Request for Insurance / Personal Statement

This form can be used to obtain or change your insurance cover.

Your Duty of Disclosure

When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the policy.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate policies of life insurance. If they do, we may apply the following rights separately to each type of cover.

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the policy within 3 years of entering into it.

If we choose not to avoid the policy, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

Disclosure – MLC Transfer Applications

If you apply to transfer your insurance from an existing MLC policy to a new MLC policy (transfer application), we will rely on the matters disclosed and representations made to us prior to entering into the existing MLC policy and, if applicable, the matters disclosed and representations made to us with your application for a new MLC policy (including an application for any change, increase or addition to the existing MLC policy) when making a decision whether to accept the transfer application and on what terms.

If we refuse your transfer application for any reason, your existing insurance will continue unless you choose to cancel it or your insurance ends.

By submitting a transfer application you consent to this process.

SECTION A – INSURANCE DETAILS

Policy name

Policy number

Please specify the type of insurance cover being applied for:

☐ Death only cover ☐ Death and TPD

☐ Salary Continuance ☐ Trauma

SECTION B – ADVISER DETAILS

Adviser Name

Adviser Phone Number

( )

Adviser Email

I agree to the Insurer or any one of their authorised representatives contacting the client directly if required to collect further information to assist with the completion of this application.

I am lawfully authorised to advise on, and deal in, MLC Group Insurance policies under an Australian Financial Services Licence. I do not provide these services on behalf of MLC Limited (ABN 90 000 000 402) (AFSL 230694).

Signature of the financial adviser listed above

X Date (DD/MM/YYYY)

SECTION C – PERSONAL DETAILS

1 Person whose life is to be insured

Title Surname (Family name)

Given names

Male ☐ Female ☐ Date of birth / /

Marital status

2 Contact address for notices

Postcode

Home telephone ( )

Work telephone ( )

Mobile phone number

Facsimile ( )

Email address (Please provide your email so notices relating to your application can be sent to you)

SECTION D – EMPLOYMENT DETAILS

3 Current employer's name

4 What is your current occupation?

5 What professional or trade qualification do you have?

6 On what basis are you employed?

☐ Full-time ☐ Part-time ☐ Casual

☐ Contractor ☐ Fixed-term employment

Date you started with your CURRENT employer. / /

7 What is your annual salary? $

SECTION E – ADDITIONAL DETAILS

8 Are you in receipt of or have you ever made a claim for any type of accident or sickness (including lump sum total and permanent disablement, workers' compensation or third party insurance benefit) or have you ever applied for unemployment, sickness or accident benefits or other Centrelink or Veterans' Affairs Benefits?

No ☐

Yes ☐ Give details

9 Have you ever had an application for insurance on your life declined, postponed, cancelled, accepted with an exclusion or a higher than standard premium, or modified in any way?

No ☐

Yes ☐ Give details

10 Are you covered by, or are you applying for other life, disability, critical illness, or income protection insurance with any company including the Insurer (other than this application) —including benefits under superannuation?

No ☐

Yes ☐ Give details for each.

If there is not enough space here, please list at Question 29, page 5.

Type of Insurance

Commencement Date / /

Company

Policy Number

Sum Insured or Monthly Benefit

If income protection Waiting Period

Benefit Period

Is this application replacing this insurance? No ☐ Yes ☐

If you answered "Yes" to this question please ensure you cancel your insurance with the Insurer or another provider once this application has been accepted.

11 Do you now engage or do you intend to engage in any of the following activities?

	No	Yes
a Flying as a pilot or crew in an aircraft	☐	☐
b Motor car, motor cycle or motor boat racing	☐	☐
c Underwater diving	☐	☐
d Football, parachuting, hang-gliding	☐	☐
e Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain climbing, mountain biking, downhill mountain biking)	☐	☐

If you answered 'Yes' to any of these, complete the Supplementary Pastimes Questionnaire on page 9.

If you answered 'Yes' to any of these, give full details of each below.

If there is not enough space here, please list at Question 29, page 5

Activity

Location

Amateur ☐ Professional ☐ Events/Hours per year ☐

Other details

SECTION F – HEALTH AND MEDICAL HISTORY

12 What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the doctor you last visited)

If you have known this doctor for less than 12 months, please also advise your previous doctor's details at question 29 on page 5.

This question must be completed.

Doctor's name or medical centre

Address

Postcode

Business Number ( )

How long have you been attending this practice?

years months

Please provide details of your last check-up or consultation.

Date of last consultation / /

Reason for last check-up or consultation

Result

Medication prescribed, referral given or tests ordered

13 Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition?

☐ No ☐ Yes

14 In the past three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? Note – HIV risk situations are situations in which you have been potentially exposed to HIV infection. These situations include but are not limited to, intercourse with someone you know or suspect to be HIV positive, intravenous drug use, or unprotected anal intercourse, (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years)

☐ No

☐ Yes — A confidential questionnaire will be sent out to you to complete and return to the Insurer's Chief Underwriter.

15 Have you ever had any of the following conditions?

If you answer 'Yes' to a, b, c, d, e and/or f, please complete and submit the relevant supplementary questionnaire from pages 10 to 14.

	No	Yes
a Asthma (questionnaire on page 10)	☐	☐
b any cyst, mole or skin lesion requiring medical advice or treatment (questionnaire on page 10)	☐	☐
c a strained back, sciatica, whiplash, spondylitis or any other back, neck or spinal problem (if applying for GSC or TPD, questionnaire on page 13, otherwise give details at question 27)	☐	☐
d any disorder of the bones, joints or muscles, arthritis, gout or repetitive strain injury (questionnaire on page 14)	☐	☐
e treatment or counselling for depression, or any nervous, anxiety, stress or mental disorder (questionnaire on page 12)	☐	☐
f high blood pressure or high cholesterol (questionnaire on page 11)	☐	☐

16 Further medical requirements may be necessary to assess your application (eg. Blood tests, Medical exam). Do you wish the Insurer to arrange these?

☐ No ▶ You will be advised what requirements to organise.

☐ Yes ▶ The Insurer's provider will contact you directly.

17 Do you drink alcohol?

☐ No

☐ Yes — Number of standard drinks: per day or per week

Note: 1 standard drink = 1 glass of beer/wine/nip of spirit

18 Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

☐ No

☐ Yes — What type? eg cigarettes, gum, patch | Daily quantity

19 What is your height/weight? cm kg

20 Do you currently have or have you ever had any of the following?

If you answered 'Yes' to any item in this question please give details at Question 27.

	No	Yes
Heart complaint **a**	☐	☐
Epilepsy or any neurological disorder **b**	☐	☐
Stroke or vascular disorder **c**	☐	☐
Lung complaint **d**	☐	☐
Diabetes, bowel, kidney or bladder disorder **e**	☐	☐
Alcohol or drug dependence **f**	☐	☐
Professional advice to reduce alcohol consumption **g**	☐	☐
Migraine, persistent headache or chronic fatigue **h**	☐	☐
Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease **i**	☐	☐
Cancer or leukaemia **j**	☐	☐
Haemophilia or blood disorder **k**	☐	☐
Thyroid disorder **l**	☐	☐
Liver disorder, hepatitis or test indicating past or present hepatitis infection **m**	☐	☐
Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat **n**	☐	☐
Any other operation, disability, illness or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned **o**	☐	☐

21 Other than already stated, have you in the last 5 years:

		No	Yes
Taken any prescribed medication on a regular or ongoing basis? (Other than for colds or flu)	**a**	☐	☐
Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?	**b**	☐	☐

If you answered 'Yes' to any item in this question please give details at Question 27.

22 Do you currently have any other disability, illness, injury or symptoms not already mentioned?

☐ No ☐ Yes

If you answered 'Yes' to this question please give details at Question 27.

23 Are you contemplating seeking any medical advice, test, investigation or treatment?

☐ No ☐ Yes

If you answered 'Yes' to this question please give details at Question 27.

Males: Go to Question 27.

Females Only

24 Have you had any complications of pregnancy or childbirth?

No ☐

Yes ☐ **Give details at Question 27.**

25 Are you currently pregnant?

No ☐

Yes ☐ Date due

/ /

26 Have you ever had an abnormal pap smear?

No ☐

Yes ☐ When

Treatment

Date and result of most recent pap smear

27 Did you answer 'Yes' to any item in Questions 15(c), 20, 21, 22, 23 and 24?

No ☐ **Go to next question**

Yes ☐ **Give full and accurate details below of each instance. If you are completing any of the questionnaires at the back of this application, you do not need to give the same details here. If there is not enough space here, please list at question 29.**

Question number in Section F	Illness, injury, condition or test	Test results	When did it start?	When did it cease?	Type of treatment and when treatment ceased	How long off work?	Have you completely recovered?	Name and address of institution and attending person

28 Have any of your parents, brothers or sisters (living or deceased) suffered from any of the following?

- Cancer (specify type and site)
- Diabetes
- Huntington's disease
- Familial polyposis
- Heart disease
- Kidney disease
- Motor neurone disease
- Any other hereditary disorder
- Stroke
- Rheumatoid arthritis
- Muscular dystrophy
- Multiple sclerosis

No ☐

Yes ☐ **Please provide details below**

Relationship	Medical condition	Cancer type and site	Age condition began	Age at death (if applicable)

29 Further information

You can use this space to provide further information. Please note the page and question number the additional information refers to.

Page Number	Question Number	Further Information

SECTION G – DECLARATION

Read this section carefully before signing.

My decision to apply for insurance under MLC Group Insurance is based on the Product Disclosure Statement and/or Policy Document for the relevant product that I have received and my understanding of the information it contains.

I understand and agree that:

(a) I have read the Duty of Disclosure set out on page 1. I understand that, until the Insurer accepts this application, I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to the Insurer's acceptance of this application and that if I fail to comply with my duty of disclosure the Insurer's may (as permitted by law) decline to pay, or reduce our liability to pay, the benefits under this policy;

(b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;

(c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;

(d) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.

(e) Where this application is for insurance cover under a superannuation fund, I will provide the Insurer or the Trustee or any appointed adviser, intermediary or administrator with any information which relates to my membership of that fund which they may request;

(f) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;

(g) I was actively at work performing the normal duties of my occupation when I applied for this insurance;

(h) All statements and declarations given by me on this form are true and correct; and

(i) The information contained in this application may be released to the trustee which has arranged this group insurance, or to an adviser, intermediary or administrator appointed by the trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise the Insurer to:

(a) Collect further medical information from any doctor, medical centre, hospital or any other health service provider identified by me in this application for the purpose of assessing my application for insurance; and

(b) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance; and

(c) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at Question 12 of Section E, Health and Medical History; and

(d) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at Question 12 of Section E, Health and Medical History unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b), (c) and (d) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my personal information in a manner set out in the Insurer's privacy policy available on **mlc.com.au**

I acknowledge that where my Employer (or former Employer) or the trustee of my superannuation fund has appointed an adviser, intermediary or administrator to arrange and/or administer the group insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance.

I understand that I can withdraw this consent at any time by contacting the Insurer on **(02) 8908 6111** or email **group_insurance@mlc.com.au**

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

I acknowledge that MLC Group Insurance does not represent a deposit with or liability of NAB Limited or any other member of the National Group of companies. Neither NAB Limited, nor any other company in the National Group of Companies guarantees or accepts liability in respect of MLC Group Insurance.

Signature of Life to be Insured

X .....

Date

/ /

YOU MUST SIGN THE MEDICAL AUTHORITY ON PAGE 7.

Have you completed or were you requested to complete any questionnaires in this application form?

No ☐ Please return pages 1 to 8 of the completed form.

Yes ☐ Please return pages 1 to 14 of the completed form INCLUDING any completed questionnaires.

SEND TO:

Mail:
MLC Group Insurance
PO Box 200
North Sydney NSW 2059

Phone:
(02) 8908 6111

Email:
group_insurance@mlc.com.au

Website:
mlc.com.au

(DO NOT DETACH)

Medical Authority

Please sign and date

Authority to obtain a report from a medical practitioner or hospital.

I request and authorise any doctor/hospital/clinic to supply the Insurer and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction. **A photocopy of this authorisation shall be as valid as the original.**

Print Name

If married, what is your maiden name?

Signature of Life to be Insured

X Date / /

Pathology Request for Insurance

This must be completed when a blood test is required.

Life to be Insured's Details

Title | Surname (Family Name) (please print) | Given Names | Sex | Date of birth

Policy name

Policy number

Family doctor or hospital – name and address

Postcode

Report and account to	Collection date and time	Tests required
Chief Medical Officer MLC Group Insurance PO Box 200 North Sydney NSW 2059 Phone: 133 442	Date of appointment / / Time of appointment am/pm	☐ Multiple Biochemical Analysis 20 (Chol. (HDL & LDL), Trigs., Glucose, Creat., Uric acid, LFTs, Electrolytes), and Hepatitis B and C serology ☐ HIV Antibodies ☐ Other (specify)

Life to be Insured's consent (not to be signed prior to attendance)

I give my consent to the tests nominated above including any reflex testing for Hepatitis B and C to be performed. Where one is for the presence of antibodies to the AIDS virus (HIV). I acknowledge that I have read the material provided by the Insurer (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to the Insurer and to my family doctor as shown above.

☐ No
☐ Yes

Signature of Life to be Insured X Date / /

MLC Limited ABN 90 000 000 402 AFSL 230694 (the Insurer) uses the MLC brand under licence. MLC Limited is part of the Nippon Life Insurance group and not a part of the NAB group of companies. Any references to 'we', 'us' and 'our' means MLC Limited.

Information about the HIV Antibody Blood Test

To fully assess this application for insurance, we may request you undergo an HIV antibody blood test. This test could be arranged through your own doctor, by consulting a doctor arranged by us or directly with the pathology laboratory. This test is completely voluntary. However, if you refuse the test, it could affect our willingness to accept this application.

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV) which destroys some of the white blood cells in our bodies. These white blood cells help protect our bodies against infection and cancers. Some people infected with HIV therefore suffer infections or cancers and, in some cases, direct damage to the brain by the virus. The most recent evidence suggests that the virus will persist in the body indefinitely. As yet, there is no cure for AIDS.

Following infection, there may be mild flu-like symptoms or no symptoms at all. The body subsequently manufactures antibodies to the virus, usually within 8 to 12 weeks, but occasionally longer. These antibodies can be detected by a blood test and this is the test proposed. The infected individual may remain free of symptoms for many years, but during this time may pass on the infection to others. The first symptoms may include weight loss, fever, swollen glands, diarrhoea, coughs, cancer or nervous system diseases.

A POSITIVE RESULT

If the result of the HIV antibody test is positive, this means:

1. You have been infected by HIV,
2. You can pass this infection:
   (a) to any unprotected sexual partner,
   (b) to anyone receiving your blood, donated organs or semen,
   (c) if you are an intravenous drug user, to anyone sharing syringes or needles with you,
   (d) if you are a woman, to a baby during pregnancy, and perhaps at birth or by breast feeding.

   There is no evidence that the virus can be spread by other types of contact, such as touching, sharing eating utensils, coughing, sneezing or from mosquito bites.
3. Full AIDS is notifiable throughout Australia. In some States and Territories, HIV infection and other early stages of the disease are also notifiable to the health authority. In most cases, notification is by name and address, though in some States, it is by code.
4. Knowing that you are HIV antibody positive has legal consequences in all States and Territories, although they vary. It may exclude you from some jobs and from access to some services. It can be an offence to knowingly transmit the virus or put someone at risk of infection through sexual activity. There are quarantine provisions which may be used if the authorities consider it appropriate.
5. In many cases, the full effects of AIDS will develop at some stage and the long-term outlook is still uncertain. As a result, life and disability insurance is unlikely to be available to anyone infected with HIV.

If the result of the test is positive, it is important that you receive appropriate counselling from a doctor. You are asked to nominate your family doctor to give you this counselling in the consent declaration contained in the Application form attached to this brochure, see Section F. You may wish to nominate an alternative doctor. We will pass a positive result on to that doctor for onward communication to you.

A NEGATIVE RESULT

If the result of the HIV antibody test is negative, this means, either that you have not been infected or that you have been infected recently but your body has not yet had time to manufacture antibodies. However, you should be alert to the risk of becoming infected and refrain from activities which make that possible—particularly unsafe sexual practices and sharing of syringes or needles.

THE CHOICE IS YOURS

You may choose not to have the test for a variety of reasons, eg you may feel you would not be able to cope with the knowledge of a positive result and the medical implications which follow, or you may be concerned about the social implications (discrimination, stigma, etc). You may feel that you would like more information first, in which case you are advised to seek advice from your own doctor. If you do not have one, or would prefer advice from elsewhere, you should see a specialist counsellor on the subject. Government and community organisations provide AIDS counselling services.

If you choose to have the test arranged by us, we are concerned to protect your privacy. The result will be sent under confidential cover to our Chief Medical Officer. A positive result will not be transferred to our general records on your application for insurance.

Supplementary Pastimes Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

UNDERWATER DIVING

1 Do you hold a diving qualification?

No ☐

Yes ☐ Type of qualification and time held

2 How many dives do you make per year?

3 What is the average depth of dives? metres

4 What is the maximum depth of dives? metres

5 Do you ever dive alone?

No ☐

Yes ☐

6 Do you dive in caves, potholes, or at night?

No ☐

Yes ☐ Give details

7 Do you use mixed gases to dive?

No ☐

Yes ☐ Give details

8 Have you ever had an accident whilst diving or suffered an injury?

No ☐

Yes ☐ Give details

MOTOR CAR, CYCLE OR BOAT RACING

9 What vehicle type do you race?

10 In what events and categories do you race?
(Please use CAMS category descriptions where applicable)

11 What is the engine size?

12 What maximum speed is reached?

13 How many times do you race per year?

AVIATION

14 Do you hold an aviation licence?

No ☐ **Go to Question 16**

Yes ☐ Type of licence and period of time held

15 Do you intend to change the scope of your licence, or engage in any other form of aviation other than as shown in question 3 below?

No ☐

Yes ☐ Give details, including the qualifications you intend to obtain

16 Please complete number of flying hours in the following table

	Last year		Future average	
	Crew	**Passenger**	**Crew**	**Passenger**
Commercial Airline				
Charter				
Private				
Aero club / Flying school				
Agriculture				
Ultralight				
Helicopter				

Return to Question 11 on page 2

Supplementary Asthma Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 When did you have your first episode?

2 How frequently do you need to use medication (inhalers, tablets, etc.)?

3 Approximately how many episodes occur per year?

4 When was your most recent episode?

5 How much time have you lost from work due to asthma in the

6 Have you ever been hospitalised for this condition or needed to attend a hospital, casualty or doctor's surgery for urgent treatment?

No ☐

Yes ☐ Please provide names of hospitals, doctors and dates

7 Have you consulted any other doctor for this condition?

No ☐

Yes ☐ Please provide names of hospitals, doctors and dates

8 Are you now taking medication or have you used any medication (including steroids) within the last 12 months?

No ☐

Yes ☐ Please provide name of drug, daily dosage and date ceased (if applicable)

9 Do you record your own peak flow levels?

No ☐

Yes ☐ Please provide details of how often you record your own peak flow levels and on average what the results are.

Return to Question 15(a) on page 3.

Supplementary Cyst / Mole / Skin Lesion Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 Site

2 Date diagnosed / /

3 Type

4 Was the cyst/mole/skin lesion removed?

No ☐

Yes ☐ When?

By what method? (eg surgically, freezing or otherwise)

5 Were any special tests, investigations or treatments required?

No ☐

Yes ☐ Please provide details

6 Was the growth reported to be malignant or benign by your treating doctor?

☐ Malignant ☐ Benign

Please forward copies of any histopathology reports you have.

7 Have you been or are you required to attend for any further treatment or follow-up since the original removal including re-excision of the lesion?

No ☐

Yes ☐ Please provide details of date(s) and what was advised

8 Name and address of doctor consulted

Postcode

Return to Question 15(b) on page 3.

Supplementary High Blood Pressure / High Cholesterol Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 (a) What was your last blood pressure/cholesterol reading, and when was this taken?

Blood pressure

Systolic	Diastolic	Date
		/ /

Cholesterol

Reading	Date
	/ /

(b) Is this reading consistent with others when checked?

No ☐ What is your typical reading?

Yes ☐

2 When are you due for your next checkup?

3 How often are you required to attend your doctor for review/checkups?

Monthly ☐ Twice yearly ☐

Quarterly ☐ Annually ☐

4 When were you first told you had raised blood pressure/raised cholesterol levels?

5 Are you currently taking medication for your blood pressure/cholesterol levels?

No ☐ **Go to Question 7**

Yes ☐ Please provide names of medication and daily dosage

6 Has your treatment (type or dosage) been changed within the last 12 months?

No ☐ **Go to Question 8**

Yes ☐ When was it changed?

What was changed?

Why was it changed?

7 Have you ever been prescribed medication for blood pressure/cholesterol?

No ☐ How has the condition been managed?

Yes ☐ When and why did you cease taking this?

8 What was your last blood pressure/cholesterol reading at the time of diagnosis?

Blood pressure (eg 120/80)

Systolic	Diastolic

Cholesterol

Reading

9 Have you ever undergone or been referred for any other investigations: eg ECG (resting or exercise stress), Echocardiogram, 24 hr Holter monitoring, urinalysis?

No ☐

Yes ☐ What were the results?

Who holds the results of any investigations (eg GP)?

10 Has an underlying cause been found for your raised blood pressure/cholesterol?

No ☐

Yes ☐ Please provide full details

Return to Question 15(f) on page 3.

Supplementary Mental Health Questionnaire

Complete this questionnaire only if requested to do so. To be completed by the Life to be Insured.
If there is not enough space here please complete additional details at Question 29, page 5.

1 Please indicate the conditions you have had or received treatment for?

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including Anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Other Please describe

2 Please describe your symptoms including the date they started and how long they lasted

3 Has any reason for your condition been identified?

No ☐

Yes ☐ Please provide details

4 When was your condition first diagnosed?

5 Have you had any recurrences of this condition?

No ☐

Yes ☐ How many times? When?

6 Have you ever received any counselling or treatment for this condition? (eg medication, CBT, hospitalisation)

No ☐

Yes ☐ **Please provide details below**

Type of treatment	Date commenced	Date ceased

7 Are you currently receiving treatment?

No ☐ When did you cease treatment? / /

Yes ☐ Please advise details:

8 Please provide the names and addresses of doctors you have consulted including the date first and last consulted. Please complete additional details at Question 29, page 5.

Doctor's Name

Address

Postcode

Date first consulted / /

Date last consulted / /

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

No ☐

Yes ☐ Please advise details:

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

No ☐

Yes ☐ Please advise details:

11 Do you continue to experience symptoms?

No ☐ **Go to Question 12**

Yes ☐ **Go to Question 13**

12 When did you last experience symptoms?

13 Describe your symptoms?

Return to Question 15(e) on page 3.

Supplementary Back/Neck Disorder Questionnaire

Complete this Questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 When did you first suffer from a back/neck disorder?

2 What is the cause of your back/neck disorder?

3 What is/was the exact nature of the back/neck disorder including symptoms?

4 What area of your back/neck is affected?

5 Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted and approximate dates.

Name

Address

Postcode

Approximate dates

Name

Address

Postcode

Approximate dates

6 Have you undergone any x-ray, scan or other test?

No ☐

Yes ☐ Please provide details and results

7 What treatment have you had? (eg physiotherapy, medication, brace, surgery)

8 Are you still undergoing treatment?

No ☐ When did treatment cease? / /

Yes ☐

9 When did you last experience symptoms?

10 Do you continue to experience symptoms?

No ☐ **Go to Question 13**

Yes ☐

11 What are your current symptoms?

12 How often do you experience symptoms?

13 Have you lost time from work due to this disorder?

(a) In the last 12 months?

No ☐ **Go to (b)**

Yes ☐

From	To
/ /	/ /
/ /	/ /
/ /	/ /

(b) Prior to the last 12 months?

No ☐

Yes ☐ Please provide full details of all periods of time off work including dates

Return to Question 15(c) on page 3.

Supplementary Joint/Musculoskeletal Questionnaire

Complete this Questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 Which joint(s) or area(s) of the body are affected?
(Advise if left or right joint, where applicable)

2 What is/was the nature of the joint disorder, including symptoms?

3 What is the cause of the disorder?

4 When did the symptoms first occur?

5 When did you last experience symptoms?

6 Do you continue to experience symptoms?

No ☐ **Go to Question 9**

Yes ☐

7 What are your current symptoms?

8 How often do you experience symptoms?

9 What treatment have you had?

10 Are you still undergoing treatment?

No ☐ When did treatment cease? / /

Yes ☐

11 Have you had an x-ray or other test?

No ☐

Yes ☐ Please provide details, including dates and results

12 Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted.

Name

Address

Postcode

Name

Address

Postcode

13 Have you lost time from work due to this disorder?

(a) In the last 12 months?

No ☐ **Go to (b)**

Yes ☐

From	To
/ /	/ /
/ /	/ /
/ /	/ /

(b) Prior to the last 12 months?

No ☐

Yes ☐ Please provide full details of all periods of time off work including dates

Return to Question 15(d) on page 3.

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