Group Insurance Member's Personal Statement

TOWER Australia Limited ABN 70 050 109 450
80 Alfred Street Milsons Point NSW 2061 PO Box 142 Milsons Point NSW 1565
Customer Service Centre 1800 812 922 Facsimile [02] 9465 2061

Policy Number	
Member Number	
Plan Administrator	

OFFICE USE ONLY

Please address correspondence to:
Group Administration – TEB
PO Box 142 Milsons Point
NSW 1565 Australia

To be completed by Member

Important Notice for the Member

TOWER thanks you for applying for cover and assures you that full consideration will be given to your application. It is, however, extremely important that you read and understand your legal obligations.

Your Duty of Disclosure

Before TOWER Australia Limited (TOWER) advises acceptance of cover on your life, the Insurance Contracts Act 1984 says you have a duty 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 renewed, 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 3 years of granting it. If your non-disclosure was fraudulent, TOWER may cancel cover at any time. If TOWER is entitled to cancel this policy, 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.

A. Member – Personal Details & Insurance History

Name of Plan ______ Policy Number ______

Member Details

Surname	Given Names	Sex	Date of Birth
			/ /

Residential Address	Postcode	Telephone Number

Email Address ______

Occupation ______ Industry ______

Duties Performed ______

Percentage of time supervising or performing manual labour ______ % Annual Salary (*per annum*) $ ______

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? No ☐ Yes ☐

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

Have you ever made a claim for disability benefits under an Insurance, Superannuation or Workers' Compensation policy or under Social Security (including CTP and public liability)? No ☐ Yes ☐

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

B. Habits & Activities

1. Do you drink alcohol? No ☐ Yes ☐ If "YES" state type and daily quantity ☐

2. Do you smoke? No ☐ Yes ☐ If "YES" state form and daily quantity ☐

3. Do you currently or intend to engage in any hazardous pastime and/or sporting activity such as aviation, motor racing of any kind, diving or football? No ☐ Yes ☐

If "Yes" please give full details

C. Medical Statement

C. Section (i)

1. Name and Address of your Doctor

2. If you have attended that Doctor for less that 12 months, name and address of Previous Doctor

3. Details of last medical consultation, including doctors, physiotherapists, chiropractors or ANY other health professional.

Date / / Reason

Outcome/Result

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

Name	Address	Reason for Consultation	Date of Consultation

C. Section (ii)

Please state your: Height cm Weight kg

Within the last 5 years have you: (tick ✔ appropriate box)

	No	Yes
1. Either occasionally or regularly taken any stimulants, sedatives, medications or drugs whether prescribed or not?	☐	☐
2. Had any examination, advice or treatment by a doctor, physiotherapist, chiropractor or other health professional?	☐	☐
3. Had any test-blood test, ECG, X-Ray, other investigations, blood transfusions or surgery of any kind?	☐	☐
4. Been advised to have, **or are you now contemplating having**, an operation, seeking any medical examinations or advice in future?	☐	☐

Please provide full details for all YES answers in **Section (ii)**

Question Number	Dates From	Dates To	Name/Address of Doctor or Hospital, Clinic etc	Condition, Medications, Treatment & Time Off Work	Recovery %

C. Section (iii)

Have you ever received any advice or treatment for: (tick ✔ appropriate box)

	No	Yes
1. High blood pressure, raised cholesterol, chest pains or any heart complaint?	☐	☐
2. Cancer, sunspot, melanoma, growth or tumour of any type?	☐	☐
3. Asthma, bronchitis or other lung complaint?	☐	☐
4. Paralysis, stroke, epilepsy, fits of any kind or fainting attacks?	☐	☐
5. Hepatitis or any kidney, bladder, liver, bowel or gall bladder disease?	☐	☐
6. Abnormal passing of blood, any blood disorder or immune disorder?	☐	☐
7. Diabetes?	☐	☐
8. Depression, stress, anxiety, mental or nervous condition, or chronic fatigue?	☐	☐
9. Indigestion, hernia, gastric or duodenal ulcer, colitis or any intestinal disorder?	☐	☐
10. Arthritis, tendonitis, "RSI", tenosynovitis or regional pain?	☐	☐
11. Back or neck pain or disorder of any joint, bone, nerve, or muscle?	☐	☐
12. Any impairment of sight, hearing or speech?	☐	☐
13. Any skin disorder or any physical impairment or deformity?	☐	☐
14. For females, are you pregnant? Please also provide expected delivery date / /	☐	☐

Please provide details for all Yes answers in Section (iii). *Further space is provided on page 6 if required.*

Question No. and Specific Condition	Q. –	Q. –	Q. –	Q. –
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. When did you last suffer from any symptoms?				
K. Degree of recovery (%).				
L. Please supply the name and address of all doctors or hospitals or other of consultations.				

D. Family History

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)

E. Declaration in Connection with AIDS

I hereby declare that all of the following statements are true:

1. I have not been infected by the virus which causes AIDS (the Human Immunodeficiency Virus) and I am not carrying anti-bodies to that virus.
2. I have not sought, nor am I expecting to receive, treatment for AIDS or AIDS related condition.
3. I have not:
   - shared a needle or syringe for the injection of any drug;
   - worked as, nor engaged in sexual activity with, a prostitute;
   - engaged in anal sexual activity.
4. To the best of my knowledge, all my sexual partners would be able to make the same declaration in relation to the above 3 statements.

Signature Date / /

F. Medical Authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be and is hereby authorised and directed by me to divulge to TOWER Australia Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full Name of Member

Signature of Member Date / /

G. Medical Authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be and is hereby authorised and directed by me to divulge to TOWER Australia Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full Name of Member

Signature of Member Date / /

H. Privacy

TOWER's commitment to protecting your privacy means that, amongst other things, in the process of collection, storage, quality, use and disclosure of your personal information, your privacy is respected. Our compliance with the Privacy Act from 21 December 2001 will also allow you to exercise your right to access your personal information held by us.

Personal information is collected from you and your employer to enable TOWER and the Policyowner (includes Trustee where relevant) to provide you with the product or service you request. If you apply for additional insurance cover, that information is collected from you in accordance with your Duty of Disclosure. **If you do not provide us (TOWER and Policyowner) with this information, we may not be able to provide you with this product or service.** By signing the Application Form and/or the Personal Statement or by becoming a member of this fund, you agree to us collecting your personal information.

In processing and administering this investment, or at the time of an insurance claim, we may disclose your **personal (including sensitive)** information to a number of parties. These may include: health professionals; your employer's or your Adviser or Financial Planner; other companies within the TOWER Group; organisations to whom we outsource our mailing, administration and information technologies; the Insurance Reference Service; investigators; the Trustee; the administrator of the fund; other insurers; reinsurers; government regulatory bodies; and lawyers and accountants (if applicable). **By signing the Application Form and/or the Personal Statement or by becoming a member of this fund, you agree to these organisations collecting your sensitive information (if necessary).**

I. Member's Declaration

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/We have read and understood the Privacy Disclosure Statement in the Member's Personal Statement which sets out important details of how TOWER may use my information.

Signature of Member	✗	Date	/ /
Signature of Witness	✗	Name of Witness	

See **Additional Information** on page 6

J. Additional Information

TOWER

TOWER Australia Limited
ABN 70 050 109 450

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