

Diabetes 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**.

Diabetes 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 relevant to you? Please state date first diagnosed.

Type I Diabetes

Type II Diabetes Mellitus

Gestational Diabetes

Impaired Glucose Tolerance

Impaired Fasting Glucose

Other, please specify.

Please attach a copy of any medical reports if available.

2 (i) What treatment has been prescribed?

If **diet only**, please describe nature of the diet.

If treatment is by **oral medication**, please state the names of the drug(s) dosage and frequency.

Treatment Description	Dosage	Frequency

Questionnaire (cont.)

2 (i) What treatment has been prescribed? (cont.)

If **insulin**, please state type and dosage.

Type	Dosage

(ii) Has the treatment been changed at any time?

Yes No

If "Yes", please give details.

Date	Treatment
/ /	
/ /	

3 How would you describe your control of your condition?

Poor Moderately well controlled Well controlled



4 Have you ever had a diabetic or insulin coma?

Yes No

If "Yes", please give dates and details.

Date	Details
/ /	
/ /	

5 Do you self monitor your blood glucose levels?

Yes No

If "Yes", please attach a record/log of recent results (up to the last three months).

6 Please give the date and results of most recent tests.

Test	Date	Results
HbA1c (glycosylated haemoglobin or glycated haemoglobin)	/ /	
Fasting blood sugar estimation	/ /	

Please check with your General Practitioner if uncertain.

Questionnaire (cont.)

7 Have you ever had:

- i) Eye problems? Yes No
- ii) Heart problems? Yes No
- iii) High blood pressure? Yes No
- iv) Kidney problems (including protein in your urine)? Yes No
- v) Sensory problems (such as burning in your feet)? Yes No
- vi) Any other complication? Yes No

If you answered "Yes", to any of the above questions, please provide details. (Use a separate sheet if needed).

8 Has an electrocardiogram or chest x-ray ever been taken? Yes No

If "Yes", please give details and results.

Date	Test	Result
/ /		
/ /		

9 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 / /	

10 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	Doctor or Clinic Name	Address
/ /		
/ /		
/ /		

Questionnaire (cont.)

11 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:

			/				/		
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Address:

State:

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Postcode:

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Signature:

Date:

			/				/		
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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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