

Full name of doctor or hospital

  

Full address of doctor or hospital

  
  

*Privacy laws protect your privacy. The way in which we collect, use, disclose and handle your information is described in our Privacy Statement. Please contact our Privacy Officer on (02) 9448 9416 if you have any additional questions or would like to request a copy of our Privacy Policy.*

Dear Sir/Madam,

I request and authorise you to supply TOWER Australia with full details of my medical history including details of any clinical notes that have been made. A photocopy (or similar copy) of this authorisation shall be as valid as the original.

Surname of the life to be insured

Given name(s)

Phone number

Signature of the life to be insured

Date

*Please return the completed form to:*

**TOWER Australia**  
**GPO Box 5380**  
**Sydney NSW 2001**