

Surname of the life to be insured

Given name(s)

Application number

Please indicate the mental health condition(s) that you have had or received treatment for. *Tick (✓) all that apply.*

- | | |
|---|--|
| <input type="checkbox"/> Anxiety including generalised anxiety, panic/phobic disorder | <input type="checkbox"/> Alcohol or other substance abuse or addiction |
| <input type="checkbox"/> Eating disorder including anorexia nervosa, bulimia | <input type="checkbox"/> Post traumatic stress |
| <input type="checkbox"/> Depression including major depression, dysthymia | <input type="checkbox"/> Schizophrenia or any other psychotic disorder |
| <input type="checkbox"/> Manic depressive illness, bi-polar disorder | <input type="checkbox"/> Stress, sleeplessness, chronic tiredness |
| <input type="checkbox"/> Other (<i>please specify</i>) <input type="text"/> | |

Please give details of your symptoms

Symptoms	Date commenced	Date ceased
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

Has any reason for your condition been identified?

No <input type="checkbox"/> Yes <input type="checkbox"/> Give details	<input type="text"/>
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

When was your condition(s) first diagnosed?

 / /

Have you had any recurrences of this condition(s)

No <input type="checkbox"/> Yes <input type="checkbox"/> How many times?	<input type="text"/>	When?	<input type="text"/>
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Please advise all treatments you have received, including counselling, name(s) of medications, hospitalisation, etc

Type of treatment	Date commenced	Date ceased
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

Are you currently receiving treatment?

No <input type="checkbox"/> When did you cease treatment?	<input type="text"/> / <input type="text"/> / <input type="text"/>
Yes <input type="checkbox"/> Give details	<input type="text"/>
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

Have any of your parents, brothers or sisters (living or dead) suffered from a mental health condition?

No Yes Give details of family members affected below

Relationship to you	Age condition began	Mental health condition(s) suffered

Please give details of any doctors or health care professionals you have consulted.

Name	Address	Date first consulted	Date last consulted
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Has your condition ever caused you to lose time from work?

No Yes Give details including dates

Are you limited in your ability to work or to perform your activities of daily living as a result of this condition?

No Yes Give details

Privacy laws protect the privacy of individuals. The way in which we collect, use, disclose and handle your information is described in the TOWER Privacy Statement. Please be aware that if you wish to provide information to us, the duty of disclosure explained in your application for insurance applies to the information you give in this form. If you fail to comply with this duty you may be in breach of it. The consequences of this are explained in your application. Please phone the Privacy Officer on (02) 9448 9416 if you have any questions or would like to request a copy of our Privacy Policy.

Declaration

I understand that this statement forms part of my application(s) for TOWER insurance cover and declare that its contents are true and correct.

Signature of the **life to be insured**

X

Date

/ /

Please return the completed form to:
TOWER Australia
GPO Box 5380
Sydney NSW 2001