

Neurological Disorders Questionnaire (Applicant)



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**.

Neurological Disorders Questionnaire (Applicant)

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 When were symptoms first noticed?

 / /

2 Please describe the symptoms to the best of your abilities (i.e. weakness, headaches, loss of coordination, bowel or bladder function, vision problems).

3 How long did symptoms persist?

4 What investigations were performed and what was the result of these investigations?

Date	Investigation	Result
/ /		
/ /		
/ /		

Questionnaire (cont.)

5 Has a diagnosis been made? Yes No

If "Yes", please provide details.

6 Is there any ongoing treatment? Yes No

If "Yes", please provide details.

7 Has there been any recurrence? Yes No +

If "Yes", please provide details including dates.

Date	Details
/ /	
/ /	

8 (a) Are there any residual cognitive, psychological or other impairments? Yes No

(b) Is there any other remaining disability? Yes No

If "Yes" to either of the above, please provide full details.

9 Have there been any referrals and/or inpatient treatment? Yes No

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

Doctor/Institution	Address

10 Please advise us of any other relevant information (such as family history).

Questionnaire (cont.)

11 It would help the progress of your application if you could provide copies or summaries of any specialist/s notes (Your doctor may be able to assist).

12 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.

Three empty text boxes for listing medications.

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

Three empty text boxes for providing additional information.

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:

Text box for My Name.

Date of Birth:

Date of Birth input fields: [][] / [][] / [][][][]

Address:

Text box for Address.

State:

State input fields: [][][]

Postcode:

Postcode input fields: [][][][][]

Signature:

Text box for Signature containing 'x'.

Date:

Date input fields: [][] / [][] / [][][][]

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:

Text box for Signature of the person whose life is to be insured containing 'x'.

Date:

Date input fields: [][] / [][] / [][][][]

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