

Migraine and Headaches Questionnaire



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 of common knowledge;
- that your insurer knows or, in the ordinary course of the insurer's business as an insurer, ought to know; OR
- where which 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 a policy has been issued.

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 about you that we collect. 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**.

Migraine and Headaches Questionnaire

To be completed by the proposed person 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 proposed person to be insured.

Personal Details

Name:

Date of Birth:

 / /

Group Scheme Name / Number:

OR Individual Policy Number:

Note: You will have a Group Scheme Name/Number if your application for insurance is through your Superannuation fund OR Employer, otherwise you will have an Individual Policy Number.

Questionnaire

1 What is or was the nature and severity of the pain?

Severe

Moderate

Mild

Fluctuating



2 Describe the location of the pain (e.g. central, in the left or right side of the head, across the front of the forehead, or elsewhere).

3 (i) When did the pain initially occur?

 / /

(ii) Was it related to a special event?

Yes

No

If "Yes", please provide details.

4 How frequently has the pain occurred since the initial episode?

5 How long does the pain usually last?

Questionnaire (cont.)

6 When did you last experience this pain?

7 What was the mode of onset? Please tick which is applicable.

Sudden OR Gradual And At rest OR With physical activity OR Postural

8 Was or is the pain preceded by any neurological symptoms (e.g. aura, flashes of light in field of vision, alterations in consciousness, mood, emotion)?

Yes No

9 Are there any other symptoms associated with this pain (e.g. nausea, vomiting)?

Yes No

If "Yes", please give details.

Symptom	Frequency

10 Have you experienced any incapacity arising from this pain?

Yes No

If "Yes", how much time has been lost from work or usual activities as a result of headaches/migraine?

Date	Details
/ / to / /	
/ / to / /	
/ / to / /	

11 Please provide the full name and address of all General Practitioners and Specialists who currently treat, and have previously treated you for this condition and any other conditions.

Last Consultation	Doctor or Clinic Name	Address
/ /		
/ /		
/ /		

12 What treatment have you had? Please list medicinal drugs, either "over the counter" or prescribed drugs that have been taken and whether they afforded relief or not.

Treatment/Prescription	Relief
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>

Questionnaire (cont.)

13 Have your headaches responded to prophylactic (preventative) treatments, such as Inderal, Catapres (Clonidine), Deseril (methysergide)?

Yes No

If "Yes", please provide details.

Date	Details
/ /	
/ /	

14 (i) Are you still receiving treatment?

Yes No

(ii) Is any surgery or further investigations contemplated for the future?

Yes No

If "Yes" to either question above, please give full details.

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15 Have you undergone any special investigations, including MRI scanning, CAT scan, EEG or other?

Yes No

If "Yes", provide full details.

Date	Test	Result
/ /		
/ /		
/ /		

16 Do your headaches/migraines respond to any of the following preparations? (Please tick all that apply).

- Sandomigran (Pizotifen)
 Zolmig (Zolmitriptan)
 Imigran or Suvalan (Sumatriptin)
 Naratriptan
 Ergotamine



17 Have you required treatment with strong painkillers (e.g. Morphine, Pethidine, Endone (Oxycodone), Codeine, Tramal, Doloxene, Digesic, Nurofen-Plus etc)?

Yes No

If "Yes", please give details of how often and which painkillers.

If "No", what medication have you taken for this condition?

Medication	Dosage	Frequency

Questionnaire (cont.)

18 Please provide any additional information that may help assess your application for insurance.

MetLife Medical Authority

MetLife Insurance Limited (MetLife) is considering my application for insurance and I hereby authorise any medical practitioner, hospital, clinic or other person (including a life insurance company or underwriter) to disclose to MetLife or any third party engaged by MetLife full details of my health and medical history. A photocopy of this Authority should be accepted as my personal authority. +

My Name:

Date of Birth:

		/			/		
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Address:

State:

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Postcode:

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Signature:

Date:

		/			/		
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Declaration

I declare that the answers I have given are to the best of my knowledge, true and complete and that I have not withheld any material information that may influence the assessment or acceptance of my application. I acknowledge that this questionnaire is part of the application for life Insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of the person whose life is to be insured:

Date:

		/			/		
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MET0157 02/09

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