

SUPERANNUATION

ARC MASTER TRUST

Personal statement form

Dated 1 July 2009
 TOWER Australian Limited
 ABN 70 050 109 450

Your duty of disclosure

Before TOWER Australia Limited (TOWER) advises acceptance of cover on your life, you have a duty under the Insurance Contracts Act 1984 to inform TOWER of every matter that you know, or could reasonably be expected to know, which may affect TOWER's decision to insure you or the terms of that insurance cover. You have the same duty to inform TOWER before cover is varied, extended or reinstated. This duty of disclosure does not apply to anything that reduces TOWER's risk, that is common knowledge that TOWER should know in the ordinary course of business or that TOWER does not require you to disclose. Your duty of disclosure applies even after this Personal Statement is completed until TOWER advises acceptance of the cover.

If you do not disclose relevant matters and TOWER would not have granted cover at all, TOWER may cancel cover within three years of granting it. If your non-disclosure was fraudulent, TOWER may cancel cover at any time. If TOWER is entitled to cancel the insurance cover or a subsequent increase in insurance cover, it may within the first three years adjust the sum insured based on the premium charged, to the amount that would have applied had full disclosure been made.

All questions on this Personal Statement are relevant as to whether or not TOWER accepts the risk and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dot or dash is not acceptable.

Make sure you complete Section 8 to indicate the type and level of cover you would like to apply for.

1. MEMBER – PERSONAL DETAILS & INSURANCE HISTORY

A. Member number (if known)

B. Name Title Surname
 Given name(s)

Date of birth / /

C. Residential address
 Suburb State Postcode

Mailing address (if different to Residential address)
 Suburb State Postcode

Contact details Home () Business ()
 Mobile Email

Are you:
 Self-Employed or Employee Full Time or Part Time hours p/week weeks p/year

D. Occupation Industry

E. Duties Performed

F. Annual Salary (includes packaged items but excludes Bonuses/Commission) \$

1. MEMBER – PERSONAL DETAILS & INSURANCE HISTORY CONTINUED

- G.** Has Life, Disability, Accident & Sickness or Superannuation cover on your life ever been declined, deferred by or withdrawn from any Insurance Company or accepted with a loading, exclusion or other than as applied? Yes No

If yes, please provide full details (including dates, name of company and reason for deferral, loading etc)

- H.** Have you ever made a claim for disability benefits under an Insurance, Superannuation or Workers' Compensation policy, Veteran's Affairs or under Social Security (including CTP and public liability)? Yes No

If yes, please provide details (including dates, cause of claim, type of benefit and amount paid)

- I.** Other than this application, do you have or are you applying for, any life, Total and Permanent Disablement, crisis or disability insurance with TOWER or any other company? Yes No

If yes, please provide below required details.

Company	Type of Insurance	Benefit Amount	Owner	Is it to be replaced with this cover?
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>

If insurance under ARC is to replace all or part of existing insurance, it will not start until the existing insurance has been cancelled.

Is a concurrent application being submitted to TOWER for this member? Yes No

If yes, please provide us with the member/Policy Number

2. HABITS AND ACTIVITIES

- A.** Do you drink alcohol? Yes No If yes, state type and daily quantity

- B.** Have you smoked in the past 12 months? Yes No If yes, state form and daily quantity

- C.** Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a recognised airline), motor racing of any kind, diving, football, parachuting, hang gliding, etc? Yes No

If yes, please give full details

- D.** Are you an Australian or New Zealand Citizen or do you have an Australian Permanent Resident's Visa? Yes No

If no, please provide details of citizenship below

- E.** Do you intend travelling overseas in the immediate future (ie next 2 years)? Yes No

If yes, please provide details below (where, when, duration and reason)

3. MEDICAL STATEMENT

A. Name of your Doctor

Address of your Doctor

Phone number

B. Details of last medical consultation, including doctors, physiotherapists, chiropractors or **any** other health professional.

Date

Reason

C. Outcome/result

If you consult or have consulted more than one doctor or other health professional (eg chiropractor, etc) please advise name and address and reason(s) for consultations.

Name	Address	Reason for consultation	Date of consultation
			/ /
			/ /
			/ /

D. Please state your: Weight Height

E. Within the **last three years** have you, other than advised above:

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? Yes No
2. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection? Yes No

F. Have you **ever** had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation? Yes No

G. Have you **ever** had any blood tests which revealed an abnormality eg. raised blood sugar, liver function or renal function results, or anaemia etc? Yes No

H. Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future? Yes No

Please provide full details for all yes answers above.

	From	Dates	To	Name/Address of Doctor or Hospital, Clinic, etc	Condition, medications, treatment & time off work	Recovery %
E1						
E2						
F						
G						
H						

3. MEDICAL STATEMENT CONTINUED

I. Have you ever received any advice or treatment for: *(tick appropriate box)*

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

FEMALES ONLY

- | | | | | |
|----------------------------------------------------------------------------------------------------------|-----|--------------------------|----|--------------------------|
| 18. Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 19. Have you ever had any complications of pregnancy or childbirth? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 20. Are you currently pregnant? If yes, what is expected delivery date <input type="text" value=" / /"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 21. Have you ever had a breast lump (even if you have not seen a doctor about it)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

For each yes answer in section 'I', please complete details within the following schedule.

Question Number	Q	Q	Q
Specific Condition			
A. Date symptoms first started and description of symptoms?			
B. What was the condition and which part of the body was affected?			
C. What was the medical diagnosis including results of x-rays and investigations?			
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?			
E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
F. How long were you unable to work or perform your normal duties/activities?			
G. If a hospital visit was required, please provide date and duration of your stay			
H. What advice/treatment did you receive?			
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?			
J. Degree of recovery (%)			
K. Please supply the name and address of all doctors or hospitals or other consultations.			

4. FAMILY HISTORY

- A. Have any of your parents, brothers or sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer, Huntington's Disease or any other hereditary disease? Yes No

If yes, please provide details including date of diagnosis and death (if applicable).

5. QUESTIONS IN RELATION TO AIDS

- A. 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? Yes No
- B. Have you **ever** sought or are expecting to receive treatment for AIDS or an AIDS related condition or have you **ever** had a positive test for HIV? Yes No
- C. 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? Yes No
- D. If you have answered yes to questions A,B or C, we will send you a separate questionnaire

6. FINANCIAL DETAILS

Please note that based on the financial information provided below, additional financial information may be required.

- A. If disabled, would all or part of your income continue? If yes, please advise income that would continue, for how long and source (e.g. sick pay, pension, company profits, investment, rental, etc). Yes No

- B. Employee Only - No Ownership in Employer's Business. Yes No

In respect of your principal occupation, what has been the total value of remuneration paid by your employer over the last two years. This should be determined by calculating the amount you could be expected to receive if your total remuneration was received as a salary or wage (before income tax is deducted):

Current Year		\$			Last Tax Year		\$	
Commission/Bonus/Overtime component of this amount is:		\$			Commission/Bonus/Overtime component of this amount is:		\$	

- C. Self-Employed Only - Sole Trader, Employed by own company or in a Partnership

Last Tax Year					Previous Tax Year	
	Business \$	Your Share \$			Business \$	Your Share \$
Gross Income					Gross Income	
Less Business Expenses					Less Business Expenses	
Net Income (Loss)					Net Income (Loss)	

Plus the following paid to you:

Wage/Salary/Drawings/Director's fees	
Superannuation Costs	
Total	\$

Plus the following paid to you:

Wage/Salary/Drawings/Director's fees	
Superannuation Costs	
Total	\$

NB- Any amounts received as wage/salary/drawings/director's fees must not be paid from past profits, capital or loans.

7. OCCUPATIONAL DETAILS

A. Name of your employer

B. Address of your employer
 State Postcode

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 E) Yes (please give details)

How long? Years Months % of business you own

Name of your business/ company

Address of your business/ company

How many employees do you have? (excluding yourself)

E.a. What are the main duties of your occupation?

Duties (eg. office work, sales, supervision, manual)	% of time
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> 100%

b. In what location do you perform your duties?

Location (eg. office, on-site, travel, at home)	% of time
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> 100%

F. Do you hold any professional/trade qualifications? If yes, please give details. Yes No

Type and Name of institution where obtained

G. Has your main occupation, employer or employment status changed in the last 3 years? If yes, please give details. Yes No

Previous occupation	Employer	Employment status (e.g. unemployed, employed, employed by own company, self employed, partnership)	Date from	Date to
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

H. Do you have any other occupation? If yes, please give details. Yes No

Type of occupation

Name of your employer

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

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

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

8. INSURANCE ALTERATION DETAILS

Any alteration to your insurance benefits is subject to acceptance by the Fund's Insurer. For more information about your insurance options, please refer to the section titled 'Insurance information' in the Incorporated Material on our website www.arcmt.com.au or call us for a copy. We suggest you speak to your Financial Adviser about your insurance needs.

Please indicate below the type and level of cover you wish to apply for:

- I wish to alter my existing insurance benefits as detailed below. I understand that once accepted by the Fund's Insurer, the benefits will replace my existing arrangements.
- I wish to add the insurance benefits as detailed below.

Death and Total and Permanent Disablement

- Death only or Death and Total and Permanent Disablement

Total amount of cover \$

Options

- Integrated insurance (Benefits inclusive of account balance)
- Fixed insurance (default) (Benefits in addition to account balance)

Income Protection Benefit

Waiting Period 30 days 60 days 90 days

This is the period you will be off work before Income Protection benefits may commence.

Current GROSS salary \$ pa

Monthly income benefit (Maximum of 75% of salary) % Retirement Protection benefit (Maximum of 10% of salary) %

Benefit Period 2 years Until age 65

This is the period during which you will receive Income Protection payments.

9. PRIVACY

Information on the collection, use and disclosure of your information is contained in the 'Your Privacy' in the Privacy Policy Statement on our website at www.toweraustralia.com.au, or is available on request. A copy of the PDS for this product is available on our website www.arcmt.com.au or call us for a copy. If you have any questions about your privacy rights, or wish to access the personal information we hold about you, please contact:

The Privacy Officer
PO Box 142
Milsons Point NSW 1565
Telephone: 1800 101 014

10. MEMBER'S DECLARATION

If I am applying for insurance benefits or a change in those benefits:

- I understand that cover will not become effective until TOWER accepts in writing my application for insurance or increase in insurance on standard terms or I accept in writing non-standard terms offered to me and TOWER receives sufficient contributions to meet the required premium.
- I understand that this Personal Statement and any other forms submitted to TOWER which are relevant to the insurance benefit application need to be completed in full and confirm that the answers are true, correct and complete whether or not they are in my writing.
- I have made no statements 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 this form, the ARC Master Trust Personal Statement or other forms submitted to TOWER which are relevant to the insurance benefit application.

I agree that this Personal Statement and any other medical evidence obtained shall be the basis on which TOWER grants cover on my life under the relevant Group Insurance contract. I understand that all questions asked on this Personal Statement are relevant to TOWER's decision whether to accept the risk and, if so, on what terms. I also understand that I must advise TOWER of any change in my health between now and when TOWER actually accepts the cover being sought.

I hereby declare that I have read and understood the general nature and effect of a member's Duty of Disclosure, shown on the front page of this form.

I further declare that all the answers shown on this Personal Statement are true and that I have not withheld any information which might be material to TOWER accepting cover on my life. To the extent that any answers are not in my own handwriting, they have been checked by me and I certify that they are correct.

I have read and understood the Privacy information in section 9 of this form.

I request and/or consent to the Policyowner effecting the insurance on my life to which this statement relates.

I understand that cover to which this Personal Statement relates will not commence until TOWER accepts in writing my application for insurance on standard terms or I accept in writing any non-standard terms offered to me and TOWER receives a sufficient contribution to meet the required premium.

Member's signature

Date

11. ADDITIONAL INFORMATION (TO ASSIST WITH CLARIFICATION OF ANY ISSUE)

<hr/> <hr/> <hr/> <hr/> <hr/>

12. MEDICAL AUTHORITY

I have applied to Tower Australia Limited (TOWER) for insurance and a medical report from my doctor is required. I hereby authorise my doctor to release details of my personal medical history, including referrals to or treatment by other practitioners, to TOWER. The purpose is to allow TOWER to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I have been advised of the ways this information may be used and to whom it may be disclosed, and approve these purposes.

I may request access to a copy of my doctor's report from TOWER.

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.

Full Name of Member

Member's signature

Date

CONTACT US

ARC Master Trust Customer Service Consultants

Call 1800 101 014

Monday to Friday 8.30am-5.30pm (EST)

Email: arcmt@toweraustralia.com.au

Website: www.arcmt.com.au

Please return your completed form and any supporting paperwork to:

ARC Master Trust

PO Box 142

Milsons Point NSW 1565