

Major Illness Plan Claim Form - Death Only

This form is to be completed in the event of death of a Life Insured

To assist us in ensuring you receive a prompt settlement, please complete the details below. If you need any assistance with this form, please call TOWER's Claims Department on 1800 101 019.

Please note that any benefit amount payable under Major Illness Plan will be paid to you as policy owner, or to your estate if you are also the life insured, in accordance with Probate or Letters of Administration.

1 Claim Application

Policy Number	<input type="text"/>
Policy Owner	<input type="text"/>
Full Name of Deceased	<input type="text"/>
Date of Death	<input type="text"/>

Please complete either Part 'A' OR Part 'B' if the deceased was the policy owner

A. To be completed if the deceased had a will

Executor(s) named in the Will	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Has probate been applied for?	<input type="text"/>
Has probate been granted?	<input type="text"/>
If the claim application is being completed by someone other than those stated above, please give details:	
	<input type="text"/>
	<input type="text"/>

B. To be completed if the deceased did not have a will

Have Letters of Administration been applied for?	<input type="text"/>
If so, by whom?	<input type="text"/>
Have Letters of Administration been granted?	<input type="text"/>
If Letters of Administration are not being applied for, please state the full name of the claimant and their relationship with the deceased	
	<input type="text"/>
	<input type="text"/>

2 Policy Discharge *(Please note, this section of the form will only be used if TOWER accepts liability for the claim)*

I / We hereby request payment of \$ being the sum insured for the above policy, by cheque, made payable to (Payee) of (Address)

in full satisfaction for all claims whatsoever under the above policy for the above life insured, and do hereby discharge

TOWER Australia Limited from all liability thereunder other than for payment of the amount stated.

Signature of Claimant	<input type="text" value="X"/>	Date	<input type="text"/>
Signature of Witness	<input type="text" value="X"/>	Date	<input type="text"/>



Medical Authority Form Major Illness Plan

Policy Owner

Full Name of Deceased

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

X

Date

Signature of Witness

X

Date