

Application for Insurance

Please return completed form to:
MetLife Insurance Limited
GPO Box 3319
Sydney NSW 2001
or
auserVICES@metlife.com

MetLife

About the Application

- This application needs to be completed by the person to be insured.
- Please complete the application in BLACK ink pen only.
- Any changes made to this application are to be initialled by the person to be insured.
- Please answer all the questions as accurately as possible and provide additional information wherever requested.
- As part of your application, you may be required to undergo additional medical tests.
- As part of the overall assessment process MetLife will contact you on your preferred phone number if further information is required.

Privacy - Use and Disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' and the 'Insurer')

The personal information you provide in this form is necessary for us to provide you with the products and services you have requested from us, and to manage your claims. You do not have to provide us with your personal information, but if you do not do so we may not be able to provide you with our products or services.

MetLife Insurance Limited complies with the Privacy Act 1988 and the principles laid out in its privacy policy which details information about how you may access or seek correction of your personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Name of Scheme or Superannuation Fund: _____

About You

First Name _____ Middle Name _____ Last Name _____

Residential Address _____ City _____ State _____ Postcode _____

Date of Birth (dd/mm/yyyy) _____ / _____ / _____ Gender Male Female Email Address _____

Contact Number Preferred _____ Contact Number Other _____ Preferred Time of Contact Morning (9am-12pm) Afternoon (12-6pm)

Are you a permanent resident of Australia? Yes No

About Your Insurance Needs

Total Required Cover:	Death Cover	Total & Permanent Disability Cover	Income Protection
Existing Policy Cover (if known)	<input type="text" value="\$"/>	<input type="text" value="\$"/>	<input type="text" value="\$"/> per month
Additional Policy Cover Requested	<input type="text" value="\$"/>	<input type="text" value="\$"/>	<input type="text" value="\$"/> per month
Total Cover Requested (= Existing + Additional Policy Cover Requested)	<input type="text" value="\$"/>	<input type="text" value="\$"/>	<input type="text" value="\$"/> per month

About Your Work

1. What industry do you work in? (eg. banking, agriculture, education) What is your current occupation? What is your current gross annual salary?
- _____
2. Do you work more than **15 hours** per week? Yes No

About Your Insurance History

3. Has an application for Life, Trauma, TPD or Disability Insurance on your life ever been declined, deferred or accepted with a loading or exclusion or any other special condition or terms? Yes No
4. Are you contemplating or have you ever made a claim for or received sickness, accident or disability benefits, Workers' Compensation, or any other form of compensation due to illness or injury? Yes No
5. Do you currently have or are you applying for insurance with MetLife (in addition to this application) or any other insurance company or superannuation fund? Yes No

If "Yes", please give details in the table below.

Product/Type	Total Amount of Cover	To be replaced by this cover?
Life Insurance	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total & Permanent Disability	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
Income Protection	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

About Your Health

6. What is your height? What is your weight?
- _____ cm _____ kg
7. Have you smoked any substance in the last 12 months? Yes No
8. In the last **3 years** have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?
Please tick all boxes that apply.
- Headache or Migraine (eg. tension or cluster headaches or migraines)
 Lung or Breathing Conditions (eg. asthma, sleep apnoea)
 Eyesight Conditions (does not incl. contact lenses or glasses for near or far sightedness)
- Ear or Hearing Conditions (eg. hearing loss, tinnitus or swimmer's ear)
 Muscle, Tendon or Ligament Problems
 Trapped Nerves (eg. carpal tunnel syndrome, pinched nerve, tennis elbow)
- Infectious Diseases (excl. cold & flu)
 Gout
- None of the above conditions**

If you have selected any of the above conditions in question 8, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

9. In the last 5 years have you suffered from, been diagnosed with or sought medical advice or treatment for any of the following?

Please tick all boxes that apply.

- High Blood Pressure
 High Cholesterol
 Chronic Fatigue / Fibromyalgia
 None of the above conditions

If you have selected any of the above conditions in question 9, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

10. Have you ever suffered from, been diagnosed with or sought medical advice or treatment for any of the following?

Please tick all boxes that apply.

- Bone, Joint or Limb Conditions
 Back Pain
 Digestive Conditions
 Brain or Nerve Conditions (incl. stroke)
 Psychological or Emotional Conditions
 Cancer, Cyst, Growth, Lump, Polyps or Tumour
 Thyroid Conditions
 Skin Conditions
 Urinary or gender specific conditions and abnormal findings
 Autoimmune Conditions
 Heart Related Conditions
 Kidney or Liver Conditions
 Diabetes
 Blood Conditions
 None of the above conditions

If you have selected any of the above conditions in question 10, please give details in the table below.

Condition	Details (incl. dates, symptoms, treatment)

11. Are you currently pregnant? (Females Only) Yes No

12. What is the name of your usual doctor/medical centre? _____

Address: _____

_____ Contact Number: _____

About Your Family History

13. Has your mother, father, any brother, sister or child been diagnosed under the age of 55 years, with any of the following conditions: Alzheimer's Disease, Cancer, Dementia, Diabetes, Familial Polyposis, Heart Disease, Huntington's Disease, Motor Neurone Disease, Polycystic Kidney Disease, Multiple Sclerosis, Muscular Dystrophy, Stroke or any inherited or hereditary disease? Yes No Unknown

Note: You are only required to disclose family history information pertaining to first degree blood related family members, living or deceased.

If "Yes", please give details in the table below.

Relationship to proposed insured	Age at diagnosis	Specific condition(s)

About Your Lifestyle

14. Do you intend to travel to any country outside Australia in the next 6 months?

Yes No

If "Yes", please give details in the table below.

Country	Length of stay

15. Do you regularly engage in or intend to engage in any of the following activities? Please tick all boxes that apply.

- Water Sports (eg. underwater diving, rock fishing)
 Motor Sports (eg. motorcycle, auto, motor boat)
 Sky Sports (eg. skydiving, hang gliding, parachuting, ballooning)
- Aviation (other than as a fare paying passenger on a commercial airline)
 Horse Sports (eg. polo, horse riding, rodeo, dressage, jumping)
 Combat Sports or Martial Arts (eg. martial arts, boxing, fencing)
- Field Sports (eg. hockey or football including touch or tag and soccer)
 Hunting (of any kind)
 Any other hazardous activity not mentioned (eg. base jumping, caving, outdoor rock climbing)
- None of the above activities

Please provide details for any activities you have selected above:

Activity	Details

16. Have you within the last 5 years used any drugs that were not prescribed to you (other than over the counter drugs) or have you exceeded the recommended dosage of any medication?

Yes No

If "Yes", please give details in the table below.

Drug/Medicine	Reason for Use

17. On average, how many standard alcoholic drinks do you consume each week (a standard drink is equivalent to either 125ml glass of wine, a schooner of light beer, a middy/pot of full strength beer or a 30ml shot of spirits)?

_____ / Week

18. Have you ever been advised by health professional to reduce your alcohol consumption?

Yes No

19. Are you infected with HIV (Human Immunodeficiency Virus), the virus which can cause/lead to AIDS (Acquired Immune Deficiency Syndrome)?

Yes No

If "No", have you been referred for or waiting on an HIV test result and/or taking preventative medication?

Yes No

20. Other than already disclosed in this application, do you presently suffer from any condition, injury or illness, which you suspect may require medical advice or treatment in the future?

Yes No

If "Yes", please provide details below.

Condition	Details

Duty of Disclosure

A person who enters into a life insurance contract in respect of your life has a duty, before entering into the contract, to tell us anything that he or she knows, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms.

The person entering into the contract has this duty until we agree to provide the insurance.

The person entering into the contract has the same duty before he or she extends, varies or reinstates the contract.

The person entering into the contract does 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 you do not tell us something that you know, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to tell us something that he or she must tell us.

IF THE PERSON ENTERING THE CONTRACT DOES NOT TELL US SOMETHING

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

If the person entering into the contract does not tell us anything he or she is required to, and we would not have provided the insurance if he or she had told us, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if he or she had told us everything he or she should have.

However, if the contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if he or she had told us everything he or she should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

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

DECLARATION

- I have read and understand my Duty of Disclosure and understand that this duty applies until formal notification of acceptance.
- My answers to the questions are true, and I have not deliberately withheld any information or material to the proposed insurance.
- I agree to be bound by the terms and conditions set out in the insurance policy document.
- I consent to the collection, use and disclosure of personal information by MetLife and its service providers in order to assess my application and any claim under the policy.
- I have read and understood the Privacy Disclosure Statement contained in the section head "Privacy - Use and Disclosure of personal information." I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement above and MetLife's Privacy Policy.
- I consent to MetLife seeking medical information from any doctor/hospital/health care professional whom I have consulted.
- I understand that cover under a policy does not begin until acceptance by the insurer, of which I will be notified in writing.
- I have read the insurance section of the current Product Disclosure Statement.

Signature

Signature of Applicant

Date

▶ _____ / ____ / ____

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