Mental health questionnaire

This form is to be completed only on request by Zurich Underwriting. To be completed by the life insured. To avoid delays, please check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy number/s

Policy type: ☐ Wealth Protection ☐ Active ☐ Sumo ☐ FutureWise

Duty to take reasonable care not to make a misrepresentation

Your duty to take reasonable care not to make a misrepresentation is explained in the PDS and the Life Insured's Statement and it applies each time you provide us with information before we issue a policy.

Not meeting your legal duty can have serious impacts on your insurance. Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer 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.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with your personal and, perhaps, sensitive information. The collection and management of this information is governed by the Privacy Act 1988. For a more detailed explanation of Zurich's Privacy Policy please visit our website at www.zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au.

1 Life insured details

Title	Surname		
Given names		Date of birth / /	
Address		State	Postcode
Contact details	Work ( )	Home ( )	
	Mobile	Email	

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2 Personal details

(a) Were you advised by your treating practitioner of a diagnosis or name for your condition? ☐ **Yes** ☐ **No**

If No, go to question (c)

If Yes, please check the following condition(s) you experienced and confirm age or date of diagnosis: (if more than one condition, please check all that apply)

☐	Grief reaction, stressful life events or difficulties	Age , Or Date / /
☐	Post natal depression	Age , Or Date / /
☐	Depression (including major depression or dysthymia)	Age , Or Date / /
☐	Anxiety (including panic disorder or generalised anxiety disorder)	Age , Or Date / /
☐	Bipolar disorder	Age , Or Date / /
☐	Obsessive compulsive disorder (OCD)	Age , Or Date / /
☐	Post traumatic stress disorder (PTSD)	Age , Or Date / /
☐	Schizophrenia or other psychotic disorder	Age , Or Date / /
☐	Dissociative disorder (Including dissociative identity disorder)	Age , Or Date / /
☐	Eating disorder (including anorexia or bulimia)	Age , Or Date / /
☐	Attention Deficit or Hyperactivity Disorder (ADD/ADHD)	Age , Or Date / /
☐	Personality disorder (including Borderline personality disorder)	Age , Or Date / /
☐	Any other mental health condition not already mentioned What name was given to your condition?_____	Age , Or Date / /

(b) Have you experienced any of these conditions more than once? ☐ **Yes** ☐ **No**

If Yes, which condition did you experience more than once, and when did this happen?

_____

_____

(c) When did you first experience symptoms relating to your mental health?

Age , Or Date / /

(d) How have you been affected by your mental health?

Please select each which apply

☐	**Have taken time off work under the care of a doctor:** When was the last time you were unable to work due to your mental health? What is the longest number of consecutive days you have been off work due to your mental health?	Age , Or Date / / Days
☐	**Have taken time off work under personal or employer sponsored leave:** When was the last time you were unable to work due to your mental health? What is the longest number of consecutive days you have been off work due to your mental health?	Age , Or Date / / Days
☐	**My work or social relationships have been negatively impacted:** When was the last time you were impacted in this way?	Age , Or Date / /
☐	**My ability to engage in my usual work and social activities have been negatively impacted:** When was the last time you were impacted in this way?	Age , Or Date / /
☐	**My ability to function has been impacted by my mental health in other ways:** Please describe how you have been impacted by your condition: When was the last time you were impacted in this way?	_____ _____ _____ Age , Or Date / /
☐	**My mental health has never impacted my ability to function or my relationships:** When did you last experience symptoms of this condition?	Age , Or Date / /

2 Personal details (continued)

(e) Have you ever taken or been prescribed any medication for your mental health condition? ☐ **Yes** ☐ **No**

If Yes, please complete below (please check all that apply)

	Medication type	**Date first prescribed**	**Are you still taking this?**	**Has this been prescribed more than once?**
☐	Antidepressants (e.g. Zoloft, Cipramil, Effexor, Lovan, Aropax)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Mood stabilisers (e.g. Lithium)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Antipsychotics (e.g. Clozaril, Seroquel, Zyrprexa, Risperdal)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Anticonvulsants (e.g. Epilim, Tegretol, Lamictal)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Sedatives / Hypnotics (e.g. Normison, Diazepam)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Stimulants (e.g. Ritalin, Concerta, Provigil)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Substance abuse related medications (e.g. Campral, Naloxone, Suboxone, Methadone)	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Other or unknown form of medication: Drug name: _____	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Other or unknown form of medication: Drug name: _____	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No
☐	Other or unknown form of medication: Drug name: _____	/ /	☐ Yes ☐ No Ceased / /	☐ Yes ☐ No

(f) Have you ever received or been recommended any talk-based therapy such as counselling, CBT, other forms of mental health treatment or been referred to a psychiatrist? ☐ **Yes** ☐ **No**

If Yes, please complete below (please check all that apply)

	Treatment type	**Date commenced / recommended**	**Are you still attending?**	**Date ceased (if applicable)**
☐	General counselling	/ /	☐ Yes ☐ No	/ /
☐	Cognitive behaviour therapy (CBT) or Dialectical behaviour therapy (DBT)	/ /	☐ Yes ☐ No	/ /
☐	Other forms of talk-therapy: Please specify: _____	/ /	☐ Yes ☐ No	/ /
☐	Consultation with a psychiatrist	/ /	☐ Yes ☐ No	/ /

(g) Have you ever been treated in hospital for your mental health condition? ☐ **Yes** ☐ **No**

If Yes, when did this happen, what is the name of the hospital where you stayed, and how long was your admission

_____

_____

_____

_____

2 Personal details (continued)

(h) Have you ever thought of hurting yourself? ☐ **Yes** ☐ **No**

If Yes, please complete below

When did you last have these thoughts? Age , Or Date / /

Had you experienced these feelings previously? ☐ Yes ☐ No

If Yes, please describe how often you had experienced these feelings previously, and when you first had these thoughts:

Have you ever acted on those thoughts? ☐ Yes ☐ No

If Yes please provide details including when this has happened

(i) Provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address State Postcode

Phone number

Dates consulted: From / / Most recent / /

(j) Have you consulted any other health professionals for this condition? ☐ **Yes** ☐ **No**

Doctor's/Clinic's name

Address State Postcode

Phone number

Dates consulted: From / / Most recent / /

Doctor's/Clinic's name

Address State Postcode

Phone number

Dates consulted: From / / Most recent / /

3 Declaration

The proposed life insured states as follows:

1. 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.
2. 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.
3. I acknowledge that Zurich will rely on statements in this questionnaire in deciding whether to issue an insurance policy and what terms and premium to offer.
4. I authorise Zurich to disclose any information in relation to my application for insurance to any person for the purpose of assisting Zurich to make a decision in relation to my application for insurance.
5. I understand that the insurance applied for shall not become effective until Zurich accepts my application.
6. I authorise my medical practitioner or other professional (i.e. accountant) to disclose any information that they may possess about me to Zurich in relation to my application for insurance or any claim under it.
7. I authorise Zurich to approach any person named in this questionnaire to verify any aspect. In the same way, I authorise any person named in my questionnaire to disclose any information they may possess about me to Zurich.

Name of life insured

Signature of life insured Date

✗ / /

Any questions? Call 131 551

Please return the completed form to us:

By post, to **Zurich Australia Limited, Underwriting Department, Locked Bag 994, North Sydney NSW 2059**, or

By email, as a scanned attachment, to **life.newbusiness@zurich.com.au**

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