

Standard Medical Examination Form

September 2021

OnePath Life Limited (OnePath Life)

ABN 33 009 657 176 AFSL 238341

GPO Box 4129, Sydney NSW 2001

Group Risk Administration

Phone 1800 199 414

Email group.riskuw@onepath.com.au

Website onepath.com.au

Complete Part 1 and 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 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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname																			
First name																			
Date of birth (dd/mm/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>																
Occupation																			
Address																			
Suburb	<input type="text"/>	State	<input type="text"/>	Postcode	<input type="text"/>														

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:

1. Any heart trouble, murmur, palpitations, stroke or vascular disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. High cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. High blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Pain in the chest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Rheumatic fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Asthma, bronchitis, persistent cough or any other chest or lung condition?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Sleep Apnoea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Thyroid or glandular trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Recurring indigestion, gastric or duodenal ulcer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Bowel disease?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Hepatitis, or any liver or gall bladder disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Anaemia, leukaemia, haemophilia or any other blood disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Epilepsy, fits, hydrocephalus, dizziness, fainting or any kind of persistent headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Alzheimer's disease or dementia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Stress, anxiety, depression or any other mental condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Kidney, prostate or bladder problems (including renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Diabetes Mellitus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Coughing of blood or passage of blood from the bowel or in the urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Any disease of, or injury to, the neck or spine including back strain, disc disorder, lumbago, fibrositis, sciatica, neuritis, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Arthritis or any other disease or deformity, or any pain, strain or disorder of any joint or limb?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

22. Gout, fibromyalgia, tendonitis, tenosynovitis, 'RSI' or any regional pain syndrome or chronic fatigue syndrome (myalgic encephalitis)? Yes No
23. Broken bones, osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?..... Yes No
24. Any abnormality affecting eye sight, hearing or speech?..... Yes No
25. Any disorder of the skin, including but not limited to cysts, moles, skin lesions, varicose veins, scleroderma or systemic sclerosis?..... Yes No
26. Hernia?..... Yes No
27. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis) or any diagnosed intellectual disability or cognitive impairment? Yes No
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? Yes No
29. Have you within the past five years suffered a needle stick injury?..... Yes No
30. Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)?..... Yes No
31. Do you now have any symptoms of ill health or disability? Yes No
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.)..... Yes No
33. Do you take, or have you ever taken drugs or any medication on a regular or ongoing basis? Yes No
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? Yes No

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 OnePath Life, 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? Yes No

If you answered Yes to question 35(A) please proceed to 35(B), otherwise continue to question 36

35.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). Yes No

36. Females only:

a. Are you currently pregnant? Yes No

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)..... Yes No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? Yes No

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?..... Yes No

37. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?..... Yes No

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?..... Yes No

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?..... Yes No

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 9.

	Question number	Question number	Question number
Disability, illness, injury, or condition			
Investigation type(s) and result(s)			
Date of first symptoms (dd/mm/yyyy)	/ /	/ /	/ /
Frequency of symptoms			
Type of treatment (and date provided and ceased) (dd/mm/yyyy)	/ /	/ /	/ /
Has further treatment, referral or investigation(s) been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Time off work	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Have you completely recovered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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 Postcode

D1. How long have you been a patient of this doctor? yrs mths

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 OnePath Life 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 (dd/mm/yyyy) / /

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

Signature of medical examiner Date (dd/mm/yyyy) / /

Part 2 – Confidential Medical Report to OnePath Life

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 & 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 & 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 & 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:

OnePath Life Limited

GPO Box 4129, Sydney NSW 2001

Email: group.riskuw@onepath.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 OnePath Life personal information about someone else, I understand that OnePath Life requires me to show them a copy of the Product Disclosure Statement and OnePath Life's Privacy Policy so that they may understand the manner in which their personal information may be used or disclosed by OnePath Life and their related entities.

Signature of medical examiner

Date (dd/mm/yyyy)

Qualifications (BLOCK LETTERS)

Payment of Fee

Name

Address

Suburb

State

Postcode

Phone

Business

Mobile

Home

Privacy Statement

In this section 'we', 'us' and 'our' refers to OnePath Life Limited. 'You' and 'your' refers to policy owners and life insured's.

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 onepath.com.au/insurance/privacy-policy

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 OnePath Life Limited which will use the information for the same purposes as OnePath Life Limited and will act under OnePath Life'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

OnePath Life 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 onepath.com.au/insurance/privacy-policy

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 onepath.com.au/insurance/privacy-policy 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.

Postal address

OnePath Life
GPO Box 4129
Sydney NSW 2001