

Rest Easy Plan

Claim Form

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 in Australia 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. We may collect your personal information for a number of purposes, which may include:

- providing you with a particular product or policy;
- processing receipts and payments;
- administering your product or policy;
- assessing, processing and investigating insurance risks or claims;
- producing statements and other mail related services;
- meeting legal and regulatory requirements;
- providing you with information about other products and services, with your consent.

We may also share your personal information with selected third parties for the purpose of administering your product or policy (some of whom may be situated outside Australia), and your information may be provided to them on a confidential basis for this purpose. We will not disclose your sensitive information (if applicable) for any purpose other than to underwrite or service your insurance cover or assess a claim. The organisations to whom we may disclose your personal information may include, among others:

To:	For:
Mailhouses	Statement production and other mail related services.
Administration services and technology services	Data entry, data processing, continuity of business, account maintenance and documentation
Investigators, medical attendants, other insurers and reinsurers	Assessing your application, underwriting and claims assessment
Insurance industry bodies	Claims matching and cross referencing
Professional and financial advisers	Administering your product or policy
Superannuation fund trustees	Administering your product or policy
Government or regulatory bodies	To comply with laws and regulations or for compliance related services
Organisations wishing to acquire an interest in any part of MetLife's business	Assessment of any proposed acquisition

Claim Form Instructions

For us to process your claim promptly please:

- 1) Complete all relevant sections of the claim form.
- 2) For a Rest Easy Benefit and/or Permanent Disability Benefit claim have your Doctor complete the Medical Statement. Please attach copies of any medical reports, medical certificates or test results you may have in your possession.
- 3) For a death claim include a certified copy of the Death Certificate and the Birth Certificate.

and mail it to: Insurance Claims
MetLife
GPO Box 3319
Sydney NSW 2001

Section 2. Rest Easy Benefit Claims

The Rest Easy Benefit is payable if, as the direct result of an *Accidental Injury*, you are unable to perform without the assistance of another person at least three (3) *Activities of Daily Living* for 24 consecutive hours.

Accidental Injury means you suffer a bodily injury caused directly by a sudden and unforeseeable event that occurs purely by chance.

Activities of Daily Living are:

- Bathing – to shower or bathe
- Dressing – to dress or undress
- Toileting – to use the toilet, including getting on and off the toilet
- Feeding – to eat and drink
- Mobility – to get into and out of a bed, chair or wheelchair
- Continence – to control bladder and bowel function

1 Are you claiming the Rest Easy Benefit?

Yes

No

If 'NO', please go to Section 4.

If 'YES', please continue.



2 What Accidental Injury did you suffer and what were you doing at the time? Please continue your description in the 'Other Comments' section if there is insufficient space here.

3 What part/s of your body is/are affected and how is/are they affected? Please continue your description in the 'Other Comments' section if there is insufficient space here.

4 When did the Accidental Injury occur?

D	D	/	M	M	/	Y	Y
---	---	---	---	---	---	---	---

5 How and where did the Accidental Injury occur?

6 Was the accident reported (e.g. to employer, police, etc)?

Yes

No

If 'YES', please give details:

Section 2. Rest Easy Benefit Claims (continued)

7 For motor accidents only:

Were you driving? Yes No Vehicle registration No.

Date of accident / Time

Did police attend? Yes No Location

Was a breathalyser or blood alcohol test taken? Yes No

If 'YES', what was the reading?

From what police station

8 Did anyone witness the accident?

Yes No

If 'YES', please give names and their relation to you:

9 Please complete the table below for those *Activities of Daily Living* you are unable to perform.

Activity	% of inability (e.g. 50%, 80%)	Can you perform the activity with the assistance of another?	How long were you continuously unable to perform the activity?	
Bathing			From:	To:
Dressing			From:	To:
Toileting			From:	To:
Feeding			From:	To:
Mobility			From:	To:
Continence			From:	To:

10 When did you first consult a doctor about your *Accidental Injury*?

 /

11 Name and address of doctor consulted:



12 Have you ever suffered from the same or a similar condition before?

Yes No

If 'YES', please provide details:

13 Provide the name and address of your usual doctor and/or surgery and the date of your most recent consultation:

Name	Medical Practitioner address and phone number	Date last seen

650103

Section 2. Rest Easy Benefit Claims (continued)

14 How long have you been attending this Medical Practitioner and/or surgery? Years Months

15 Please state the names and addresses of Medical Practitioners attending to you for this condition:

Name	Address and phone number	Qualifications	Date last seen

(please attach a separate list if insufficient space)

16 Are you required to attend any surgery, hospital, clinic or health worker for continuing treatment? Yes No
If 'YES', please provide details:

Name	Address and phone number	Treatment

17 Have you lodged a claim under Workers' Compensation, sickness/accident benefit or any other insurance policy? Yes No

If 'YES,' please provide details including claim number, name and address of insurer, and details of payments made to date: +

Claim No.

Name	Address and phone number	Payment details

18 Have you performed your usual work or performed any other work since your condition commenced? Yes No

If 'YES', please provide details:

Employer

Duties

Period From / / to / /

Basis of employment for this period: Full-time Part-time

Section 4. Permanent Disability Claims

The Permanent Disability Benefit applies only if it is shown in your Plan Schedule. The Permanent Disability Benefit is payable if, as the direct result of an *Accidental Injury*, you suffer the permanent loss of the use of a part of the body or of sight, speech or hearing. The amount payable depends on the type of permanent disability suffered (as specified in the Product Disclosure Statement) and the type of cover shown in your Plan Schedule.

- 1** Are you claiming the Permanent Disability Benefit? Yes No
If 'NO', please go to Section 5.
If 'YES', please continue.

- 2** What **permanent loss** have you suffered as a result of your *Accidental Injury*?
Please indicate all losses that are the direct result of your *Accidental Injury*.

- | | | |
|--|--|--|
| <input type="checkbox"/> Use of both feet | <input type="checkbox"/> Use of one hand | <input type="checkbox"/> Complete hearing in both ears |
| <input type="checkbox"/> Use of both hands | <input type="checkbox"/> Complete sight in one eye | <input type="checkbox"/> Complete hearing in one ear |
| <input type="checkbox"/> Use of one foot | <input type="checkbox"/> Complete sight in both eyes | <input type="checkbox"/> Complete loss of speech |

Please answer the remainder of the questions in Section 4 only if you have not answered them elsewhere.

- 3** What *Accidental Injury* did you suffer and what were you doing at the time? Please continue your description in the 'Other Comments' section if there is insufficient space here.

- 4** What part/s of your body is/are affected and how is/are they affected? Please continue your description in the 'Other Comments' section if there is insufficient space here.

- 5** When did the *Accidental Injury* occur?

D	D	/	M	M	/	Y	Y
---	---	---	---	---	---	---	---

- 6** How and where did the *Accidental Injury* occur? +
- | |
|--|
| |
| |

- 7** Was the accident reported (e.g. to employer, police, etc)? Yes No
If 'YES', please give details:

8 For motor accidents only:

Were you driving? Yes No Vehicle registration No.

Date of accident / / Time

Did police attend? Yes No Location

From what police station

Was a breathalyser or blood alcohol test taken? Yes No

If 'YES', what was the reading?

9 Did anyone witness the accident? Yes No

If 'YES', please give names and their relation to you:

10 When did you first consult a doctor about your *Accidental Injury*? / /

11 Name and address of doctor consulted:

12 Have you ever suffered from the same or a similar condition before? Yes No

If 'YES', please provide details:

13 Provide the name and address of your usual Medical Practitioner and/or surgery and the date of your most recent consultation:

Name	Address and phone number	Date last seen

14 How long have you been attending this Medical Practitioner and/or surgery? Years Months

15 Please state the name and addresses of Medical Practitioners attending to you for this condition:

Name	Address and phone number	Qualifications	Date last seen

(please attach a separate list if insufficient space) +

16 Are you required to attend any surgery, hospital, clinic or health worker for continuing treatment?

Yes

No

If 'YES', please provide details:

Name	Address and phone number	Treatment

17 Have you lodged a claim under Workers' Compensation, sickness/accident benefit or any other insurance policy?

Yes

No

If 'YES,' please provide details including claim number, name and address of insurer, and details of payments made to date:



Claim No.

Name	Address and phone number	Payment details

Other Comments (please use this space if required)

Comments:

Section 5. Death Claims

(Please attach a certified copy of the Death & Birth Certificate).

1 Date of death

D	D	/	M	M	/	Y	Y
---	---	---	---	---	---	---	---

Cause of death/injury

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Duration of illness

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2 Name and address of Medical Practitioners who would be able to provide information regarding the insured's medical history:

Name	Address and phone number

3 Is the Estate being handled by:

Solicitors

Public Trustee

Trustee Company

Other

Provide name and address below



Name	Address and phone number

Other Comments (please use this space if required)

Comments:

650110

Section 6. Declaration and Authority

I declare that the answers and statement made on this claim form are true and complete. I have not made any false or misleading statement and I have included all information relevant to the assessment of my claim.

Where I have completed this declaration and authority as the Executor / Administrator / Guardian, I have attached a certified copy of the relevant legal documents (eg. Will, Letter of Administration, Power of Attorney).

If any of the answers are not in my handwriting I certify that I have checked them and they are correct.

I hereby authorise MetLife Insurance Limited (MetLife), or any person duly authorised by MetLife, to disclose my personal information (which may include sensitive or health information) to the following nominated parties. I further consent to the nominated parties collecting information about me and releasing to MetLife any information they may hold about me (including their report) which relates to MetLife's administration of the policy/plan, including this claim.

- Any Medical Practitioner, hospital or any other healthcare provider who has attended or examined me in order for them to supply MetLife with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.
- Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, credit reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer in order for the nominated party to produce a report concerning my claim.
- Any benefit provider such as other insurers or Government Departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my unemployment, sickness and/or injury for the nominated party to supply MetLife with full particulars of any and all claims I have made for benefits in the event of my unemployment, sickness and/or injury including copies of evidence they hold.

I understand and agree that if I do not give the information requested by MetLife or its representative that MetLife may not be able to assess, investigate or pay my claim.

A photocopy of this authority is as valid as the original.



Signature

Name

Date

Please return this form and any attachments to:

Insurance Claims
MetLife
GPO Box 3319
Sydney NSW 2001

650111

Rest Easy Plan Disability Claim - Medical Statement

To be completed by a registered Medical Practitioner. The patient will incur any charge for this service.

Patient Details

Title	Surname	
<input type="text"/>	<input type="text"/>	
Given names		
<input type="text"/>		
Address		
<input type="text"/>		
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Date of birth	
<input type="text"/>	<input type="text"/>	

Patient History

- Are you the patient's usual Medical Practitioner? Yes No
If 'YES', how long have you known the patient?
- When did the patient first consult you for the present condition?
- When did the present condition commence?
- When did the *Accidental Injury* occur?
- What *Accidental Injury* did the patient suffer and what was the patient doing at the time?
- What part/s of the patient's body is/are affected and how is it/are they affected?
- Your patient has a type of life insurance policy where a benefit is payable if, as the direct result of an *Accidental Injury*, he/she is unable to perform without the assistance of another person at least three (3) *Activities of Daily Living*, for 24 consecutive hours.
Activities of Daily Living are:
 - Bathing – to shower or bathe
 - Dressing – to dress or undress
 - Toileting – to use the toilet, including getting on and off the toilet
 - Feeding – to eat and drink
 - Mobility – to get into and out of a bed, chair or wheelchair
 - Continence – to control bladder and bowel function

650112

Patient History (continued)

Please complete the table below for those *Activities of Daily Living* your patient is unable to perform.

Activity	% of inability (e.g. 50%, 80%)	Can the activity be performed with the assistance of another?	For how long were they continuously unable to perform the activity?	
Bathing			From:	To:
Dressing			From:	To:
Toileting			From:	To:
Feeding			From:	To:
Mobility			From:	To:
Continence			From:	To:

- 8** For how long do you anticipate the patient will be unable to perform the above *Activities*?
Please give reasons for any continuing disability.



9 For Permanent Disability claims only

A Permanent Disability benefit may be payable if the patient is covered for the benefit and if, as the direct result of *Accidental Injury*, the patient has suffered the permanent loss of the use of a hand, foot, complete sight in an eye, complete hearing in an ear or the complete loss of speech.

If such a permanent loss has occurred, please specify the type of loss and why you consider the loss to be permanent:

- 10** If not provided elsewhere, please provide a summary of the patient's present condition including the cause of the *Accidental Injury*, symptoms and diagnosis:

- 11** Does the patient have a prior medical history related to the present condition?
If 'YES', please provide details including dates seen:

Yes No

650113

Patient History (continued)

12 Please provide details of other persons the patient has consulted for this condition:

Other Information

Are you completing claim forms on behalf of this patient for any other company?

Yes No

If 'YES' please provide details:

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Your Details (Please print)

Title Surname

Given names

Address

Suburb State Postcode

Qualification

Phone No. Fax No.

Signature



have you met life today?®

1300 555 625
Monday to Friday 8.00am to 6.00pm EST

MetLife®

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ABN 75 004 274 882
AFSL No. 238096
www.metlife.com.au

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