TOWER

APPLICATION
| For Increase on Classic Superannuation Investments |

Existing Member No:

TOWER Australia Limited ABN 70 050 109 450
Registered Office 80 Alfred Street Milsons Point NSW 2061

All Classic Superannuation policies are closed to New Business, however, they are eligible for increases:
Increases can only be applied for on existing benefits.

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.

1. APPLICATION SUMMARY

REQUEST FOR ALTERATION ☐ Increase Benefit Amount

NAME OF PRODUCT

2. MEMBER (THESE DETAILS MUST BE THE SAME AS THE EXISTING POLICY.)

MEMBER
Title
Surname
Given Names

ADDRESS
Street Address
Suburb
State
Postcode

PHONE NO.
Home ( )
Business ( )
Mobile
Email

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

☐ Yes
☐ No

3. LIFE INSURED DETAILS

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

4. ALTERATIONS

TERM	Increase Benefit Amount by:	$
	Total Benefit Amount (existing + increase amount)	$
TOTAL AND PERMANENT DISABILITY	Increase Benefit Amount by:	$
	Total Benefit Amount (existing + increase amount)	$

PERSONAL STATEMENT (THIS SECTION MUST BE COMPLETED BY THE LIFE 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)	POLICY OWNER/PURPOSE (EG. SELF/KEYMAN)	INSURED AMOUNT	TO BE REPLACED BY THIS COVER?
			$	☐ No ☐ Yes
			$	☐ No ☐ Yes
			$	☐ No ☐ 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)	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.

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
	%
	%
	%
	%
	100%

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

LOCATION (EG. OFFICE, ON-SITE, AT HOME)	% OF TIME
	%
	%
	%
	%
	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
			/ /	/ /
			/ /	/ /

(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? $ ______

9. SMOKING

Have you smoked any substance(s) in the last 12 months? ☐ No **Go to 10**

☐ Yes Give details

Substances smoked ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other (specify) ______

Number/Amount ______ Per Day ______ Per Week ______ Per Month For ______ years

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

10. DRINKING

(A) Do you drink alcohol? ☐ No **Go to 11**

☐ Yes Give details below and **go to 11**

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

11. 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 14** ☐ 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?		

ONLY COMPLETE 12 & 13 IF THE BOXES ARE TICKED ON THE PREVIOUS PAGE.

12. 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

____

____

13. 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

____

____

14. 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 15** ☐ 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)				

15. 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.

16. 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 11. **If Back/Neck or Asthma/Bronchitis, also complete the questionnaire(s) on pages 12 and/or 13.**	NO	YES
1. High blood pressure, raised cholesterol, stroke or circulatory disorder?	☐	☐
2. Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?	☐	☐
3. Asthma, bronchitis or other lung complaint, or sleep apnoea?	☐	☐
4. Diabetes?	☐	☐
5. Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?	☐	☐
6. Hepatitis or any other liver or gall bladder disease?	☐	☐
7. Back, neck or knee complaint or any disorder of the joints, bones or muscles (eg gout, arthritis)?	☐	☐
8. Kidney or bladder disease, renal colic, stones or blood in the urine?	☐	☐
9. Depression, anxiety, stress, mental or nervous condition or chronic fatigue?	☐	☐
10. Any congenital or neurological abnormality?	☐	☐
11. Cancer, tumour, melanoma, sunspots, mole or growth of any kind?	☐	☐
12. Eczema, dermatitis, psoriasis or any other skin condition?	☐	☐
13. Tinnitus, hearing loss or any defect in hearing, sight or speech?	☐	☐
14. Anaemia, leukaemia, haemophilia or any other blood disorder?	☐	☐
15. Thyroid or prostate disorder or any disorder of the reproductive organs?	☐	☐
16. Sexually transmitted disease?	☐	☐
17. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	☐	☐
18. Epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks?	☐	☐
19. Other physical impairment, deformity or symptoms of ill health, illness or injury?	☐	☐

(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?	☐	☐
2. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection?	☐	☐

	NO	YES
(E) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation (including a genetic test)?	☐	☐
(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?	☐	☐
(G) Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future?	☐	☐

If questions C, D, E, F or G answered 'Yes', please complete details in the Additional Medical Statement on page 11.

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?	☐	☐
(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?	☐	☐
(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?	☐	☐

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

(Section 16 continues on page 11)

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

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

17. 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?			

18. 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.

______

19. 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:

20. ADDITIONAL COMMENTS/MORE INFORMATION

Use this section to provide more information in relation to any part of your Personal Statement, which will assist us in processing your application.

PAGE NO	Q.	

Adviser Comments

PAGE NO	Q.	

21. 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.

22. POLICY DECLARATION — PLEASE COMPLETE IN ALL INSTANCES

- 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 Member	✗	Date	✗ / /

23. 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, facsmile 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 ✗ Date ✗ / /

24. 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 ✗ Date ✗ / /

25. AUTHORISED REPRESENTATIVE DETAILS

PRINCIPAL AUTHORISED REP

TOWER Adviser No./Authorised Rep No.

Authorised Rep Name

Dealer Group

Commission Split (whole nos.) Servicing %

Business Phone / Mobile Phone

Email

SHARED AUTHORISED REP

TOWER Adviser No./Authorised Rep No.

Authorised Rep Name

Dealer Group

Commission Split (whole nos.) Servicing %

Note: Servicing commission must total 100%

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

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

☐ Client contact details completed so they can be contacted if required

Adviser Comments – additional space is available on page 14.

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.

Additional Representative Signature ✗ Date ✗ / /

TOWER Australia Limited
ABN 70 050 109 450
AFSL No. 237848

TOWER Australian Superannuation Limited
AFSL No. 237851
RSE Lic. No. L0000642

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