

03	7. Back, neck or knee complaint or any disorder of the joints, bones or muscles (eg gout, arthritis)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	8. Kidney or bladder disease, renal colic, stones or blood in the urine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	9. Depression, anxiety, stress, mental or nervous condition or chronic fatigue?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	10. Any congenital or neurological abnormality?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	11. Cancer, tumour, melanoma, sunspots, mole or growth of any kind?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	12. Eczema, dermatitis, psoriasis or any other skin condition?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	13. Tinnitus, hearing loss or any defect in hearing, sight or speech?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	14. Anaemia, leukaemia, haemophilia or any other blood disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	15. Thyroid or prostate disorder or any disorder of the reproductive organs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	16. Sexually transmitted disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
17. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
18. Epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
19. Other physical impairment, deformity or symptoms of ill health, illness or injury?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
20. During the last three years have you, other than advised above:			
(i) Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist, counsellors, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
(ii) Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

03	21. Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation? <input type="checkbox"/> No <input type="checkbox"/> Yes
	22. Have you EVER had any blood tests which revealed an abnormality eg. raised blood sugar, liver function or renal function results, or anaemia etc? <input type="checkbox"/> No <input type="checkbox"/> Yes
	23. Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future? <input type="checkbox"/> No <input type="checkbox"/> Yes
NOTE: QUESTIONS 24 TO 27 RELATE TO FEMALES ONLY	
	24. Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes
	25. Have you ever had any complications of pregnancy or childbirth? <input type="checkbox"/> No <input type="checkbox"/> Yes
	26. Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what is the expected delivery date? / /	
	27. Have you ever had a breast lump (even if you have not seen a doctor about it)? <input type="checkbox"/> No <input type="checkbox"/> Yes

04	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? <input type="checkbox"/> No <input type="checkbox"/> Yes

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)				

05	DECLARATION
I understand and acknowledge that I am bound by the Duty of Disclosure. I declare that the foregoing answers are true and complete and I agree that this Declaration shall be held to form part of the application for insurance on my life now made to the Company.	
Signature of Life to be insured ✕ Date / /	

06	CONFIDENTIAL MEDICAL EXAMINATION (to be completed by doctor)		
	1. Do you know the Applicant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	2. Have you ever attended the Applicant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	3. Is the Applicant's build, appearance or behavior unusual? (including eg. skin rashes, pigmentation)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	4. Are there any signs of past or present over-indulgence in tobacco, alcohol or of the misuse of drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

07	MEASUREMENTS (TAKEN BY EXAMINER)		
	HEIGHT	WEIGHT	CHEST
	ft:	st:	Full Inspiration: in or cm
	ins:	lbs:	Full Expiration: in or cm
	or cms:	or kgs:	Abdomen at umbilicus: in or cm
	Has there been any recent variation in weight?		<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please try to ascertain the cause.		
	If the chest expansion is less than 5 cms, please comment as to cause.		

08	RESPIRATORY SYSTEM		
	1. Is there any abnormality of the respiratory system to palpation, percussion or auscultation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	If Yes, please give details.		
	2. Is there any sign of past or present respiratory disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If Yes, please give details.			

09	CIRCULATORY SYSTEM		
	1. What is the rate and character of the pulse?		
	Pulse Rate	per min	Character
	2. What is the position of the Apex beat of the heart?		
	In the	interspace	cm from the mid-sternal line
	3. Is there any evidence of cardiac enlargement? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, please give details.		
	4. Is there any abnormality in the heart sounds or rhythm? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, please give details.		
	5. Is any murmur present? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.		
	6. What is the Blood Pressure? (Auscultatory method)		
	Systolic	Diastolic	mm HG
	Systolic	Diastolic	mm HG
	Systolic	Diastolic	mm HG
	The Diastolic level is to be taken at the cessation of all sound. If the first Systolic reading is above 135 or below 100, or the Diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.		
	7. Is there any abnormality of the peripheral arterial or venous circulation? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, please give details.		
	8. Do you consider the heart and vascular system to be abnormal ? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, please give details.		
	9. Is the examinee now on treatment for hypertension? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If Yes, and you have the required information, please state:		
	a) Pre-treatment blood pressure level including date(s)		
	b) Duration of treatment		
	c) Nature of treatment		

10	DIGESTIVE, ENDOCRINE AND LYMPH SYSTEMS	
	1. Is there any abnormality of tongue, mouth or throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	2. Is there any palpable abnormality of the liver, spleen or other abdominal organs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	3. Is a hernia present?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	4. Is there any abnormality of lymph glands in the neck, axillae or inguinal regions?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	

11	GENITO-URINARY SYSTEM	
	1. Is there any genito-urinary abnormality? (eg. stricture, prostate)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	2. Does the urine contain:	
	a) Albumin?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	b) Sugar?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	c) Other abnormality?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Albumin is present please ask patient to supply 3 further urine specimens (a.m., noon, p.m.) to you for testing. The appropriate fee will be paid when these results are received.	
	FEMALE APPLICANTS ONLY	
	3. Is the applicant pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please state expected date of delivery	

12	NERVOUS SYSTEM	
	1. Is there any defect of vision or abnormality of the eyes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	2. Is there any defect in hearing or speech?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	In cases of present or past ear discharge or deafness, state result of auriscopic examination.	
	3. Is there any evidence of mental abnormality?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
4. Is there any evidence of any disorder of the central or peripheral nervous system?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes, please give details.		

13	MUSCULO-SKELETAL SYSTEM AND SKIN	
	1. Is there any abnormality of the form or function of the joints?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	2. Is there any abnormality of the form or function of the muscles or connective tissues?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	3. Is there any abnormality of the form or function of the back or neck including the cervical and lumbar spine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	4. Is there any evidence of any disorder of the skin?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	

14	SUMMARY	
	1. Do you consider any medical attendant's reports or any special tests are required?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	(Note: No special tests are to be carried out in connection with the proposal for Insurance without the Company's authority)	
	2. Do you consider the person examined to be likely to require any surgical operation?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If Yes, please give details.	
	3. Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement:	
	a) In the personal or family medical history	
	b) Disclosed by your medical examination	

15	EXAMINER'S DETAILS	
	Name (in block letters please)	
	Address	
	Phone Number	
	Personal Qualifications	
	Signature of Examiner ✕	Date / /

Personal information is collected from you to enable TOWER to provide the product and/or service you request. Without this information, TOWER may be unable to provide you with product or service. Your personal information may be disclosed by TOWER to other parties, including, where necessary: health professionals; your (or your employer's, if relevant) Adviser or Financial Planner; other companies within the TOWER Group; organisations to whom we outsource our mailing, administration and information technologies; the Trustee (if relevant); the administrator of the product or fund; reinsurers; government regulatory bodies; lawyers; or accountants. By signing this form you consent to TOWER and these organisations collecting your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information.

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