

MEMBER'S PERSONAL STATEMENT

| Group Risk Insurance |

OFFICE USE ONLY	POLICY NUMBER
	MEMBER NUMBER
	PLAN ADMINISTRATOR

Please address correspondence to:
TOWER Group Risk Administration Team
PO Box 5380
Sydney NSW 2001 Australia

YOUR DUTY OF DISCLOSURE

Before you enter into a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer'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 us before you extend, vary or reinstate a contract of life insurance. Your duty however, does not require disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer
- That is of common knowledge
- That your insurer knows or, in the ordinary course of his business, ought to know
- Disclosure of which is waived by the insurer

The duty of disclosure applies even after this Application is completed until TOWER advises acceptance of insurance.

Non-Disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

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.

01	PERSONAL DETAILS		
	Name of Plan	Policy Number	
	Surname	Given Names	
	Sex	Date of Birth	/ /
May TOWER contact you directly to clarify or gather information in relation to this application? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, specify daytime contact number and best time of day to call)</i>			

02	OCCUPATION DETAILS			
	2.1	<input type="checkbox"/> Self-Employed or <input type="checkbox"/> Employee	<input type="checkbox"/> Full Time or <input type="checkbox"/> Part Time	hours p/week
				weeks p/year
	2.2	Your Occupation	Industry	
	2.3	Duties Performed		
2.4	Annual Salary <i>(includes packaged items but excludes Bonuses/Commission)</i>			

03	INSURANCE APPLICATION			
	Death Sum Insured	TPD Sum Insured		
	Monthly Income Benefit	Benefit Period	Waiting Period	
	3.1 Is this an increase?			<input type="checkbox"/> No <input type="checkbox"/> Yes
	3.2 Have you ever held or applied for any life, disability, accident & sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused?			<input type="checkbox"/> No <input type="checkbox"/> Yes
3.3 Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party?			<input type="checkbox"/> No <input type="checkbox"/> Yes	
3.4 Do you have, or are you applying for, any other life or disability cover?			<input type="checkbox"/> No <input type="checkbox"/> Yes	

If Yes to 3.2, 3.3 and or 3.4, please provide full details below.

Name of Company	Cover Type	Sum Insured	Date of Application	Accepted/Loaded Exclusion/Declined	To be Replaced?
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes
			/ /		<input type="checkbox"/> No <input type="checkbox"/> Yes

04	HABITS AND ACTIVITIES			
	4.1 Do you drink alcohol? <i>If YES, state type and daily quantity</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.2 Have you smoked in the past 12 months? <i>If YES, state form and daily quantity</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.3 Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? <i>If YES, Please provide full details</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.4 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 travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or any other extreme sport? <i>If YES, Please complete a sports and pastimes statement</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.5 Do you intend travelling outside Australia within the next 2 years? <i>If YES, please provide details below (where, when, duration and reason)</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.6 Are you an Australian or New Zealand Citizen?			<input type="checkbox"/> No <input type="checkbox"/> Yes
	4.7 Do you hold an Australian Permanent Resident's Visa?			<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If NO to 4.6 and 4.7, please provide details</i>				

05	PERSONAL STATEMENT	
	5.1 Please state your:	Height (cm) Weight (kg)
5.2 Name and Address of your usual Doctor		

5.3 Details of last medical consultation with your usual doctor.

Date / /
Reason
Outcome/Results

5.4 If you have attended that Doctor for less than 12 months, name and address of previous Doctor

5.5 a) Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquilisers?	<input type="checkbox"/> No <input type="checkbox"/> Yes
b) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c) Have you EVER had any blood tests which revealed an abnormality eg. raised blood sugar, liver function, renal function results, or anaemia etc?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d) Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Please provide full details for all 5.5 Yes answers

Question	Dates (From/To)	Name/Address of Doctor, Hospital or clinic	Condition, Medications, Treatment & Time off work	Recovery %

Please provide details for all Yes answers in the GENERAL MEDICAL QUESTIONNAIRE ON PAGE 5

06	PERSONAL STATEMENT <i>(continued)</i>	
	6.1 Have you ever had, been advised that you had, or received advice or treatment for any of the following:	
	a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	b) Bowel, stomach or intestinal problem, gallbladder or liver disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	d) Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	e) Diabetes, sugar in urine, pancreatic or thyroid problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	h) Impairment of sight, hearing or speech?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	i) Asthma, bronchitis, any lung complaint?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	j) Leukaemia, haemochromatosis, any blood problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	k) Kidney, bladder problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	l) Psoriasis, eczema, any skin problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	n) To the best of your knowledge, do you, or any of your current or past sexual partners, have HIV/AIDS, or are you experiencing any unexplained night sweats or unintentional weight loss, or do you/have you engaged in any activity/ies reasonably accepted as having an increased risk of exposure to the virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	FEMALES ONLY	
o) Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
p) Have you ever had any complications of pregnancy or childbirth?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
q) Are you currently pregnant? <i>If 'Yes' what is the expected delivery date</i> / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
r) 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	

Please provide details for all Yes answers in the GENERAL MEDICAL QUESTIONNAIRE ON PAGE 5

6.2 Family History. <i>Please give details of you family medical history</i>				
Relative	Living Relatives		Deceased Relatives	
	Current Age	Specify current state of health	Age at Death	Specify cause of death
Mother				
Father				
Sisters				
Brothers				
6.3 Have any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's Chorea or any hereditary disease? <i>If YES, Please provide full details</i>				<input type="checkbox"/> No <input type="checkbox"/> Yes

07	GENERAL MEDICAL QUESTIONNAIRE			
	<i>Please provide details for all Yes answers in 6.1 a to r. Please complete on a separate sheet if required</i>			
Question No.	Q.	Q.	Q.	Q.
Specific Condition				
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side 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. Date treatment/ medication ceased.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)				
M. Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

08	PRIVACY STATEMENT
<p>Privacy laws protect your privacy. The way in which we collect, use, disclose and handle your information is described in the TOWER Privacy Statement. Please be aware that the duty of disclosure explained on page 1 applies to the information you have submitted. If you fail to comply with this duty you may be in breach of it. The consequences of this are explained on page 1.</p> <p>We may collect and use or disclose your personal information (including health and sensitive information) to assess, verify and process your application.</p> <p>We may collect or disclose information relating to you or your application to or from a range of services including: reinsurers, superannuation trustees, past or present medical practitioners, health professionals, hospitals, government department(s) which retain health records or as part of our regulatory requirements, personal accountants or current or former employers or lawyers. You have a right of access to any personal information held about you unless we are legally entitled to deny access. If you want to know more about our approach to privacy please telephone: (02) 9448-9416.</p>	

09	DECLARATION
<p>I acknowledge that I have read the notice of my duty of disclosure above and understand that this duty also applies until formal notification of acceptance.</p> <p>I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or personal statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.</p> <p>I, the Member, authorise and direct any medical or other practitioner to divulge at any time to TOWER Australia Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history, acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.</p> <p>I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TOWER Australia Limited to its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information TOWER Australia Limited collects on this form or future forms in relation to this insurance.</p>	
FULL NAME OF MEMBER	
SIGNATURE OF MEMBER x	DATE / /

10	MEDICAL AUTHORITY
<p>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 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.</p>	
FULL NAME OF MEMBER	
SIGNATURE OF MEMBER x	DATE / /

Please return to:
 AES
 GPO Box 2258
 Melbourne VIC 3001