

Gynaecological Disorders 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**.

Gynaecological Disorders Questionnaire

Please complete this with the assistance of your Primary Health Care OR Specialist Physician if you incur difficulty.

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:

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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 the exact diagnosis and/or the exact nature of the condition?

2 When did you first experience any symptoms, or otherwise become aware of a problem?

 / /

3 (i) How frequently have you experienced these symptoms?

(ii) Have these symptoms recurred?

Yes No

If "Yes" (a) How frequently do they recur?

(b) When did these last occur?

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Questionnaire (cont.)

4 (i) Please describe the symptoms to the best of your ability.

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(ii) If there were, or are no symptoms, how did you become aware of this condition?

5 Have you had any investigations (e.g. blood tests, coloscopies, laparoscopy, or ultrasound)?

Yes No

If "Yes", please provide full details including the dates, results and where the tests were performed.

Date	Test	Location	Result
/ /			
/ /			
/ /			

6 Please provide full details of all treatment that you have received in the past.

a) Prescription and non-prescription medication:

Medication	Dosage	Frequency

b) Surgery:

Date	Type of surgery	Degree of surgery
/ /		
/ /		
/ /		

7 Please list all medication/s, not previously mentioned in this questionnaire, that you are taking regularly or intermittently whether for this or any other condition or illness.

Medication	Dosage	Frequency

Questionnaire (cont.)

- 8 Have you ever had regular absences from work, or been absent from work or restricted in your lifestyle for more than one month at a time as a result of injury or illness? Yes No

If "Yes", please provide details.

- 9 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. Yes No

If "Yes", please provide details.

Last Consultation (date)	Doctor or Clinic Name	Address
/ /		
/ /		

- 10 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:

 / /

Address:

State:

Postcode:

Signature:

Date:

 / /

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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