vision super

LIFE INSURANCE MLC

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 the Insurer every matter that you know, or a reasonable person could be expected to know that may affect our decision to insure you and on what terms.

You have this duty until the Insurer agrees to insure you.

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

You do not need to tell the Insurer anything that:

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

Where the Trustee of Vision Super obtains life insurance from the Insurer on your life, the Trustee requires you to make full disclosure to it on the same basis. The Insurer relies on the disclosures that you or the Trustee makes to them.

If you do not tell the Insurer something

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

If you do not tell the insurer something you are required to or you misrepresent something and they would have insured you on different terms if you had told the true circumstances, they may avoid the policy within 3 years of entering into it. This means they will treat the policy or cover as if it never existed. If the misrepresentation or failure to tell the Insurer was fraudulent, they can avoid the policy or cover at any time.

If they choose not to avoid the policy, they 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 the Insurer everything you should have. However, if the policy provides cover on death, they may only exercise this right within 3 years of entering into the policy.

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

If your failure to tell the Insurer is fraudulent, they may avoid the policy at any time. This means the policy is treated as if it never existed and no claim will be payable.

Information about genetic tests

If you have had a genetic test, you only need to disclose this to us if your total insurance cover (including cover under superannuation or held with other life insurers as well as cover applied for) will be more than any one of the following:

- $500,000 life cover, or
- $500,000 Total and permanent disability cover (TPD), or
- $200,000 critical illness (trauma) cover, or
- $4,000 per month income protection cover, salary continuance cover or business expenses cover.

Your cover may have been arranged through a financial adviser or directly with a life insurance company or cover is held under a group arrangement.

If you have had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

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

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

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.

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

If income protection 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 biopsy, mammogram, ultrasound, ECG) not already mentioned	**o**	☐	☐

**Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing*

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?
**Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing*

☐ 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 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) 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

(b) 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 F, Health and Medical History; and

(c) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at Question 12 of Section F, 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) and (c) 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 **mlcinsurance.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 **1800 652 447** or email **enquiries.group@mlcinsurance.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.

Signature of Life to be Insured

X

Date

/ /

YOU MUST SIGN THE MEDICAL AUTHORITY ON PAGE 7-8.

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

No ☐ Please return pages 1-9 of the completed form.

Yes ☐ Please return pages 1-16 of the completed form INCLUDING any completed questionnaires.

SEND TO:

Mail:
Vision Super
P.O. Box 18041
Collins Street East
VIC 8003.

Freecall:
1300 300 820

(DO NOT DETACH)

Authority to Release Medical Information

(to be completed in All cases)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **MLC Life Insurance**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority to Release Medical Information - Authority 1

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **MLC Life Insurance**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MLC Life Insurance** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

Authority to Release Medical Information – Authority 2

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **MLC Life Insurance**, or to third parties they engage, only if **MLC Life Insurance** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

Pathology Request for Insurance

This must be completed when a blood test is required.

LIFE INSURANCE

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 23455 Docklands Vic 3008 Phone: 1800 652 447	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 ✗ Date / /

HIV Antibody Blood Test

In accessing this application for insurance we may ask you to have a blood test to check your overall health, and to test for HIV. This is because we need to understand your state of health when taking out a life insurance policy.

The test can be done by your own doctor, by appointment with a doctor or paramedical nurse arranged by us, or directly with the pathology laboratory.

This test is voluntary, however, if you choose not to have the test, it could affect our decision to accept this application based on the other information you have provided to us.

AIDS/HIV

- Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV).
- HIV weakens and destroys some of the white blood cells in our bodies – these cells help protect our bodies against infection and cancer.
- Evidence suggests that the virus will be in the body indefinitely but there are now effective treatment options available called antiretroviral therapy (ART).

A negative result

A negative result means you have not been infected or you have been infected recently but your body is not yet displaying the infection.

A positive result

A positive result means you have been infected by HIV.

Knowing that you are HIV positive has legal consequences which vary across all States and Territories. Because the long-term outlook for HIV and developing AIDS is unknown, most insurance is unlikely.

What happens to the results?

- You'll be asked to nominate your family doctor – or an alternative – to be sent the result by us and provide you the counselling.
- This will be in the consent declaration in the Application Form attached to this brochure.
- If the test is arranged by us the result is sent to us, MLC, confidentially to protect your privacy.
- If it's positive, you will receive proper counselling from a doctor.

Your choice

There may be several reasons you choose not to have this test including the impact of a potentially positive result on the HIV test.

If you may need more information before deciding, you are advised to seek advice from your own doctor, or a specialist HIV counsellor. Government and community organisations provide counselling services.

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 16 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 past 12 months?

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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