

Customer information form ACCELERATED PROTECTION POLICY

The details in this form must be submitted via Accelerate online.
Accelerate does not accept paper applications.

PLEASE NOTE: We regularly update the Accelerate underwriting rules to improve STP rates so please use the most recent version of this form. You can find the most recent version of the form on Accelerate online.

PERSONAL DETAILS

	LIFE INSURED 1	LIFE INSURED 2
Title	<input type="text"/>	<input type="text"/>
First name	<input type="text"/>	<input type="text"/>
Middle name	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Maiden name	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text" value=" / /"/>	<input type="text" value=" / /"/>
Gender	<input type="text"/>	<input type="text"/>
Height (cm or feet/inches)	<input type="text"/>	<input type="text"/>
Weight (kgs or stone/pounds)	<input type="text"/>	<input type="text"/>
Have you smoked tobacco or any other substance or used any nicotine containing product in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes' answer below		
• Smoked cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Daily quantity (number)	<input type="text"/>	<input type="text"/>
• Smoked cigars or pipe tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Smoked another substance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Used a nicotine containing product	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
On average, do you consume more than four standard drinks of alcohol per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard drink =		
• 1 nip spirits		
• 1 wine glass		
• 10oz/285ml beer		
Is this an increase to an existing Accelerated Protection Policy, or are you replacing an existing TOWER Australia Limited policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please enter the policy number (if known)	<input type="text"/>	<input type="text"/>
Please enter the sum insured (if known)	<input type="text" value="\$"/>	<input type="text" value="\$"/>

OCCUPATION DETAILS

LIFE INSURED 1

LIFE INSURED 2

Occupation

Do you have any other occupation?

 Yes No

 Yes No

Other occupation (if applicable)

Do any of your occupation duties require you to go underground, offshore, handle or transport hazardous materials or are you a member of the Armed Forces?

 Yes No

 Yes No

If 'Yes', was this information known at quote stage?

 Yes No

 Yes No

If applying for Life or Life and Critical Illness, go straight to INCOME DETAILS

If applying for Life and TPD or Income Protection, complete remaining OCCUPATION DETAILS

How many hours (on average) do you work per week?

How many weeks (on average) do you work per year?

Please describe the principal duties of your occupation and percentage of time in each (eg: office work – 80%, sales – 10%, supervision – 10%)

 %

 %

 %

 %

 %

 %

What percentage of your duties involves manual work (including driving or lifting)?

 %

 %

Please provide your current employer's or your business name and street address

Are you self employed? (Answer 'Yes' if you are a business owner, sole trader, an employee of own company or trust, or in a partnership)

 Yes No

 Yes No

If 'No', go to INCOME DETAILS

What is your share of the business or partnership?

 %

 %

How many employees do you have (excluding yourself and your spouse)?

What percentage of your work is done from home?

 %

 %

If answer is over 50%, please complete below.

What percentage of your work requires face to face meetings (customers coming to your residence or you visiting theirs)?

 %

 %

Has your occupation or employment status changed in the last two years?

 Yes No

 Yes No

Has your occupation itself changed?

 Yes No

 Yes No

Have you had continuous employment in the last 2 years?

 Yes No

 Yes No

Do you have a written contract of employment lasting at least 12 months or are you subcontracting back to your previous employer?

Yes No

Yes No

How many times have you changed jobs in the last 5 years?

Would you like the newly self employed clause to apply to this policy? (Applicable to IP only)

Yes No

Yes No

Do you intend to change your occupation, duties or employment status or take extended leave in the next 12 months? (Applicable to IP only)

Yes No

Yes No

Depending on the answers provided, this application may be referred to underwriting. Additional information provided in the Notes section will help in the assessment. Please consider including an employment history for the last five years, any qualifications your customer has, how work is sourced (if self employed), the reasons for any breaks in employment, etc.

INCOME DETAILS

- Answer **A** only if the customer is applying for Life/Total and Permanent Disablement/Critical Illness with sum insured >\$500,000
- Start at **B**, ignore C and complete D and E if your customer is applying for Income Protection is not self employed
- Start at **C**, complete D and E if your customer is applying for Income Protection and is self employed
- For newly self employed customers, please refer to the Adviser Guide for guidelines

LIFE INSURED 1

LIFE INSURED 2

A What is your current annual income before tax?

\$

\$

Current annual income means your gross income (less any business expenses) before tax is deducted earned for the current tax year. It should not include investment income.

B What was your gross annual income from personal exertion?

Current tax year \$

Current tax year \$

(Annual income means your gross income (before tax is deducted) earned from your personal exertion. It includes salary or wages, fees, regular earned commissions, regular bonuses, regular overtime payments, superannuation and any other packaged fringe benefits (such as a motor vehicle). It does not include investment income.)

Last tax year \$

Last tax year \$

C a: What was your gross business income (turnover)

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

b: What were your business expenses

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

c: What was your total net business income before tax (net profit) (if a loss, include minus sign)

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

d: What was your share of net business income

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

e: State any salary/wages/director's fees/superannuation paid to you or your non-working spouse (not included above)

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

f: Total personal earned income (d+e)

Last tax year \$

Last tax year \$

Previous tax year \$

Previous tax year \$

D In the event of your disablement, would your income continue for more than 90 days (excluding other insurance or worker's compensation)?

Yes No

Yes No

E Have you ever been declared bankrupt, or had a business placed into receivership or liquidation within the last five years?

Yes No

Yes No

RISK ASSESSMENT – Part 1

LIFE INSURED 1

LIFE INSURED 2

PLEASE COMPLETE FOR LIFE, CRITICAL ILLNESS AND TPD

Excluding this application, are you retaining or applying for Life, Critical Illness or Total and Permanent Disability insurance with TOWER or another insurer?

Yes No

Yes No

If 'Yes'

Will the total amount of cover in force on your life (including this application) exceed \$750,000?

Yes No

Yes No

Is the other insurance on your life held under employer sponsored superannuation only?

Yes No

Yes No

PLEASE COMPLETE FOR INCOME PROTECTION

Excluding this application, are you retaining or applying for Income Protection insurance with TOWER or another insurer?

Yes No

Yes No

If 'Yes'

Does your existing insurance have a maximum benefit period of two years?

Yes No

Yes No

PLEASE ADVISE DETAILS OF INSURANCE BEING RETAINED HERE:

What type of policy is it and what is the purpose of the cover?

What is the insured amount and what benefits are on the policy?

What company is the insurance with?

Have you ever had any application for Life, Critical Illness, Total and Permanent Disablement or Income Protection declined, deferred, modified or offered on non-standard terms?

Yes No

Yes No

If 'Yes' please complete fields to the right and those below. You will enter these details towards the end of the online application.

Declined Loading/Extra premium
 Benefits Reduced Deferred
 Limited Exclusions Term of Plan

Declined Loading/Extra premium
 Benefits Reduced Deferred
 Limited Exclusions Term of Plan

Date

/ /

/ /

Company

Reason

Have you ever received compensation payments for an accident, sickness or disability or are you currently making a claim?

Yes No

Yes No

If 'Yes' please complete below. You will enter these details towards the end of the online application.

Who did you receive or are you receiving compensation from?

LIFE INSURED 1

LIFE INSURED 2

When was this claim made?

How long did you receive benefits for or are benefits continuing to be paid? What condition did you claim for?

Are you a citizen or permanent resident of Australia or New Zealand?

 Yes No

 Yes No

If 'No', please complete below. You will enter these details towards the end of the online application.

How long have you lived in Australia

 years months

 years months

What are your plans for obtaining permanent residency and when is this likely to be granted?

What type of visa do you have and what is its expiry date?

 / /
 / /

In what country were you born?

What is your nationality or what other countries do you have residency/citizenship rights in?

In the next 12 months, do you have any plans to live overseas or are you currently living outside Australia?

 Yes No

 Yes No

If 'Yes' please complete below. You will enter these details towards the end of the online application.

Please provide full details of the country you will be residing in and the purpose of being there.

In the next 12 months, do you have plans to travel overseas?

 Yes No

 Yes No

If 'Yes' please complete fields to the right and those below. You will enter these details towards the end of the online application.

Date leaving	/	/
Date returning	/	/
Countries to be visited		
Reasons for Trip:		

Date leaving	/	/
Date returning	/	/
Countries to be visited		
Reasons for Trip:		

Do you, or are you likely to, take part in any hazardous sports, pastimes or activities?

 Yes No

 Yes No

RISK ASSESSMENT – Part 1 continued

LIFE INSURED 1

LIFE INSURED 2

If 'Yes' please complete below.
You will enter these details towards
the end of the online application.

How long have you been doing this?	Years	Months	Years	Months
What do you participate in or intend to participate in?				
Qualifications?				
Professional or amateur?				
How often do you do this?				
Geographic location?				

RISK ASSESSMENT – Part 2

LIFE INSURED 1

LIFE INSURED 2

Have your natural parents, brothers or sisters been diagnosed with or died before the age of 60 from any of the following:

• Heart disease (e.g. angina, heart attack) or stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Cardiomyopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Breast or ovarian cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Bowel cancer or polyposis of the colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Alzheimer's disease, Huntington's chorea, multiple sclerosis, Parkinson's disease, polycystic kidney disease or any hereditary disorder? (circle relevant condition)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If 'Yes' please advise number of relatives and age(s) affected		
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RISK ASSESSMENT – Part 3

LIFE INSURED 1

LIFE INSURED 2

Do you have or have you ever had any of the following medical conditions?
If 'Yes', please provide the relevant condition(s) in the corresponding field.

a. Any disorder of the heart, circulatory problem or chest pain (including high blood pressure, stroke, brain haemorrhage, embolism or raised cholesterol)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Diabetes or raised blood sugar levels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Any disorder of the kidney, bladder or genitourinary system (including prostate disorders, urinary tract infections, blood or protein in the urine)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, haemochromatosis, colitis or Crohn's disease)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

LIFE INSURED 1

LIFE INSURED 2

e. Any benign or malignant cancer, tumour, lump, skin lesion, cyst or growth of which you are aware or for which you have sought medical advice or treatment?

Yes No

Yes No

f. Asthma, bronchitis, sleep apnoea or respiratory disorder?

Yes No

Yes No

g. Head injury, epilepsy, fits, convulsions

Yes No

Yes No

h. Numbness, tingling, altered sensation, tremor, double vision or problems with balance or co-ordination?

Yes No

Yes No

i. Any form of paralysis or multiple sclerosis?

Yes No

Yes No

j. Any disorder of the eyes or ears, including blurred or double vision (other than sight problems corrected by glasses or contact lenses) or impaired hearing or tinnitus?

Yes No

Yes No

k. Back or neck pain (including sciatica)?*

Yes No

Yes No

l. Any joint, bone or muscle pain or disorder (including RSI)?*

Yes No

Yes No

m. Rheumatoid arthritis, other forms of arthritis or gout?

Yes No

Yes No

n. Any blood disorder or anaemia?

Yes No

Yes No

o. Any thyroid disorder?

Yes No

Yes No

p. Eczema, dermatitis, psoriasis or any other skin condition?*

Yes No

Yes No

q. Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, post natal depression or any other mental or nervous disorder?

Yes No

Yes No

r. FEMALES ONLY: Any disorder of the cervix, ovary, uterus, breast or endometrium, or are you currently pregnant?

Yes No

Yes No

s. Have you ever used illegal drugs or received advice and/or counselling for excess alcohol consumption from any health professional?

Yes No

Yes No

*Not required to be answered for life and critical illness cover

t. Have you ever tested positive for HIV/AIDS, Hepatitis B or C, or are you awaiting the results of such a test (other than for this application)?

LIFE INSURED 1

Yes No

LIFE INSURED 2

Yes No

u. Have you ever engaged in male to male sexual activity or had sexual intercourse with someone you know or suspect to be HIV positive?

Yes No

Yes No

v. Have you in the last five years been absent from work or your usual duties for a period of more than five days through any illness or injury not previously disclosed in this application?

Yes No

Yes No

w. Do you have any symptoms of illness, any physical defect, or any condition for which you seek medical advice or treatment not already disclosed?

Yes No

Yes No

x. In the last two years, have you had medication prescribed (except contraceptives or antibiotics) or have you had any medical investigation or test (e.g. genetic test, colonoscopy, or ultrasound) for any condition that you haven't already disclosed?

Yes No

Yes No

y. Do you plan to seek medical advice, investigation or treatment for any other current health condition not already disclosed?

Yes No

Yes No

DOCTOR INFORMATION

Do you have a GP or medical practice that you usually attend?

LIFE INSURED 1

Yes No

LIFE INSURED 2

Yes No

If 'Yes', please complete below.

Name of Dr/medical practice

Address line 1

Address line 2

Suburb

State

Postcode

Telephone number

How long have you been attending this GP or practice?

_____ years _____ months

_____ years _____ months

When was the last consultation?

_____ / _____ / _____

_____ / _____ / _____

LIFE INSURED DETAILS

	LIFE INSURED 1	LIFE INSURED 2
Address line 1	<input type="text"/>	<input type="text"/>
Address line 2	<input type="text"/>	<input type="text"/>
Suburb	<input type="text"/>	<input type="text"/>
State	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Country	<input type="text"/>	<input type="text"/>
Home phone number	<input type="text"/>	<input type="text"/>
Work phone number	<input type="text"/>	<input type="text"/>
Mobile phone number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>

POLICY OWNER DETAILS

Only complete if these details are different from the life insured details

	POLICY OWNER 1	POLICY OWNER 2
Owner type	<input type="checkbox"/> Other <input type="checkbox"/> Trustee <input type="checkbox"/> Company <input type="checkbox"/> TOWER Superannuation	<input type="checkbox"/> Other <input type="checkbox"/> Trustee <input type="checkbox"/> Company <input type="checkbox"/> TOWER Superannuation
Title	<input type="text"/>	<input type="text"/>
First name/Trust name/Company name	<input type="text"/>	<input type="text"/>
Surname/ABN	<input type="text"/>	<input type="text"/>
Address line 1	<input type="text"/>	<input type="text"/>
Address line 2	<input type="text"/>	<input type="text"/>
Suburb	<input type="text"/>	<input type="text"/>
State	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Country	<input type="text"/>	<input type="text"/>
Home phone number	<input type="text"/>	<input type="text"/>
Work phone number	<input type="text"/>	<input type="text"/>
Mobile phone number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>
TFN	<input type="text"/>	<input type="text"/>

DEATH BENEFIT NOMINATION

LIFE INSURED/POLICY OWNER 1

LIFE INSURED/POLICY OWNER 2

Would you like to make a death benefit nomination?

Yes No

Yes No

If 'Yes', please complete below.

You can nominate up to five beneficiaries, the total percentage share must be 100%.

Title

First name of beneficiary

Surname of beneficiary

Address line 1

Address line 2

Suburb

State

Postcode

Country

Relationship to proposed insured

Spouse Child
 Legal representative
 Person financially dependent
 Person with interdependency relationship

Spouse Child
 Legal representative
 Person financially dependent
 Person with interdependency relationship

Date of birth (dd/mm/yyyy)

/ /

/ /

Percentage share

%

%

Title

First name of beneficiary

Surname of beneficiary

Address line 1

Address line 2

Suburb

State

Postcode

Country

Relationship to proposed insured

Spouse Child
 Legal representative
 Person financially dependent
 Person with interdependency relationship

Spouse Child
 Legal representative
 Person financially dependent
 Person with interdependency relationship

Date of birth (dd/mm/yyyy)

/ /

/ /

Percentage share

%

%

If you need to add details for another beneficiary, please add it to the Additional notes page.

PAYMENT DETAILS

	LIFE INSURED/POLICY OWNER 1	LIFE INSURED/POLICY OWNER 2
Payment method	<input type="checkbox"/> Direct debit <input type="checkbox"/> Visa <input type="checkbox"/> MC	<input type="checkbox"/> Direct debit <input type="checkbox"/> Visa <input type="checkbox"/> MC
Frequency	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
DIRECT DEBIT		
Name of bank or credit union	<input type="text"/>	<input type="text"/>
Branch	<input type="text"/>	<input type="text"/>
Account name	<input type="text"/>	<input type="text"/>
BSB	<input type="text"/>	<input type="text"/>
Account number	<input type="text"/>	<input type="text"/>
Preferred payment date (between 1–28 of month)	<input type="text"/>	<input type="text"/>
CREDIT CARD		
Name on card	<input type="text"/>	<input type="text"/>
Card number	<input type="text"/>	<input type="text"/>
Expiry date (mm/yy)	<input type="text"/>	<input type="text"/>
BILLING ADDRESS		
Address line 1	<input type="text"/>	<input type="text"/>
Address line 2	<input type="text"/>	<input type="text"/>
Suburb State	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>

HANDOVER FOR TELE-UNDERWRITING

	LIFE INSURED/POLICY OWNER 1	LIFE INSURED/POLICY OWNER 2
Time 1	<input type="checkbox"/> 9am–12noon <input type="checkbox"/> 12pm–3pm	<input type="checkbox"/> 9am–12noon <input type="checkbox"/> 12pm–3pm
Telephone number 1	<input type="text"/>	<input type="text"/>
Time 2	<input type="checkbox"/> 9am–12noon <input type="checkbox"/> 12pm–3pm	<input type="checkbox"/> 9am–12noon <input type="checkbox"/> 12pm–3pm
Telephone number 2	<input type="text"/>	<input type="text"/>

ADDITIONAL MEDICAL QUESTIONNAIRES

Collecting the information in the following questionnaires (where applicable) will assist in completing Level 2 questions for these common conditions.

HIGH BLOOD PRESSURE QUESTIONNAIRE

	LIFE INSURED 1	LIFE INSURED 2
Have you ever been advised to take or been on medication for blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Did your treatment commence within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Was this condition diagnosed within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Was it treated by diet and/or exercise only?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Are you currently on medication for blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does a health professional check your blood pressure two or more times per year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you ever been told you had any problem or complication with your heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you ever had or been diagnosed with abnormalities in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What was your most recent blood pressure reading?	<input type="checkbox"/> Less than 140/90 <input type="checkbox"/> More than 140/90 <input type="checkbox"/> Unsure	<input type="checkbox"/> Less than 140/90 <input type="checkbox"/> More than 140/90 <input type="checkbox"/> Unsure

CHOLESTEROL QUESTIONNAIRE

	LIFE INSURED 1	LIFE INSURED 2
Have you ever been advised to take or been on medication for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Did your treatment commence within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Was this condition diagnosed within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Are you currently on medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Did you cease the medication on the advice of your medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does a health professional check this condition 2 or more times per year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Was your most recent total cholesterol reading less than 6.0 mmol/l?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

ASTHMA QUESTIONNAIRE

Was this childhood asthma only from which a full and complete recovery has been made?

Yes No

Yes No

Within the last 2 years, have you required more than one week off work, had emergency treatment or been admitted to hospital for this condition?

Yes No

Yes No

Within the last 2 years, have you required steroid tablets on more than one occasion?

Yes No

Yes No

How often would you experience symptoms (such as coughing, wheezing, shortness of breath or chest tightness)?

Daily Weekly
 Monthly Seasonal
 No symptoms for more than two years

Daily Weekly
 Monthly Seasonal
 No symptoms for more than two years

Do you experience symptoms at night time or upon wakening (such as coughing, wheezing, shortness of breath or chest tightness) more than once a week?

Yes No

Yes No

Are your symptoms exacerbated by your occupation or working conditions?

Yes No

Yes No

ADDITIONAL NOTES

Blank area for additional notes.

SIGNATURES

Although PMAR's are rarely requested for Accelerate customers, if you feel one may be required, please have the Life Insured complete the Medical Evidence Authority below and retain for your records.

The Third Party Ownership Declaration must be completed if the Accelerated Protection Policy Income Plan is to have a Policy Owner other than the Life Insured. Please forward this to the Accelerate Resource Team.

MEDICAL EVIDENCE AUTHORITY

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.

Application Number	<input type="text"/>	
Life Insured Name	<input type="text"/>	
Life Insured Date of Birth	<input type="text"/>	
Signature of Life Insured	<input type="text"/>	Date <input type="text" value="/ /"/>

THIRD PARTY OWNERSHIP DECLARATION

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

"If a claim becomes payable under the Income Plan, I (the Policy Owner) request that the payment be made to the Life Insured on my behalf"

Application Number	<input type="text"/>	
Signature of Life Insured	<input type="text"/>	Date <input type="text" value="/ /"/>
Signature of Policy Owner	<input type="text"/>	Date <input type="text" value="/ /"/>

