



Medical Authority Form Life Insurance Plan

Policy Number

Full Name of Deceased

Cause of Death

I, being the next of kin or the Executor of the deceased's estate, hereby authorise and direct any Medical Attendant, Hospital, Health Insurance Commission, Coroner's Office or Insurance Company to divulge to TOWER Australia Limited, the Trustee of the Superannuation Fund or Legal Tribunal (where applicable) any information which they hold, or are able to acquire with regard to the Life Insured. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I understand that such information will be treated as confidential and will only be used in connection with this claim.

Full Name

Next of Kin Executor

Residential Address

Signature of Claimant

Date

Signature of Witness

Date