ZURICH

Standard medical examination form

Complete Part 1 and Sections A, B, C and D of the Personal Statement below in your own words prior to the examination. The medical examiner will discuss your answers with you and add any details considered appropriate. **Sign the declaration in the examiner's presence.**

Duty to take reasonable care not to make a misrepresentation

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer when applying for insurance. To meet this duty, you must also take reasonable care not to make such a misrepresentation.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating or recommencing insurance.

If you do not meet your duty

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund, or ask to extend or make changes to existing insurance benefits, the fund trustee may pass on to us personal information you provide to them. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you should:

- think carefully about each question before answering. If you are unsure of the meaning of any question, please ask us before you respond
- answer every question
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it. Please don't assume we will ask others such as your doctor.
- review your application carefully. If someone else helped prepare your application, please check every answer (and if necessary, make any corrections).

Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you would now answer our questions differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we'll let you know whether it has any impact on the cover.

If you need help

It's important that you understand this information and the questions we ask. Ask us for help if you have difficulty answering our questions or understanding the application process.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. You can have a support person you trust with you.

Part 1 – Personal Statement by life to be insured

Plan name

Member number

Surname

First name

Date of birth (dd/mm/yyyy) / /

Occupation

Address

Suburb/Town State Postcode

The Medical Examiner is requested to ensure a clear and complete answer is given to each of the following questions.

A. Habits

A1. a. Do you consume alcohol? ○ Yes ○ No

b. If **yes**, please state how many standard drinks you consume per day. (A standard drink is 125 ml wine, 250 ml beer or 30 ml spirits)?

A2. a. Do you smoke? ○ Yes ○ No

b. If **yes**, please state the type and quantity per day.

A3. a. Have you ever been advised to stop or reduce your alcohol intake or stop smoking due to a medical condition? ○ Yes ○ No

b. If **yes,** please give details.

B. Medical history

B1. Have you ever had any of the following:

		No	Yes
1	Any heart trouble, murmur, palpitations, stroke or vascular disorder?	○	○
2	High cholesterol?	○	○
3	High blood pressure?	○	○
4	Pain in the chest?	○	○
5	Rheumatic fever?	○	○
6	Asthma, bronchitis, persistent cough or any other chest or lung condition?	○	○
7	Sleep apnoea?	○	○
8	Thyroid or glandular trouble?	○	○
9	Recurring indigestion, gastric or duodenal ulcer?	○	○
10	Bowel disease?	○	○
11	Hepatitis, or any liver or gall bladder disease?	○	○
12	Anaemia, leukaemia, haemophilia or any other blood disorder?	○	○
13	Epilepsy, fits, hydrocephalus, dizziness, fainting or any kind of persistent headaches?	○	○
14	Alzheimer's disease or dementia?	○	○

		No	Yes
15	Stress, anxiety, depression or any other mental condition?	○	○
16	Kidney, prostate or bladder problems (including renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis)?	○	○
17	Diabetes mellitus?	○	○
18	Cancer (including carcinoma in situ of any organ), tumour, growth of any kind or breast lumps (even if you have not seen a doctor)?	○	○
19	Coughing of blood or passage of blood from the bowel or in the urine?	○	○
20	Any disease of, or injury to, the neck or spine including back strain, disc disorder, lumbago, fibrositis, sciatica, neuritis, etc?	○	○
21	Arthritis or any other disease or deformity, or any pain, strain or disorder of any joint or limb?	○	○
22	Gout, fibromyalgia, tendonitis, tenosynovitis, 'RSI' or any regional pain syndrome or chronic fatigue syndrome (myalgic encephalitis)?	○	○
23	Broken bones, osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?	○	○
24	Any abnormality affecting eye sight, hearing or speech?	○	○
25	Any disorder of the skin, including but not limited to cysts, moles, skin lesions, varicose veins, scleroderma or systemic sclerosis?	○	○
26	Hernia?	○	○
27	Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment?	○	○
28	Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason?	○	○
29	Have you within the past five years suffered a needle stick injury?	○	○
30	Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)?	○	○
31	Do you now have any symptoms of ill health or disability?	○	○
32	Are you contemplating surgery, intending to consult a doctor or have you been advised to have an operation or other medical investigation or test in the future (e.g. X-ray, blood test, etc)?	○	○
33	Do you take, or have you ever taken drugs or any medication on a regular or ongoing basis?	○	○
34	Have you ever used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence?	○	○
35	**a.** Is the combined total of your existing insurance(s) detailed in Section 3 question 1 of the personal statement, and any new insurance you are applying for with Zurich, more than any one of the following; $500,000 Death; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? If you answered Yes to question 35(A) please proceed to 35(B), otherwise continue to question 36	○	○
	b. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (Please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you).	○	○

FEMALES ONLY

36	**a.** Are you currently pregnant? If **yes**, please advise due date here: (dd/mm/yyyy) / /	○	○
	b. Have you ever had any complications with pregnancy or childbirth? (e.g. gestational diabetes)	○	○
	c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	○	○
	d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast or endometrium?	○	○

37	Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?	○	○
38	Have you ever tested positive for HIV (Human Immunodeficiency Virus) which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS-related condition?	○	○
39	Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis?	○	○

If you answered **yes** to questions 1–39, please complete the following table. If there is not enough space here, please provide details on page 10.

	Question no:	Question no:	Question no:
Disability, illness, injury or condition			
Investigation type(s) and result(s)			
Date of first symptoms (dd/mm/yyyy)	/ /	/ /	/ /
Frequency of symptoms			
Type of treatment			
Date treatment provided and ceased (dd/mm/yyyy)	/ /	/ /	/ /
Has further treatment, referral or investigation(s) been recommended?	◯ Yes ◯ No Details:	◯ Yes ◯ No Details:	◯ Yes ◯ No Details:
Time off work	◯ Yes ◯ No Details:	◯ Yes ◯ No Details:	◯ Yes ◯ No Details:
Have you completely recovered?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Date of last symptoms (dd/mm/yyyy)	/ /	/ /	/ /
Name and address of medical facility and attending doctor			

C. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

C1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder?

◯ Yes

◯ No

C2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)?

◯ Yes

◯ No

If you answered **yes** to either C1 or C2, please complete the following table:

Relation	Condition/Disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood-related family members – living or deceased (mother, father, brothers, sisters).

D. Usual doctor or medical centre details

Name of regular doctor

Phone

Address

Suburb State Postcode

D1. How long have you been a patient of this doctor? Years Months

D2. Date of last consultation (dd/mm/yyyy) / /

D3. Reason for and outcome of last consultation

Declaration and consent

I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.

I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete and understand that these will be used (together with my original application) by Zurich to decide whether to provide or amend my insurance.

I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) in this form in accordance with the Privacy Statement attached.

Signature of life to be insured

✗ Date / /

The above was signed in my presence and discussed where I considered it appropriate.

Signature of medical examiner

✗ Date / /

Part 2 – Confidential Medical Report to Zurich

Name of examinee

Note: Information regarding your findings should **not** be given to any other person. Exception may be made, subject to the examinee's consent, if in your opinion there is medical information which should be conveyed to his/her medical attendant. The company's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The **examiner** is therefore requested **not** to express to the examinee any opinion concerning the examinee's insurability.

E. Introduction

E1. Are you acquainted with the examinee

a. professionally? ◯ Yes ◯ No

b. personally? ◯ Yes ◯ No

If **yes**, If so, how long? **a.** **b.**

E2. Is there anything abnormal in appearance, development or behaviour? ◯ Yes ◯ No

If **yes**,

E3. Is there any indication of past or present abuse of alcohol or of the misuse of drugs? ◯ Yes ◯ No

If **yes**,

F. Measurements

F1. Give the following measurements:

Height (without shoes) cm

Weight (clothed) kg

F2. Chest and Abdomen at umbilicus (next to skin)

Chest Expiration cm

Chest Inspiration cm

Abdomen cm

F3. If chest expansion is less than 5cm, comment as to apparent cause or provide F.E.V.1. meter reading if available.

G. Respiratory system

G1. Is there any abnormality of the respiratory system to palpation percussion or auscultation? ◯ Yes ◯ No

If **yes**,

G2. Is there any sign of past or present respiratory disease? ◯ Yes ◯ No

If **yes**,

H. Circulatory system

H1. What is the rate and character of pulse?

Pulse rate per minute

Character

H2. What is the position of the apex beat of the heart?

In the interspace,

cm from the mid sternal line.

H3. Is there any evidence of cardiac enlargement? ◯ Yes ◯ No

If **yes**,

H4. Is there any abnormality in the heart sounds or rhythm? ◯ Yes ◯ No

If **yes**,

H5. Is any murmur present? ◯ Yes ◯ No

If **yes**,

Describe fully, including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.

H6. What is the Blood Pressure (Auscultatory method)? The Diastolic level is to be taken at the cessation of all sound. If the first Systolic reading is above 135 or below 100, or the Diastolic above 85, or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.

Systolic Diastolic mm Hg

Systolic Diastolic mm Hg

Systolic Diastolic mm Hg

H7. Is there any abnormality of the peripheral arterial or venous circulations? ◯ Yes ◯ No

If **yes**,

H8. Is there any abnormality of the heart and .vascular system? ◯ Yes ◯ No

If **yes**,

H9. Is the examinee now on treatment for hypertension? If known, please state:

Pre-treatment blood pressure level including date(s):

/ / / /

/ / / /

Duration of treatment

Nature of treatment

I. Digestive and lymphatic systems

I1. Is there any abnormality of tongue, mouth or throat? ◯ Yes ◯ No

If **yes**,

I2. Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen? ◯ Yes ◯ No

If **yes**,

I3. Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions? ◯ Yes ◯ No

If **yes**,

I4. Is a hernia present? ◯ Yes ◯ No

If **yes**,

J. Genito-urinary system

J1. Examination of the urine. The urine should be passed at the time of examination. If not, please state circumstances:

If albumin is found, an early morning specimen should be examined and findings recorded before completing report.

Albumin Glucose Blood

J2. Is there any evidence of abnormality of the genito-urinary system? ◯ Yes ◯ No

If **yes**,

J3. **Females only** – is the examinee pregnant? ◯ Yes ◯ No

If so, give expected date of confinement / /

K. Nervous system

K1. Is there any defect of vision or abnormality of the eyes? ◯ Yes ◯ No

If **yes**,

K2. **a.** Is there any defect in hearing or speech? In case of present or past ear discharge or deafness, state result of auriscopic examination. ◯ Yes ◯ No

If **yes**,

b. Is there any evidence of mental abnormality? ◯ Yes ◯ No

If **yes**,

c. Is there any evidence of any disorder of the central or peripheral nervous system? ◯ Yes ◯ No

If **yes**,

L. Musculo-skeletal system and skin

L1. **a.** Is there any abnormality of the form or function of the joints? ◯ Yes ◯ No

If **yes**,

b. Is there any abnormality of the form or function of the muscles or connective tissues? ◯ Yes ◯ No

If **yes**,

c. Is there any abnormality of the form or function of the back or neck including the cervical and lumbar spine? ◯ Yes ◯ No

If **yes**,

L2. Is there evidence of any disorder of the skin? ◯ Yes ◯ No

If **yes**, please give details

M. Summary

Do you consider any medical attendant's reports or any special tests are required? ◯ Yes ◯ No

(No special tests are to be carried out in connection with the application for insurance without the Company's authority)

If **yes**,

Do you consider the person examined to be likely to require any surgical operation? ◯ Yes ◯ No

If **yes**,

Comment fully on any unfavourable features (either physical or mental) which could either **reduce life expectancy or cause disablement** of the person examined:

a. as disclosed in Sections A, B C and D of this form.

b. disclosed by your medical examination.

Important: This medical examination is a matter of importance to the person you have just examined and it would be appreciated if you would forward the report without delay to:

Zurich Australia Limited
GPO Box 4129
Sydney NSW 2001
Email: group.risk.uw@zurich.com.au

If I have provided information (including health and other sensitive information) about another person in this application (for example a beneficiary or life insured), I declare that I have the consent of that person to do so. If I give Zurich personal information about someone else, I understand that Zurich requires me to show them a copy of the Product Disclosure Statement and Zurich's Privacy Policy so that they may understand the manner in which their personal information may be used or disclosed by Zurich and their related entities.

Signature of medical examiner

✗

Date (dd/mm/yyyy)

/ /

Qualifications (BLOCK LETTERS)

Payment of Fee

Name

Address

Suburb State Postcode

Business phone Mobile phone Home phone

Email

Privacy Statement

In this section 'we', 'us' and 'our' refers to Zurich Australia Limited (Zurich). 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information (including health and other sensitive information) from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information (including health and other sensitive information). Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from zurich.com.au/important-information/privacy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information (including health and other sensitive information) to certain third parties as outlined below.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

PROVIDING YOUR INFORMATION TO OTHERS

The parties to whom we may routinely disclose your personal information (including health and other sensitive information) include:

- An organisation that assists us to detect and protect against consumer fraud;
- Any related company of Zurich which will use the information for the same purposes as Zurich and will act under Zurich's Privacy Policy;
- Organisations performing administration and/or compliance functions in relation to the products and services we provide;
- Organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- Our solicitors or legal representatives;
- Organisations maintaining our information technology systems;
- Organisations providing mailing and printing services;
- Persons who act on your behalf (such as your agent or financial adviser);
- The policy owner (or parties acting on behalf of the policy owner);
- Regulatory bodies, government agencies, law enforcement bodies and courts;
- Our related companies (members of the Zurich Insurance Group Ltd group), including for carrying out any group business functions;
- Organisations, including those in alliance with us or our related companies, to distribute, manage and administer our products and services, carry out business functions and analytics activities.

We will also disclose your personal information (including health and other sensitive information) in circumstances where we are required by law to do so. Examples of such laws are:

- The *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- There are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

INFORMATION REQUIRED BY LAW

Zurich Australia Limited may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at zurich.com.au/important-information/privacy

PRIVACY CONSENT

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at zurich.com.au/important-information/privacy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

PRIVACY POLICY

Our Privacy Policy contains information about:

- When we may collect information from a third party;
- How you may access and seek correction of the personal information (including health and other sensitive information) we hold about you; and
- How you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing: GPO Box 75
Sydney NSW 2001

Email: privacy.officer@zurich.com.au

We may charge you a reasonable fee for obtaining this information.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667.

More information can be found in our Privacy Policy which can be obtained from our website at zurich.com.au/important-information/privacy

OVERSEAS RECIPIENTS

We may disclose your personal information (including health and other sensitive information) to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in our Privacy Policy at zurich.com.au/important-information/privacy

Additional information/comments

Phone: 1800 199 414
Email: group.risk.uw@zurich.com.au
Website: zurich.com.au
GPO Box 4129, Sydney NSW 2001

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