

# Request for Insurance / Personal Statement

MLC Limited  
ABN 90 000 000 402  
AFSL 230694

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

## Your Duty of Disclosure

### Insurance Contracts Act 1984

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 which 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 such a contract of life insurance is extended, varied or reinstated.

Your duty, however, does not require a 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 business, ought to know;
- For which your duty of compliance 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 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.

Your Duty of Disclosure continues until the Contract of Life Insurance has been accepted by the insurer and confirmation in writing is issued. It also applies if you seek to extend, vary or reinstate the Contract.

## SECTION A – INSURANCE DETAILS

Policy name

Mercy Super

Policy number

G2896/G2897

Please specify the type of insurance cover being applied for:

- Life only cover
- Life and TPD
- Salary Continuance

## SECTION B – 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

Facsimile

Email

## SECTION C – 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 D – 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

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- 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

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- 10** Are you covered by, or are you applying for other life, disability, critical illness, or income protection insurance with any company including MLC (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	
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
Company		Policy Number	
<input type="text"/>		<input type="text"/>	
Sum Insured or Monthly Benefit	If income protection Waiting Period	Benefit Period	Is this application replacing this insurance?
<input type="text"/>	<input type="text"/>	<input type="text"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

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

- |   |                          |                          |  |
|---|--------------------------|--------------------------|--|
|   | <b>No</b>                | <b>Yes</b>               |  |
| <b>a</b> Flying as a pilot or crew in an aircraft   | <input type="checkbox"/> | <input type="checkbox"/> | <b>If you answered 'Yes' to any of these, complete the Supplementary Pastimes Questionnaire on page 9.</b> |
| <b>b</b> Motor car, motor cycle or motor boat racing  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <b>c</b> Underwater diving  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <b>d</b> Football, parachuting, hang-gliding  | <input type="checkbox"/> | <input type="checkbox"/> | <b>If you answered 'Yes' to any of these, give full details of each below.</b>                             |
| <b>e</b> Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain climbing, mountain biking, downhill mountain biking) | <input type="checkbox"/> | <input type="checkbox"/> |  |
- If there is not enough space here, please list at Question 29, page 5**

Activity

Location

Amateur  Professional  Events/Hours per year

Other details

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## SECTION E – 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	
<input type="text"/>	
Address	
<input type="text"/>	
Postcode	<input type="text"/>
Business Number	( <input type="text"/> ) <input type="text"/>
How long have you been attending this practice?	
<input type="text"/> years	<input type="text"/> months
Please provide details of your last check-up or consultation.	
Date of last consultation	Reason for last check-up or consultation
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
Result	
<input type="text"/>	
Medication prescribed, referral given or tests ordered	
<input type="text"/>	

- 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 MLC'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                      |
|---|--------------------------|--------------------------|
| <b>a</b> Asthma (questionnaire on page 10)  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>b</b> any cyst, mole or skin lesion requiring medical advice or treatment (questionnaire on page 10)   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>c</b> 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) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>d</b> any disorder of the bones, joints or muscles, arthritis, gout or repetitive strain injury (questionnaire on page 14)   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>e</b> treatment or counselling for depression, or any nervous, anxiety, stress or mental disorder (questionnaire on page 12)   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>f</b> high blood pressure or high cholesterol (questionnaire on page 11)   | <input type="checkbox"/> | <input type="checkbox"/> |

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

- No  You will be advised what requirements to organise.  
 Yes  MLC'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 <b>a</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or any neurological disorder <b>b</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke or vascular disorder <b>c</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung complaint <b>d</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes, bowel, kidney or bladder disorder <b>e</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol or drug dependence <b>f</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Professional advice to reduce alcohol consumption <b>g</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine, persistent headache or chronic fatigue <b>h</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease <b>i</b> | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| Cancer or leukaemia <b>j</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Haemophilia or blood disorder <b>k</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid disorder <b>l</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver disorder, hepatitis or test indicating past or present hepatitis infection <b>m</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat <b>n</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other operation, disability, illness or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned <b>o</b> | <input type="checkbox"/> | <input type="checkbox"/> |

**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) <b>a</b>                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist? <b>b</b> | <input type="checkbox"/> | <input type="checkbox"/> |

**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





## SECTION F – 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 MLC accepts this application, I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to MLC's acceptance of this application and that if I fail to comply with my duty of disclosure MLC 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) Where this application is for insurance cover under a superannuation fund, I will provide MLC 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;
- (e) This insurance application is not effective until MLC accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;
- (f) I was actively at work performing the normal duties of my occupation when I applied for this insurance;
- (g) All statements and declarations given by me on this form are true and correct; and
- (h) 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 MLC 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 MLC 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 MLC 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 NAB's privacy policy and agree that any member of the NAB Group may collect, use, disclose and handle my personal information in a manner set out in the Group's privacy policy available on [mlc.com.au](http://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 MLC 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, MLC 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 MLC on **(02) 8908 6111** or email [group\\_insurance@mlc.com.au](mailto:group_insurance@mlc.com.au)

Where, in MLC's opinion, your medical information or our findings are of a personal or sensitive nature, MLC 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 (other than a liability of MLC Limited). Neither NAB Limited, nor any other company in the National Group of Companies (other than MLC Limited as insurer) guarantees or accepts liability in respect of MLC Group Insurance.

Signature of Life to be Insured



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

Mercy Super Pty Ltd  
PO Box 8334  
Woolloongabba QLD 4102

##### Phone

1300 368 891 or (07) 3163 8867

##### Fax

(07) 3163 2421

##### Email

[information@mercysuper.com.au](mailto:information@mercysuper.com.au)

##### Website

[www.mercysuper.com.au](http://www.mercysuper.com.au)

(DO NOT DETACH)

# Medical Authority



Please sign and date

MLC Limited  
ABN 90 000 000 402  
AFSL 230694

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

I request and authorise any doctor/hospital/clinic to supply MLC 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.

MLC Limited  
ABN 90 000 000 402  
AFSL 230694

### Life to be Insured's Details

Title	Surname (Family Name) <i>(please print)</i>	Given Names	Sex	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	/ /
Policy name	Family doctor or hospital – name and address			
<input type="text"/>	<input type="text"/>			
Policy number	<input type="text"/>			Postcode
<input type="text"/>	<input type="text"/>			<input type="text"/>

### 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	<input type="checkbox"/> Multiple Biochemical Analysis 20 (Chol. (HDL & LDL), Trigs., Glucose, Creat., Uric acid, LFTs, Electrolytes), and Hepatitis B and C serology <input type="checkbox"/> HIV Antibodies <input type="checkbox"/> Other <i>(specify)</i> <input type="text"/>
	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	Time of appointment	
	<input type="text"/> am/pm	

### 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 MLC (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to MLC Limited and to my family doctor as shown above.

No

Yes

Signature of Life to be Insured

X \_\_\_\_\_ Date / /

# 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 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?

<b>Blood pressure</b>	Systolic	Diastolic	Date
	<input type="text"/>	<input type="text"/>	/ /

<b>Cholesterol</b>	Reading	Date
	<input type="text"/>	/ /

(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

  


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**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?

<b>Blood pressure (eg 120/80)</b>	Systolic	Diastolic
	<input type="text"/>	<input type="text"/>

<b>Cholesterol</b>	Reading
	<input type="text"/>

**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

  


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**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 provide 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 provide 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
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(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?



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**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?



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**8** How often do you experience symptoms?

**9** What treatment have you had?



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**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



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**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
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(b) Prior to the last 12 months?

No

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



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**Return to Question 15(d) on page 3.**

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