Adjustment Disorder 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**.

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Adjustment Disorder 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 **Please describe the symptoms leading to treatment.**

2 **Did the symptoms include or were they accompanied by any of the following? (Please tick all that apply).**

- ☐ Anxiety or anxiety state
- ☐ Panic states
- ☐ Phobias
- ☐ Obsessive &/or Compulsive Disorder
- ☐ Adjustment Disorder
- ☐ Personality Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Other Affective or mood disorder, suicidal ideation, substance abuse or any other change in consciousness/mood

If "Yes" to any, please give full details.

3 **What was the date of onset – or dates if more than one episode?**

i) __ __ / __ __ / __ __ ii) __ __ / __ __ / __ __ iii) __ __ / __ __ / __ __

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Questionnaire (cont.)

4 Have you ever had or been diagnosed of any of the following conditions? (Please tick all that apply).

- ☐ Anxiety or anxiety state
- ☐ Panic states
- ☐ Phobias
- ☐ Obsessive or compulsive behaviours
- ☐ Adjustment Disorder
- ☐ Personality Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Other Affective or Mood Disorder, or "Chemical Imbalance" causing mood or cognitive changes

If "Yes" to any, please give full details.

5 Did the illness surface as a reaction to particular circumstances/life stressors? Yes ☐ No ☐

If "Yes", please outline those circumstances.

6 Have you ever had any thoughts about suicide or actual attempted suicide? Yes ☐ No ☐

If "Yes" (to attempts), please give full details with dates.

Date	Details
/ /	
/ /	
/ /	

7 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	Name	Address
/ /		
/ /		
/ /		

8 (a) Have you ever had in-patient hospital treatment for this condition? Yes ☐ No ☐

(b) Undergone or been recommended electroconvulsive therapy (ECT) treatment? Yes ☐ No ☐

If "Yes", to either of the above, please give full details including dates, duration and number of treatments.

Date	No. of treatments	Description of treatment
/ / to / /		
/ / to / /		
/ / to / /		

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Questionnaire (cont.)

9 What treatment(s) has/have been prescribed for these symptoms?

Medication	Dosage	Frequency

10 Do you take on-going medication? Yes ☐ No ☐

If "Yes", please give full details.

If "No", how long is it since you ceased medication for this condition?

11 If applicable, how long have you been symptom free?

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

13 Do you have any history of use of illegal drugs or use of prescription drugs in any manner other than as prescribed? Yes ☐ No ☐

If "Yes" please give details (attach a page if there is not enough room).

14 Are there any other relevant features? (e.g. family history of mental emotional illness, or suicide).

Questionnaire (cont.)

15 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.

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

16 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: x 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: x Date: / /

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