

# Sleep Apnoea Syndrome 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**.

## Sleep Apnoea Syndrome 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 When did symptoms of Sleep Apnoea originally commence?

  /   /  

2 Do you at times suffer from daytime drowsiness or unrefreshing sleep?

Yes  No

If "Yes", please give details.

  

3 When was Sleep Apnoea first diagnosed?

  /   /  

4 Has the Diagnosis been confirmed by polysomnography (overnight sleep test)?

Yes  No

If "Yes", do you know the actual Apnoea Index (number of pulses of breathing or period during an hour)? Please provide details below and refer to your doctor if you are uncertain.

  

5 Please tick whether the Sleep Apnoea been described as:

Obstructive Sleep Apnoea

Central Sleep Apnoea

Questionnaire (cont.)

6 Please provide details of any treatment you are receiving.

Date	Treatment
/ /	
/ /	
/ /	

7 a) Have you been recommended to use CPAP (Continuous Positive Airways Pressure)? Yes  No   
If "Yes", please give details.


b) Do you have any difficulty complying with CPAP therapy? Yes  No

8 Have you required oxygen therapy? Yes  No   
If "Yes", please give details.


9 Has your treatment changed in the time since initial diagnosis? Yes  No   
If "Yes", what treatment have you had?

Date	Treatment
/ /	
/ /	

10 Who is monitoring your condition and caring for your follow-up?  

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11 How often do you visit your primary care or specialist physician for your follow-up?  

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12 Have you ever been diagnosed of or suspected of having any of the following: (Please tick all that apply).

- Any central nervous system impairment
- Airways obstruction
- Cardiovascular or pulmonary Disorder
- Drug or alcohol abuse.

13 Is the quality of your life affected by Sleep Apnoea? Yes  No   
If "Yes" please give details.


## Questionnaire (cont.)

- 14** 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
/ /		
/ /		
/ /		

- 15** 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:

 /  / 

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MET0187 02/09

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