

# Multiple Sclerosis (MS) Questionnaire (Medical Attendant)



## 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 we collect about you. 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**.

## Multiple Sclerosis (MS) Questionnaire (Medical Attendant)

For completion by Medical Attendant.

If space is insufficient, please attach an extra sheet of paper.

Please complete the questionnaire in **BLACK** ink pen only.

### Patient Details

Name:

Date of Birth:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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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 When did you become aware of the patient's symptoms of possible MS?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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Please describe these presenting symptoms.

2 When was the diagnosis of MS confirmed?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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3 Please describe current and/or recent symptoms including details regarding occupational disability, self-care, mobility and bladder/bowel problems.

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

**Questionnaire (cont.)**

**4** Have symptoms been steadily progressive from the outset (primary progressive), relapsing/remitting or initially relapsing/remitting but now progressive (secondary progressive)? Please include details such as the frequency, duration and severity of relapses.

Duration	Frequency	Severity		
/ / to / /		Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
/ / to / /		Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
/ / to / /		Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>

**5** Please provide details of any treatment that has been prescribed or recommended including the names and dosages of any medications (whether for this condition or others) and whether these are still being taken.

Medication	Dosage	Frequency

**6** What investigations have been performed, e.g. MRI or lumbar puncture etc.? Please provide details of results. +

Investigation	Result

**7** Have there been any referrals and/or inpatient treatment?

Yes  No

If "Yes", please provide full details including the name(s) and address(es) of doctors or institutions etc.

Doctor/Institution	Address

**8** Please advise any other relevant information that may assist in the assessment of your patient's application for insurance.


**It would help the assessment of your patient's application if you would make available copies or a summary of any specialist notes that are available.**

## Medical Examiner Details

Name of Medical Examiner: (Please Print Clearly)

Qualifications:

Signature:

Date:

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