

# Group Insurance Standard Personal Statement



## 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 of common knowledge;
- that your insurer knows or, in the ordinary course of the insurer's business as an insurer, ought to know;
- 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 take into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

**Please note:** that your Duty of Disclosure continues until you have been accepted in writing by the insurer.

### Privacy Statement

MetLife is subject to the National Privacy Principles under the Privacy Act 1988 and has a Privacy Policy that explains how we handle the information about you that we collect. For a copy of the MetLife Privacy Policy please refer to the MetLife website or contact the MetLife Privacy Officer on **1300 555 625**.

**1300 555 625**

Monday to Friday 8.00am to 6.00pm EST

**MetLife Insurance Limited**

ABN 75 004 274 882

AFSL No. 238096

## Personal Statement and Declaration of Health

**Preliminary - For the Administrator of the scheme or superannuation fund to complete:**

Name of Scheme or Superannuation Fund:

Number of Scheme or Superannuation Fund:

### For Completion by the Life Insured

Name of Employer and/or Member Number:

#### 1 Your Personal Details

Surname:

First Names:

Gender:  Male  Female

Date of birth:   /   /

Address:

Contact Number(s):

#### Occupation Details

2 What is your current occupation?

3 Please provide details of duties (e.g. types of clerical, manual work etc) and qualifications/trade certificates if applicable:

#### Insurance History

4 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:

5 Do you have or are you applying for any Life, Trauma, TPD or Disability Insurance policies with MetLife or any other company? Yes  No

If YES, Is this application replacing existing cover? Yes  No

If you have answered 'YES' to Question 5, please give details:

Company Name	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 an existing policy or policies indicated in the table above, you must cancel such policies upon notice from MetLife that your policy has been accepted. If you do not cancel the existing policy or policies indicated in the table above, we may avoid the MetLife application and no claim would be payable.

6 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

7 Do you plan to travel, reside or work overseas? Yes  No

If YES, please advise where, for how long and for what reason:

#### Sports and Pastimes

8 Have you, do you currently, or do you intend to take part in any of the following activities? Yes No

a) Aviation other than as a fare paying passenger:

b) Motor sports or racing:

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## Sports and Pastimes (Continued)

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| c) Scuba/Skin Diving:  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Mountaineering or rock climbing:  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Football (all codes):   | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Other hazardous activities: e.g hang gliding, parachuting, ocean racing, etc. | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered YES to any of the above questions, please complete the Pastimes and Activities Questionnaire in Question 18.

## Habits

- 9** Have you smoked tobacco or any other substance(s) in the last 12 months? Yes  No
- If YES, what type and average daily quantity?

- 10** Do you drink alcohol? Yes  No
- If YES, please give details including form and average daily quantity:

## Doctor Details

- 11** What is the name of your usual Doctor? Yes  No

Address:

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

- 12** a) What is your height?  cms      b) What is your weight?  kgs

- 13** Have you ever had or sought advice or treatment for:
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a) Chest pain, high blood pressure, heart or circulatory disorder, stroke or vascular disorder?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Asthma, bronchitis or any other lung complaint?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Gastric or duodenal ulcer, or persistent indigestion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Thyroid disorder, diabetes or other pancreas disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Epilepsy, fainting or fits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Cancer, tumour, cyst or skin lesion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Disease (e.g. arthritis, gout) or injury to the muscles, tendons, bones, or joints, including the neck and back? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Mental or nervous disorder including depression, anxiety, stress, chronic tiredness or fatigue?                  | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered YES to any part of Question 13 above, you will also need to complete the 'Supplementary Risks Questionnaire' in Question 17.

- 14** Have you ever had or sought advice or treatment for:
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a) Stomach, intestinal or rectal disorder, gall bladder or liver disorder, including hepatitis?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Paralysis or disorder of the brain or spinal cord, multiple sclerosis or any other neurological disorder?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Any skin disorder (e.g. dermatitis, eczema or psoriasis)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Kidney disease (e.g. renal colic), bladder disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Any defect in sight, hearing or speech, or any other physical deformity or abnormality?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Any blood disorder (e.g. leukaemia, haemophilia or anaemia)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Drug or alcohol dependence, or used any drug not prescribed by a doctor (other than over-the-counter medicines for colds etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Other than already stated, have you within the last five years:  |                          |                          |
| - received or had any other medical examinations, advice, treatment, operation or been in hospital?                               | <input type="checkbox"/> | <input type="checkbox"/> |

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Yes No

- taken any prescribed medication on a regular basis?  Yes  No
- 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  No
- i) Do you intend to seek medical advice / treatment or have you ever been advised or do you contemplate surgery in the near future?  Yes  No
- j) Females only:
  - i) Are you currently pregnant?  Yes  No
  - If YES, when is the due date: 

D	D	/	M	M	/	Y	Y
---	---	---	---	---	---	---	---
  - ii) Have you ever had any 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 14, 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)
		/ /			/ /	%	
		/ /			/ /	%	
		/ /			/ /	%	
		/ /			/ /	%	
		/ /			/ /	%	

If insufficient space, please attach a separate page with this information, with your signature and date.

### Family History

- 15** Has any 1st 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

- 16** This must be completed in **all** circumstances. (please tick (✓) applicable option)
- 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

- 17** To be completed for any YES answer to Question 14. Please answer fully. If there is insufficient space or more than two conditions/illness, 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	D	/	M	M	/	Y	Y
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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 are attacks/symptoms? (please circle)

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

 Yes  No

If YES, for how long?

k. Did you ever require hospitalisation?

 Yes  No

If YES, where?

and how long?

l. Were any tests conducted?

 Yes  No

If YES, what were the tests and results:

m. What treatment or medication was given/prescribed?

n. Are you on treatment or still being treated?

 Yes  No

If YES, please describe the treatments(s):

o. Degree of recovery:

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

Doctor 1:

Name:

Address:

Doctor 2:

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 are attacks/symptoms? (please circle)

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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:

m. What treatment or medication was given/prescribed?

n. Are you on treatment or still being treated?  
 If YES, please describe the treatments(s):

o. Degree of recovery:  %

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

Doctor 1:  
 Name:   /  /   
 Address:

Doctor 2:  
 Name:   /  /   
 Address:

**Pastimes and Activities Questionnaire**

**18** To be completed if answering YES to Question 8.



a. Scuba/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  Average depth  Maximum depth and number of times at this depth

b. Aviation  
 What type of license do you hold?

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

Number of hours flown last year  Anticipated hours in the next year

c. Motor Racing Yes  No   
 What type of license do you hold?  If CAMS, state classification

Vehicle type

Maximum speed

Professional/Amateur

Engine size/capacity

Times per year

Type of racing/event(s)

d. Football/Soccer/Australian Rules/Rugby

Yes  No

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)

Yes  No

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.

  
  

#### APPLICATION DECLARATION

Declaration of Life Insured: I have read and understood the Duty of Disclosure and Privacy Statement. I declare that the information given in this application form is complete and correct and information relevant to the insurer's decision to accept the risk has not been omitted. I authorise any medical practitioner, hospital or clinic to provide MetLife with information that relates to my medical history.

Signed at \_\_\_\_\_

Signature of Life to be Insured <sup>x</sup> \_\_\_\_\_

Date \_\_\_\_\_

#### Office Use Only

Scheme number:

DTH/DTPD1/DTPD2/SCI

Decision:

Free Cover:

Cover:

**1300 555 625**

Monday to Friday 8.00am to 6.00pm EST

# MetLife®

**MetLife Insurance Limited**

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ABN 75 004 274 882

AFSL No. 238096

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