

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

For Completion by the Primary Health Care Practitioner/Physician/Medical Attendant.

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.

Patient 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 When was the above illness/condition first diagnosed?
 / /

3 Please advise the type of treatment prescribed for this patient. If the treatment is dietary advice only, please describe the diet; if oral hypoglycaemics have been prescribed please give details of the drugs, their prescribed dosages; if insulin, please state the type and dosage.

| Treatment Description | Dosage | Frequency |
|-----------------------|--------|-----------|
| | | |
| | | |

Questionnaire (cont.)

4 Has the treatment been changed at any time since diagnosis?

Yes No

If "Yes", please give full details.

| Date | Treatment |
|------|-----------|
| / / | |
| / / | |

5 Has your patient conscientiously followed your advice concerning treatment?

Yes No

If "No", please give details of lack of compliance and frequency of episodes of lack of compliance.

| Details of lack of compliance | Frequency of episodes of lack of compliance |
|-------------------------------|---------------------------------------------|
| | |
| | |
| | |

6 How well does your patient control his/her condition?

Poorly Moderately well Well



7 Has your patient ever suffered a diabetic or hypoglycaemic coma?

Yes No

If "Yes", please give dates and details.

| Date | Details |
|------|---------|
| / / | |
| / / | |

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

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

9 Are there any complications of diabetes present?

Yes No

If "Yes", please give full details.

| Date | Complication | Details |
|------|--------------|---------|
| / / | | |
| / / | | |

Questionnaire (cont.)

10 Has an electrocardiogram, chest x-ray Urinalysis MBA, FBC, been performed?

Yes No

If "Yes", please give details and results with special reference to results outside the testing laboratory's normal range or attach copies of results.

| Date | Test | Result |
|------|------|--------|
| / / | | |
| / / | | |
| / / | | |

11 Are there any other relevant features that should be considered such as family history that may assist in the assessment of this patient's application for insurance?

Yes No

If "Yes", please give details and results.

| |
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| |
| |
| |

Medical Examiner Details

Name of Medical Examiner: (Please Print Clearly)

Qualifications:

Contact Phone Number:

Contact Email:

Signature:

Date:

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

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