

Nervous 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 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**.

Nervous 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 What was the diagnosis of the condition?

2 What was the date of onset of your symptoms – or dates if more than one episode?

(i) / / (ii) / / (iii) / /

3 What were the presenting symptoms?

4 What is your current mental/emotional state?

5 Did the illness develop as a reaction to particular circumstances?

Yes No

If "Yes", please outline those circumstances.

Questionnaire (cont.)

6 Have you had thoughts about suicide or actually attempted suicide?

Yes No

If "Yes", please give full details with dates.

Date	Details
/ /	
/ /	

7 Have you ever been referred to a specialist?

Yes No

If "Yes", please give full details including name and address.

Doctor or Clinic Name	Address

8 Have you ever been prescribed drugs or medication for these symptoms, condition or illness?

Yes No

If "Yes", please give name of medication used.

9 Have you ever had in-patient hospital treatment or electroconvulsive (ECT) treatment?

Yes No

If "Yes", please give details including dates, duration and number of treatments.

Date	Details	Number of treatments
/ / to / /		
/ / to / /		
/ / to / /		

10 What is your current treatment (e.g. medicine or therapy)?



i) If medications taken, please name them and give dosage instructions and frequency.

Medication	Dosage	Frequency

ii) If Psychotherapy, please state the number of sessions, frequency.

Sessions	Frequency

Questionnaire (cont.)

10 What is your current treatment (e.g. medicine or therapy)? (cont.)

iii) Other, please specify.

11 If you are now symptom free, how long since your last symptoms?

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.

13 Have you ever ceased medication/s for this condition?

Yes No

If "Yes", please provide date medication/s ceased.

Date ceased	Medications
/ /	
/ /	

14 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:

		/			/		
--	--	---	--	--	---	--	--

Products are offered by MetLife Insurance Limited, which is an affiliate of MetLife, Inc. (Incorporated in the USA) and operates under the "MetLife" brand. None of the obligations of MetLife Insurance Limited are guaranteed by MetLife, Inc. or any other member of the MetLife group. Prepared February 2008.

PEANUTS © United Feature Syndicate, Inc.

MET0172 02/09

480104