Standard Medical Examination Form

Part 1  Personal Statement by the Life to be Insured

Part 2  Confidential Medical Report to MLC Life Insurance for Insurance Cover

Your Duty of Disclosure
When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the policy.

You do not need to tell us anything that:
• reduces the risk we insure you for; or
• is common knowledge; or
• we know or should know as an insurer; or
• we waive your duty to tell us about.

If someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate policies of life insurance. If they do, we may apply the following rights separately to each type of cover.

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the policy within 3 years of entering into it.

If we choose not to avoid the policy, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

Part 1  Personal Statement by the Life to be Insured

Name of Financial Adviser authorising examination

Division  Financial Adviser number  Phone number

Special instructions for the Medical Examiner (to be completed by the Financial Adviser)

☐ Resting ECG required  ☐ Exercise ECG required

☐ Please make particular comment on

__________________________________________________________

__________________________________________________________

__________________________________________________________
Life Insured’s details

Personal statement made in connection with a proposal for insurance on the life of:

First name  
Family name  

Email address (Please provide your email so notices relating to your application can be sent to you)

Home telephone  
Business telephone  

Mobile phone number  
Best contact time  
am/pm  
Day(s)  

Residential address (your residential address cannot be a PO Box)

Unit number  
Street number  
Street name  
Suburb  
State  
Postcode  
Country  

Postal address

Same as residential  

PO Box number  
Unit number  
Street number  
Street name  
Suburb  
State  
Postcode  
Country  

Occupation and industry

Occupational duties

Complete sections A, B, C & 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 on page 6 in the Examiner’s presence.

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

1. (a) Do you drink alcohol?
   Yes [ ] Number of standard drinks: [ ] per day or [ ] per week Note: one standard drink = 1 glass of beer / wine / nip of spirit
   No [ ]

   (b) Have you ever been advised by a health professional or attended a support group to reduce or cease your alcohol intake?
   Yes [ ] Please provide details:
   No [ ]

2. Have you smoked tobacco, e-cigarettes, or any other substance or used any nicotine-containing product in the last 12 months?
   Yes [ ] What type? eg cigarettes, gum, patch Daily quantity
   No [ ]

B. Medical history

If you answer ‘Yes’ to any item in questions 3, 4, 5 or 6, please give details at Question 9.

3. Do you have or have you ever had any of the following?

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<tr>
<th>Item code</th>
<th>Yes</th>
<th>No</th>
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4 Other than already stated, have you in the last 5 years:

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<th>Item code</th>
<th>Yes</th>
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5 Do you now have any other disability, illness, injury or symptoms not already mentioned?

6 Do you contemplate seeking any advice, test, investigation or treatment?

Males: Go to Question 9

Females only

7 Are you currently pregnant?
   Yes [ ] Due date (DD/MM/YYYY): [ ]
   No [ ]

8 Have you ever had an abnormal pap smear?
   Yes [ ] When? (DD/MM/YYYY) [ ]
   Treatment given [ ]
   Date and result of most recent pap smear (DD/MM/YYYY) [ ]
   No [ ]

9 Did you answer ‘Yes’ to any item in questions 3, 4, 5 or 6?

Give full and accurate details below of each instance:

<table>
<thead>
<tr>
<th>Question No. and Item Code (see page 3)</th>
<th>Disability, illness, condition or test</th>
<th>Test results</th>
<th>When did it start?</th>
<th>When did it cease?</th>
<th>Type of treatment</th>
<th>How long off work?</th>
<th>Have you completely recovered?</th>
<th>Name and address of medical facility and attending person</th>
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C. Family history

10 Have any of your parents, brothers or sisters (living or dead) suffered from any of the following?

- Cancer (specify type and site)
- Heart disease
- Stroke
- Diabetes
- Rheumatoid Arthritis
- Haemochromatosis
- Huntington's disease
- Motor neurone disease
- Muscular dystrophy
- Familial polyposis
- Multiple sclerosis
- Parkinson’s disease
- Polycystic kidney disease (PCKD)
- Any other hereditary disorder

Yes ☐ Please provide details below

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<th>Family member (e.g. mother, brother)</th>
<th>Medical condition</th>
<th>Cancer type and site</th>
<th>Age condition began</th>
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No ☐

D. Doctor’s details / last consult

11 What is the name and address of your usual doctor or medical centre? 
(If no usual doctor, then the last doctor you last visited)

Doctor’s name or medical centre

Postal address

Suburb State Postcode

Business number How long have you been attending this practice?

[ ] [ ] [ ] years [ ] months

Please provide details of your last check-up or consultation

Date of last consultation (DD/MM/YYYY) Reason for last check-up or consultation

[ ] [ ] [ ] [ ]

Result

Medication prescribed, referral given or tests ordered

[ ... ]
Declaration

Read this section carefully before signing

I understand and agree that:

a) the answers to the questions in this Personal Statement are true and complete and that this supplementary Personal Statement forms part of my application for insurance;

b) We are authorised to obtain any information from any medical practitioner that they possess in relation to the insurance; and

c) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.

Signature of Life to be Insured

Date (DD/MM/YYYY)

I declare that the signature of the Life to be Insured was signed in my presence and that I have discussed the personal statements made by the Life to be Insured where appropriate.

Signature of Medical Examiner

Date (DD/MM/YYYY)

Part 2 Confidential Medical Report to MLC Life Insurance for Insurance Cover

On the Medical Condition of

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.

Introduction

1 Are you acquainted with the examinee:

a) Professionally?

Yes ☐ For how long? ______________

No ☐

b) Personally?

Yes ☐ For how long? ______________

No ☐

2 Is there anything unfavourable in appearance, development or behaviour?

Yes ☐ Please give details

No ☐
3 Is there any indication of past or present abuse of alcohol or the misuse of drugs?
Yes ☐ Please give details
No ☐

Measurements

4 Give the following measurements:
 a) Height (without shoes) b) Weight (clothed) c) BMI cm kg
 d) Chest and abdomen at umbilicus (next to skin):
   Chest Expiration cm Chest Inspiration cm Abdomen cm

5 If chest expansion is less than 5 cm, comment as to the apparent cause or provide peak flow meter reading if available

Respiratory system

6 Is there any abnormality of the respiratory system to palpation percussion or auscultation?
Yes ☐ Please give details
No ☐

7 Is there any sign of past or present respiratory disease?
Yes ☐ Please give details
No ☐

Circulatory system

8 What is the rate and character of the pulse?
Pulse rate Character per minute

9 What is the position of the apex beat of the heart?
In the interspace cm from the mid-sternal line
10 Is there any evidence of cardiac enlargement?
Yes ☐ Please give details

No ☐

11 Is there any abnormality in the heart sounds or rhythm?
Yes ☐ Please give details

No ☐

12 Is there any murmur present?
Yes ☐ Describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.

No ☐

13 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.

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14 Is there any abnormality of the peripheral arterial or venous circulation?
Yes ☐ Please give details

No ☐

15 Do you consider the heart and the vascular system to be abnormal?
Yes ☐ Please give details

No ☐
16. Is the examinee now on treatment for hypertension or hypercholesterolaemia?

Yes ☐ If known, please advise
a) Pre-treatment level including dates

b) Duration of treatment

c) Nature of treatment

No ☐

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**Digestive and lymphatic system**

17. Is there any abnormality of tongue, mouth or throat?

Yes ☐ Please give details

No ☐

18. Is there any abnormality or evidence of disease of any abdominal organ, including liver or spleen?

Yes ☐ Please give details

No ☐

19. Is there any abnormality of the lymph nodes in the neck, axillae or inguinal regions?

Yes ☐ Please give details

No ☐

20. Is a hernia present?

Yes ☐ Please describe fully

No ☐
Genito-urinary system

21 Examination of the urine:
The urine should be passed at the time of the examination. If not, please state the circumstances.
If Albumin is found, an early morning specimen should be examined and findings recorded before completing the report.
a) Albumin  b) Glucose  c) Blood

22 Is there any evidence of abnormality of the genito-urinary system?
Yes  □  Please give details
No  □

Females only

23 Is the examinee pregnant?
Yes  □  Expected date of confinement (DD/MM/YYYY)
No  □

Nervous system

24 Is there any defect of vision or abnormality of the eyes?
Yes  □  Please give details
No  □

25 Is there any defect in hearing or speech?
Yes  □
No  □
In case of present or past ear discharge or deafness, state result of auriscopic examination

26 Is there any evidence of mental disorder?
Yes  □  Please give details
No  □
27 Is there any evidence of any disorder of the central or peripheral nervous system?
Yes ☐ Please give details

No ☐

**Musculoskeletal system and skin**

28 Is there any abnormality in the form or function of the joints, muscles or connective tissue?
Yes ☐ Please give details

No ☐

29 Is there any abnormality in the form or function of the back or neck including the cervical and lumbar spine?
Yes ☐ Please give details

No ☐

30 Is there any evidence of any disorder of the skin?
Yes ☐ Please give details

No ☐

**Summary**

31 Do you consider any medical attendant’s report or any special tests are required? (No special tests are to be carried out in connection with the proposal for insurance without the company’s authority)
Yes ☐ Please give details

No ☐

32 Do you consider the person examined to be likely to require any surgical operation?
Yes ☐ Please give details

No ☐
33 Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause temporary or permanent disablement:

a) in the personal medical history

b) disclosed by your medical examination

Name of Medical Examiner (PLEASE PRINT)

Qualifications

Postal address

Suburb: [ ] State: [ ] Postcode: [ ]

Telephone number

Signature of Medical Examiner

Please include a GST Tax Invoice with your report to allow payment

Send us the form

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:

MLC Life Insurance
PO Box 200
North Sydney NSW 2059

If you have any questions, please call us on 132 652 any business day between 8.00 am and 6.00 pm (AEST/AEDT).

Office Use Only

Amount: $ Date (DD/MM/YYYY): [ ] [ ] [ ] [ ] [ ] [ ] [ ] Authorised: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]