

A. PERSONAL STATEMENT BY THE LIFE INSURED

Surname of the life to be insured	Given name(s)	Date of birth
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> / <input style="width:95%;" type="text"/> / <input style="width:95%;" type="text"/>
Residential address		Postcode
<input style="width:95%;" type="text"/>		<input style="width:95%;" type="text"/>
Occupation	Name of industry in which you work	Name of adviser authorising exam
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

B. MEDICAL DETAILS

Have you ever had any of the following? *If "Yes", please give details in the table below.*

1. Heart or vascular disorder, heart murmur, high blood pressure, pain in the chest or rheumatic fever	No <input type="checkbox"/> Yes <input type="checkbox"/>
2. Gastric or duodenal ulcer, bowel disease, colitis, hepatitis or any liver or gall bladder disease	No <input type="checkbox"/> Yes <input type="checkbox"/>
3. Epilepsy, fainting attacks or fits of any kind	No <input type="checkbox"/> Yes <input type="checkbox"/>
4. Mental illness, depression, stress or anxiety state	No <input type="checkbox"/> Yes <input type="checkbox"/>
5. Diabetes or any pancreatic disease	No <input type="checkbox"/> Yes <input type="checkbox"/>
6. Cancer, cyst or tumour of any kind	No <input type="checkbox"/> Yes <input type="checkbox"/>
7. Disease of, or injury to, neck/spine including back strain, disc disorder, lumbago, fibrositis, sciatica, neuritis	No <input type="checkbox"/> Yes <input type="checkbox"/>
8. Tendonitis, tenosynovitis, "RSI" or muscle overuse syndrome	No <input type="checkbox"/> Yes <input type="checkbox"/>
9. Any impairment of sight or hearing	No <input type="checkbox"/> Yes <input type="checkbox"/>
10. Hernia	No <input type="checkbox"/> Yes <input type="checkbox"/>
11. Asthma, bronchitis or lung complaint	No <input type="checkbox"/> Yes <input type="checkbox"/>
12. Anaemia, leukaemia, haemophilia or any other blood disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
13. Paralysis, stroke or cerebrovascular disease	No <input type="checkbox"/> Yes <input type="checkbox"/>
14. Kidney or bladder disease (including renal colic, nephritis, pyelitis, cystitis)	No <input type="checkbox"/> Yes <input type="checkbox"/>

15. Coughing of blood or the passage of blood from the bowel or urine	No <input type="checkbox"/> Yes <input type="checkbox"/>
16. Arthritis or gout	No <input type="checkbox"/> Yes <input type="checkbox"/>
17. Any injury, deformity or disease involving any joint or limb	No <input type="checkbox"/> Yes <input type="checkbox"/>
18. Any skin disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
19. Any other operation, disability, illness or injury	No <input type="checkbox"/> Yes <input type="checkbox"/>

For reasons other than those stated in Questions 1-19, have you in the last 5 years:

If "Yes", please give details in the table below.

20. Had any exam, advice or treatment by a medical practitioner, chiropractor or other health care professional?	No <input type="checkbox"/> Yes <input type="checkbox"/>
21. Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers?	No <input type="checkbox"/> Yes <input type="checkbox"/>
22. Been a patient in a hospital, clinic or nursing home?	No <input type="checkbox"/> Yes <input type="checkbox"/>
23. Undertaken any tests, including blood tests, ECG, X-rays, etc?	No <input type="checkbox"/> Yes <input type="checkbox"/>
24. Have you been advised to or do you intend to seek any medical advice or treatment in the near future? <i>If "Yes", give details in the table below.</i>	No <input type="checkbox"/> Yes <input type="checkbox"/>

For females only

25. Are you pregnant?	No <input type="checkbox"/> Yes <input type="checkbox"/>
<i>If "Yes", specify expected delivery date</i>	<input style="width:95%;" type="text"/> / <input style="width:95%;" type="text"/> / <input style="width:95%;" type="text"/>

If "Yes" to any of Questions 1 - 24, give details in the table below. *If you need extra space, this table continues on page 2.*

No.	Name of illness, injury or test	Date commenced	Time off work	Details of treatment including date of last symptoms and degree of recovery %	Name and address of doctor/hospital (if any)

B. MEDICAL DETAILS *continued*

If "Yes" to any of Questions 1 - 24, give details in the table below. *Attach separate schedule if there is insufficient space.*

No.	Name of illness, injury or test	Date commenced	Time off work	Details of treatment including date of last symptoms and degree of recovery %	Name and address of doctor/hospital (if any)

C. FAMILY HISTORY

1. Please give details of your family medical history

Relative	Living relatives		Deceased relatives	
	Current age	Specify current state of health (if not good, state reason)	Age at death	Specify cause of death (please state fully and exactly)
Father				
Mother				
Brothers				
Sisters				

2. Has any near blood relative suffered from diabetes, heart disease, mental disorder or breakdown, haemophilia, Huntington's Chorea, kidney disease, high blood pressure, cancer or any hereditary disease?

No Yes Give details

D. ADDITIONAL MEDICAL DETAILS

1. Indicate your alcohol consumption habits

I have never drunk alcohol Specify:
 I do not currently drink alcohol, but I used to Type:
 I currently drink alcohol Quantity: Daily / Weekly

2. Indicate your smoking habits (include tobacco & other substances)

I have never smoked Specify:
 I do not currently smoke, but I used to Type:
 I currently smoke Quantity: Daily
 Date stopped (if applicable) / /

3. Have you used drug(s) not prescribed by a doctor?

No Yes Give details

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E. DECLARATION AND SIGNATURE

I declare that the answers to the questions in this Personal Statement are true and correct and I understand that they form part of my application for insurance.

SIGN ONLY IN PRESENCE OF MEDICAL EXAMINER

Signature of the life insured Date

I confirm that this form was signed in my presence and discussed where I considered it appropriate.

Signature of medical examiner Date

A. BACKGROUND DETAILS

Confidential Medical Report on the health of:

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With particular attention to:

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Information regarding findings should NOT be given to any other person. Exception may be subject to the examinee's consent, if, in your opinion, there is medical information which should be conveyed to his/her medical attendant. The company's decision concerning the application for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The EXAMINER is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

1. Are you professionally acquainted with the examinee?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ For how long?	
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2. Are you personally acquainted with the examinee?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ For how long?	
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3. Is there anything abnormal in appearance, development or behaviour?

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

4. Is there any indication of past or present abuse of alcohol or of the misuse of drugs?

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

B. CIRCULATORY SYSTEM

1. What is the rate and character of the pulse?

Rate	<i>per minute</i>	Character	
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2. What is the position of the apex of the heart?

in the		interspace		cm from mid-sternal line
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3. Is there any evidence of cardiac enlargement?

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

4. Is there any abnormality in the heart sounds or rhythm?

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

5. Is there any murmur present?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Describe, include site, timing, intensity & transmission. Indicate any effect on posture or respiration of the murmur.

B. CIRCULATORY SYSTEM *continued*

6. What is the blood pressure (*auscultatory method*)?

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.

Systolic		Diastolic		<i>mm Hg</i>
Systolic		Diastolic		<i>mm Hg</i>
Systolic		Diastolic		<i>mm Hg</i>

7. Is there any abnormality of the peripheral arterial or venous circulation?

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

8. Do you consider the heart and vascular system to be abnormal?

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

9. Is the examinee now on treatment for hypertension?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Give details below	
Specify pre-treatment blood pressure			
Systolic		Diastolic	
Date treatment commenced			
/ /			
Nature of treatment			

C. MEASUREMENTS

1. Height (*without shoes*) and weight (*clothed*)

Height	<i>cm</i>	Weight	<i>kg</i>
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2. Chest and abdomen at umbilicus (*next to skin*)

Chest, expiration	<i>cm</i>	Chest, inspiration	<i>cm</i>
Abdomen	<i>cm</i>		

3. If chest expansion is less than 5 cm, comment as to apparent cause or provide peak flow meter reading.

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D. RESPIRATORY SYSTEM

1. Is there any abnormality of the respiratory system to palpation, percussion or auscultation?

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

2. Is there any sign of past or present respiratory disease?

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

E. DIGESTIVE AND LYMPHATIC SYSTEMS

1. Is there any abnormality of the tongue, mouth or throat?

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

2. Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen?

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

3. Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?

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

4. Is a hernia present?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	Describe fully	

F. GENITO-URINARY SYSTEM

1. Examination of the urine. The urine should be passed at the time of examination. If not, state circumstances.

Was albumin found in the sample? <i>NOTE: If albumin is found, an early morning specimen will need to be examined and the findings forwarded to us.</i>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Was glucose found in the sample?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Was blood found in the sample?	No <input type="checkbox"/> Yes <input type="checkbox"/>

2. Is there any abnormality of the genito-urinary system?

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

3. *For females only* – Is the examinee pregnant?

No <input type="checkbox"/>	Yes <input type="checkbox"/>	Specify expected confinement date	

G. NERVOUS SYSTEM

1. Is there any defect of vision, hearing or speech?

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

2. Is there any evidence of mental abnormality or any disorder of the central or peripheral nervous system?

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

H. MUSCULO-SKELETAL SYSTEM AND SKIN

1. Is there any abnormality of the joints, muscles or connective tissues, the back or neck?

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

2. Is there any evidence of any disorder of the skin, including melanomas or other lesions?

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

I. SUMMARY

1. Do you consider any medical attendants' reports or any special tests are required? *NOTE: NO special tests are to be carried out in connection with the application for insurance without the Company's authority.*

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

2. Do you consider the person examined likely to require any surgical operation?

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

3. Comment fully on any unfavourable features (physical or mental) which could either reduce life expectancy or cause disablement in the personal or medical family history or as disclosed by your medical examination.

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

Please attach a copy of the patient records, to assist us in assessing the application for insurance.

Signature of Medical Examiner

Date

X

/ /

Name

Use BLOCK letters

Qualifications

Postal address

Postcode

Phone number

Fax number

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This Medical Examination is a matter of importance to the person you have just examined and it would be appreciated if you would forward the report without delay to:

*Please make invoice payable to TOWER Australia
Please return the completed form to:*
**TOWER Australia
GPO Box 5380
Sydney NSW 2001**