authorised by tax laws, the Superannuation Industry (Supervision) Act 1993 and the Privacy Act 1988. Changes to tax file number law require trustees to ask you to provide your tax file number to your superannuation fund. By completing this form and providing it to your fund will allow your fund trustee to use your tax file number for the purposes contained in the Superannuation Industry (Supervision) Act 1993 and for the purpose of paying eligible termination payments.

The purposes currently authorised include:

- taxing eligible termination payments at concessional rates;
- finding and amalgamating your superannuation benefits where insufficient information is available;
- passing your tax file number to the Australian Taxation Office where you receive a benefit or have unclaimed superannuation money after reaching the aged pension age; and
- allowing the trustee of your superannuation fund to provide your tax file number to a superannuation fund receiving any benefits you may transfer. Your trustee won't pass your tax file number to any other fund if you tell the trustee in writing that you don't want them to pass it on.

You are not required to provide your tax file number. Declining to quote your tax file number is not an offence. However, if you do not give your superannuation fund your tax file number, either now or later:

- you may pay more tax on your superannuation benefits than you have to (you will get this back at the end of the financial year in your income tax assessment); and
- it may be more difficult to find your superannuation benefits if you change address without notifying your fund or to amalgamate any multiple superannuation accounts.

The lawful purposes for which your tax file number can be used and the consequences of not quoting your tax file number may change in future, as a result of legislative change. For more information, please contact your fund or the ATO Superannuation Helpline (13 10 20).

NOTE: This form may only be used to quote a tax file number to a superannuation fund

FUND DETAILS

Fund Name	<input type="text"/>	Phone Number	(<input type="text"/>) <input type="text"/>
Fund address	<input type="text"/>		

EMPLOYER DETAILS (if applicable)

Employer's name	<input type="text"/>	Phone Number	(<input type="text"/>) <input type="text"/>
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MEMBER DETAILS

Title(s)	<input type="text"/>	Given names(s)	<input type="text"/>
Surname	<input type="text"/>		
Postal address	<input type="text"/>		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Membership no. of superannuation fund (if known)	<input type="text"/>		

TAX FILE NUMBER DETAILS

It is not compulsory to quote your Tax File Number, however, TOWER has agreed with the Trustee of the Partner Superannuation Fund that you agreeing to quote your Tax File Number to the Trustee will be an eligibility criterion for cover under a Superannuation Term Insurance Policy through the Partner Superannuation Fund. This means that if you do not quote your Tax File Number, TOWER will not issue a Policy to the Trustee.

Do you agree to provide your tax file number

No Yes Please enter your tax file no. below

Signature of member

X

Date

/ /

Privacy laws protect your privacy. The way in which we collect, use, disclose and handle your information is described in our Privacy Statement. Please contact our Privacy Officer on 1800 221 142 if you have any additional questions or would like to request a copy of our Privacy Policy.

Please return the completed form to: **TOWER Australia Limited, PO Box 142 Milsons Point NSW 1565**

35. PAYMENT AUTHORISATION

POLICY DETAILS

Policy number Instalment premium \$
Frequency* Monthly Half yearly Yearly

PAYMENT OPTION 1 – PAY BY CREDIT CARD

Complete this section if you would like to pay for your insurance by credit card.

Type of payment to be made Initial payment only All payments Debit date / /
Type of credit card MasterCard Visa
Credit card number Expiry date /
Cardholder's name
Cardholder's Signature X Date / /

PAYMENT OPTION 2 – PAY BY DIRECT DEBIT REQUEST

Complete this section if you would like to pay by direct debit from your nominated bank account.

Type of payment to be made Initial payment only All payments Debit date / /
I request that monies due in accordance with my payment arrangements be drawn under the Direct Debit System from my account with:
Name of financial institution
BSB number - Account number
Account name

I request you, until further notice in writing, to debit my account described with any amounts which TOWER Australia Limited ABN 70 050 109 450, User ID 245397 may debit or charge me through the direct debit system in terms of the payment arrangement made between us.

I acknowledge and agree that:

1. This Direct Debit Request ('DDR') is governed by the terms and conditions of the Direct Debit Service Agreement ('Agreement') as described overleaf.
2. By signing this DDR, I acknowledge that I am bound by all of the terms and conditions of the Agreement.

Signature of Account Holder 1 X Date / /
Signature of Account Holder 2 X Date / /

PAYMENT OPTION 3 – PAY BY CHEQUE

Tick if you would like to pay for your insurance by cheque.

Please make cheques payable to "TOWER Australia" for the amount specified.

Note: We **will not** accept monthly payments by cheque.

36. DIRECT DEBIT SERVICE AGREEMENT

1. Agreement

If you sign the attached Direct Debit Request ("DDR") you agree that you have read this agreement and the DDR (together referred to as the "Agreement") and that the Agreement sets out all of the terms by which you authorise TOWER Australia Limited ("TOWER") to make debits to your account as described in the DDR ("your account").

2. Authority to Debit Your Account

- 2.1. If a premium falls due for payment to TOWER in accordance with the insurance policy you have agreed to purchase from TOWER ("premium(s)") TOWER may debit your account as specified in the DDR to the amount of that premium.
- 2.2. If a premium is payable on a day that the financial institution nominated in the DDR ("financial institution") is not open for business, the debit relating to the premium will be debited from your account on the next day that the financial institution is so open for business.
- 2.3. We will advise you, via your financial adviser, in writing, the details of the direct debit arrangements (amount, frequency, commencement date) at least 2 calendar days prior to the first drawing.

3. Your Obligations

- 3.1. You will ensure that there are sufficient funds available in your account to allow each debit under this Agreement to be made.
- 3.2. You represent to TOWER that you are authorised to operate your account without any other person's signature or authority.
- 3.3. You represent to TOWER that the financial institution at which your account is held makes a direct debit facility available in respect of your account and you represent that the details of your account in the DDR are correct.
- 3.4. You will promptly advise TOWER in writing if any of the details of your account change.
- 3.5. It is your responsibility to arrange with us a suitable alternate payment method if you wish to cancel the direct debit request.

4. Your Rights

- 4.1. You may terminate this Agreement at any time by giving written notice directly to us, or through your Financial Institution. Notice sent to us should be received by us at least 5 business days prior to the due date.
- 4.2. You may stop the payment of a drawing under this Agreement by giving written notice directly to us, or through your Financial Institution. Notice sent to us should be received by us at least 5 business days prior to the due date.
- 4.3. You may request to change the amount and/or frequency of a drawing under this Agreement by contacting us and advising us your requirements no less than 5 business days prior to the due date.

5. TOWER's Rights

- 5.1. If a debit is not made in accordance with this Agreement, TOWER shall not be liable for any direct, indirect or consequential loss or damage you or any other person may suffer.
- 5.2. If a debit cannot be made to your account in accordance with this Agreement or is returned unpaid, you agree to pay TOWER any fee or charge that TOWER incurs or imposes in connection with processing the debit or TOWER's attempt(s) to do so.
- 5.3. TOWER may terminate this agreement if one or more debits are returned unpaid by your nominated Financial Institution and to arrange with you an alternative payment method.

6. Termination and Variation

- 6.1. You may terminate this Agreement at any time by giving written notice directly to us, or through your Financial Institution. Notice sent to us should be received by TOWER at least 5 business days prior to the due date.
- 6.2. TOWER may change amount or frequency of drawings arrangement upon giving you 14 days written notice.

7. Confidentiality

- 7.1. Subject to Clause 7.2, TOWER will make all reasonable efforts to keep the information in the DDR secure.
- 7.2. We will keep all information pertaining to your nominated account at the Financial Institution, private and confidential.

8. Dispute Resolution

If you believe that a debit to your account has been incorrectly made under this Agreement; or if you wish to inquire of TOWER the reason for a proposed variation to a term of this Agreement or the value or frequency of the debit authorised by it:

- you may notify TOWER in writing, by letter addressed to:

The Company Secretary,
TOWER Australia Limited,
PO Box 142 Milsons Point NSW 1565; or

- lodge a Direct Debit claim through your Financial Institution.

