

# Full Personal Statement and Declaration of Health



## MetLife®

### Duty of Disclosure (Insurance Contracts Act 1984)

#### Your Duty of Disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you vary or reinstate a contract of life insurance.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is common knowledge;
- that your insurer knows or, in the ordinary course of the insurer's business as an insurer, ought to know; OR
- where compliance with your duty is waived by the insurer.

#### Non-disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

**Please note:** Your Duty of Disclosure continues until an insurance cover has been accepted by MetLife.

#### Privacy Statement

MetLife is subject to the National Privacy Principles under the Privacy Act 1988 and has a Privacy Statement that explains how we handle the information we collect about you. For a copy of the MetLife Privacy Statement, please refer to the Product Disclosure Statement which was provided to you or contact MetLife Customer Service on **1300 555 625**.

## Full Personal Statement and Declaration of Health

To be completed by the person whose life is to be insured.

If space is insufficient, please attach an extra sheet of paper.

Please complete the questionnaire in **BLACK** ink pen only.

Any changes made to this questionnaire to be initialled by the person whose life is to be insured.

Please answer all questions to the best of your ability as omissions will delay issue of your cover.

### Preliminary – For the Administrator of the scheme or superannuation fund to complete:

Name of Scheme or Superannuation Fund:

Number of Scheme or Superannuation Fund:

Reason for underwriting:

 Outside Eligibility Over Automatic Acceptance Limit No Automatic Acceptance Limit Other

If "Other", please specify.

	Life	TPD	Trauma	SCI
Amount already insured:				
Amount currently requesting:				
Total insurance if the amount requested is accepted:				

### For Completion by the Life Insured

Name of Employer and/or Member Number:

### Your Personal Details

Name:

Date of Birth:

 /  / 

Address:

State:

Postcode:

Contact Number(s):

Preferred:
Other:

Gender:

 Male Female

Preferred Contact Time?

 Morning (9-12am) Afternoon (12-6pm)

## Occupation Details

1 What is your current occupation?

2 Please give details of any qualifications (e.g. tertiary degree, trade certificate, etc).

  

3 How many hours per week do you work in your current occupation?

4 What are your main duties?

5 What percentage of your time do you spend performing the following types of duties?

Sedentary/Administrative

 %

Supervising

 %

Light Manual

 %

Heavy Manual

 %

Others including hazardous duties like working at heights or handling explosives etc

 %

6 How long have you been working in this occupation?

7 If less than 12 months, please state your occupations for the last 3 years.

  
  

8 Do you work from home?

Yes

No

If "Yes", please provide details (e.g. hours per week, separate entrance/office, etc).

  
  

9 Do you have a second occupation?

Yes

No

If "Yes", please provide details (e.g. type of occupation, hours per week, etc).

## Income Details

**10** If you are an employee, what is your current salary or remuneration package including superannuation?

**11** (a) If you are self-employed, please provide your business income details for the last three financial years.

Year Ending	Gross Income	Less Expenses	Net Income Before Tax/Loss	Drawings/Personal Super Contributions

(b) Have you or any business you have been associated with ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?

Yes  No

If "Yes", please provide details.

## Insurance History

**12** Has an application for Life, Trauma, TPD or Disability Insurance on your life ever been declined, deferred or withdrawn by any company, or accepted with a loading or exclusion or any other special condition or terms?

Yes  No

If "Yes", please give details.

**13** Do you have or are you applying for any Life, Trauma, TPD or Disability Insurance policies with MetLife or any other insurance company or Superannuation Fund?

Yes  No

**14** Is this application replacing existing cover with MetLife or any other insurance company or Superannuation Fund?

Yes  No

If you have answered "Yes" to Questions 12 or 13, please give details:

Company Name/ Superannuation Fund	Type of Cover	Sum Insured or Monthly Benefit	Waiting Period	Benefit Period	Is this Cover to be replaced?
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>

**Important Notice:** If this application for insurance is intended to replace existing cover indicated in the table above, you must cancel such cover upon notice that applied cover has been accepted by MetLife. If you do not cancel the existing cover indicated in the table above, MetLife may avoid the contract and no claim would be payable.

## Insurance History (cont.)

- 15** Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation?

Yes  No

If "Yes", please give details.


## Residence and Travel Details

- 16** Are you a permanent resident of Australia or New Zealand?

Yes  No

If "No", please give details.


- 17** Do you plan to travel, reside or work overseas in the next 12 months?

Yes  No

If "Yes", please advise where, for how long and for what reason.


## Sports and Pastimes

- 18** Have you ever participated in or do you currently take part or intend to take part in any of the following activities?

(a) Aviation other than as a fare paying passenger

Yes  No

(b) Motor sports or racing

Yes  No

(c) Underwater Diving

Yes  No

(d) Mountaineering or rock climbing

Yes  No

(e) Football (all codes)

Yes  No

(f) Other hazardous activities: e.g. hang gliding, parachuting, ocean racing, etc.

Yes  No

If you have answered "Yes" to any of the above questions, please complete the Pastimes and Activities Questionnaire in Question 32.



## Habits

- 19** Do you currently smoke or have you ever been a smoker?

Yes  No

If "Yes", what is/was your average daily quantity?

--

Form:  Cigarettes  Pipes  Cigars  Others (please specify)

--

If you have ceased smoking, please indicate when.

--

## Habits (cont.)

20 Have you ever been advised to reduce or cease smoking due to medical reasons?

Yes  No

If "Yes", please give full details.

21 Do you drink alcohol?

Yes  No

If "Yes", please provide details and average daily quantity.

Form	Daily Quantity (e.g. average glass/bottle)
Beer	
Wine	
Spirits	
Other (please specify)	

22 Have you ever been counselled, treated or advised to reduce or cease drinking alcohol due to medical reasons?

Yes  No

If "Yes", please give full details.

23 Do you use or have you ever used any drug not prescribed by a doctor (other than over-the-counter medicines for colds etc)?

Yes  No

If "Yes", please give full details.

## Doctor Details

24 What is the name of your usual Doctor?

Address:

State:

Postcode:

How long has he/she known you?

 years  months

Date you last consulted him/her:

 /  / 

Reason for your last consultation:

Result of your last consultation:

## Your Health History

25 (a) What is your height?

 cms

(b) What is your weight?

 kgs

26 Has your weight altered significantly in the past 12 months?

Yes  No

If "Yes", please give details and reason.

27 Have you ever had or sought advice or treatment for:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| (a) Chest pain, high blood pressure, heart, vein or circulatory disorder (e.g. heart attack, high cholesterol, varicose veins, rheumatic fever)?                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Asthma, bronchitis, coughing of blood, tuberculosis or any other lung complaint?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Gastric or duodenal ulcer, or persistent indigestion?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Diabetes or other pancreas disorder?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Epilepsy, fainting or fits?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Cancer, tumour, cyst or skin lesion?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Neuritis, sciatica or disease or injury to the muscles, tendons, bones, or joints, including the neck and back?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Mental illness or psychiatric disorder including depression, anxiety, stress, nervous disorder, eating disorder, chronic tiredness, panic or phobic disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (i) Arthritis, gout or rheumatism?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered "Yes" to any part of Question 27 above, you will also need to complete the 'Supplementary Risks Questionnaire' in Question 31.



28 Have you ever had or sought advice or treatment for:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| (a) Stomach, intestinal or rectal disorder, gall bladder or liver disorder, including hepatitis?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Paralysis or disorder of the brain or spinal cord, multiple sclerosis or any other neurological disorder?                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Any skin disorder (e.g. dermatitis, eczema or psoriasis)?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Kidney disease (e.g. renal colic), or bladder disorder?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Any defect in sight, hearing or speech, or any other physical deformity or abnormality?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Any blood disorder (e.g. leukaemia, haemophilia or anaemia)?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Other than already stated, within the last five years, have you:   |                              |                             |
| - received or had any other medical examinations, advice, treatment, operation or been in hospital?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| - taken any prescribed medication on a regular basis?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| - had an ECG, x-ray or other tests, including blood tests, for which you have received a consultation (excluding ailments such as cold and flu)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

## Your Health History (cont.)

(h) Do you intend to seek medical advice/treatment, or have you ever been advised to have or do you contemplate surgery in the near future? Yes  No

(i) Females only:

i) Are you currently pregnant? Yes  No

If "Yes", when is the due date?

/  /

ii) Have you ever had an abnormal pap smear, breast ultrasound/mammogram or breast lump (even if you have not consulted a doctor)? Yes  No

If you have answered "Yes" to any part of Question 28, please complete the table below.

Question Reference	Illness, Injury or tests	Date Commenced	Reason for and type of treatment	Time off work	Date of last symptoms	Degree of recovery	Full name and address of doctor or hospital (if any)
		/ /			/ /	%	
		/ /			/ /	%	
		/ /			/ /	%	

## Family History

29 Has any 1<sup>st</sup> degree relative suffered from diabetes, heart disease, cancer, stroke, kidney disease, mental illness, haemophilia, Huntington's chorea or any inherited or hereditary disease? Yes  No

If "Yes", please fill in the following schedule of family history.

Relationship	Condition (if cancer, please specify site and type)	Age at Diagnosis	Age at Death (if applicable)

## AIDS Statement

30 This must be completed in all circumstances.

(a) Have you any reason to believe that you are suffering from Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related illness, or that you are carrying the virus that causes AIDS, or that your spouse or any sexual partner is suffering from AIDS or carrying the virus that causes AIDS? Yes  No

(b) Since 1980, have you:

i) engaged in male to male anal sexual activity? Yes  No

ii) injected yourself with any drug not prescribed by a medical practitioner? Yes  No

iii) worked as or engaged in sexual activity with a prostitute? Yes  No

If you have answered "Yes" to any of the questions above, please provide details.

(Please note: a confidential questionnaire may be sent to you for completion and return).

## Supplementary Risks Questionnaire

**31** To be completed for any "Yes" answer to Question 27.

Please answer fully. If there is insufficient space or more than two conditions/illnesses, please attach a separate page with this information.

### Condition/Illness 1

(a) Specify illness, injury or complaint

(b) Which parts of the body were affected and which side (left/right) if applicable?

(c) Date the symptoms first started

 /  / 

(d) Describe the symptoms

(e) How many times have you suffered from this condition?

(f) What was the average duration of each attack/symptom?

(g) What was the duration of the most recent attack/symptom?

(h) Date of last attack/symptom

 /  / 

(i) How severe were attacks/symptoms?

Mild  Moderate  Severe

(j) Did the attacks/symptoms necessitate you being off work?

Yes  No

If "Yes", for how long?

 days

(k) Did you ever require hospitalisation?

Yes  No

If "Yes", where?

and how long?

 days

(l) Were any tests conducted?

Yes  No

If "Yes", what were the tests and results?

Date	Test	Result
/ /		
/ /		

(m) What treatment or medication was given/prescribed?

Treatment/Medication	Dosage	Frequency

**Supplementary Risks Questionnaire (cont.)**

(n) Are you on treatment or still being treated?

Yes  No

If "Yes", please describe the treatment(s).

(o) Degree of recovery

 %

(p) State name and address of doctor(s) consulted and date of last consultation.

Last consultation	Name	Address
/ /		
/ /		

**Condition/Illness 2**

(a) Specify illness, injury or complaint

(b) Which parts of the body were affected and which side (left/right) if applicable?

(c) Date the symptoms first started

 /  / 

(d) Describe the symptoms

(e) How many times have you suffered from this condition?

(f) What was the average duration of each attack/symptom?

(g) What was the duration of the most recent attack/symptom?

(h) Date of last attack/symptom

 /  / 

(i) How severe were attacks/symptoms?

Mild  Moderate  Severe

(j) Did the attacks/symptoms necessitate you being off work?

Yes  No

and how long?

 days

(k) Did you ever require hospitalisation?

Yes  No

If "Yes", where?

and how long?

 days

(l) Were any tests conducted?

Yes  No

If "Yes", what were the tests and results?

Date	Test	Result
/ /		
/ /		

## Supplementary Risks Questionnaire (cont.)

(m) What treatment or medication was given/prescribed?

Treatment/Medication	Dosage	Frequency

(n) Are you on treatment or still being treated?

Yes  No

If "Yes", please describe the treatment(s).

(o) Degree of recovery

 %

(p) State name and address of doctor(s) consulted, and date of last consultation.

Last consultation	Name	Address
/ /		
/ /		

## Pastimes and Activities Questionnaire

32 To be completed if answered "Yes" to Question 19.

(a) Underwater/Skin Diving

What type of diving do you engage in? (e.g. scuba, snorkel, hookah etc.)

Professional/Amateur

Where do you usually dive? (including any cave or wreck diving)

Qualifications

How many times per year do you dive?

Average depth

Maximum depth and number of times at this depth

(b) Aviation

If you are a pilot, what type of licence do you hold?

Pilot  Passenger

Please indicate type of aircraft you fly or are a passenger of and type of aviation you are involved in. (e.g. Commercial, Private, Agricultural, Aero Club, Helicopter, Ultralight Aircraft).

Pastimes and Activities Questionnaire (cont.)

Number of hours flown last year

Anticipated hours in the next year

**(c) Motor Racing**



What type of license do you hold?

If CAMS, state classification

Vehicle type

Engine size/capacity

Maximum speed

Number of events/races per year

Professional/Amateur

Type of racing/event(s)

**(d) Football/Soccer/Australian Rules/Rugby**

What sports do you participate in?

Professional/Amateur

Number of times per year

If Professional, please indicate annual amount (\$) received

**(e) Other.** (e.g. Boxing, Mountain Climbing/Abseiling, Competition Sports etc)

Activity

Professional/Amateur

Please provide full details including number of times per year, locations, heights, are activities undertaken individually or in a group/club etc.

## Declaration

- I have read and understand the Duty of Disclosure and understand that this duty applies until formal notification of acceptance.
- My answers to the questions are true, and I have not deliberately withheld any information material to the proposed insurance.
- I agree to be bound by the terms and conditions set out in the insurance policy document.
- I consent to the collection, use and disclosure of my personal information by MetLife and its service providers in order to assess my application and any claim under this policy.
- I have read and understood the Privacy Statement and agree to the collection, use and disclosure of personal information as described.
- I consent to MetLife seeking medical information from any doctor who I have consulted.
- I understand that cover under any policy does not begin until acceptance by MetLife of which I will be notified in writing.

Signature of the person whose life is to be insured:

Date:

		/			/		
--	--	---	--	--	---	--	--

Full Name:



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