

# Supplementary Personal Statement

## Cholesterol questionnaire

November 2021

**Customer Services**  
**Phone** 133 667  
**Email** client.onepath@zurich.com.au  
**Website** onepathinsurance.com.au

**OnePath Life Limited (OnePath Life)**  
 ABN 33 009 657 176 AFSL 238341

**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 Personal 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.

### Details of Life Insured

Application/Policy number(s) if known

Title  Mr  Mrs  Ms  Miss  Dr  Other

Surname

Given name(s)

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

### Please answer the following questions

1. When was your high cholesterol first diagnosed? ..... Date diagnosed (dd/mm/yyyy)  /  /

2. What were your cholesterol readings at that time?

Cholesterol	Triglycerides
HDL Cholesterol	LDL Cholesterol

3. Did you undergo any tests or investigations? .....  Yes  No

If **yes**, please provide details:

Test performed	Date (dd/mm/yyyy)	Results
<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"/>

4a. Have you ever used any medication? .....  Yes  No

If **yes**, please provide details:

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
<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"/>	<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"/> / <input type="text"/>	<input type="text"/>

b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)?  Yes  No

If **yes**, please provide date of when treatment changed and the reason(s) for change:

Two empty text input boxes for date and reason.

5. Is the treating doctor different to your usual doctor?  Yes  No

If **yes**, please provide details:

Form fields for Name, Address, Suburb/Town, State, Postcode, and Date of last consultation (dd/mm/yyyy).

6. What was the date of your last cholesterol check?.....Date (dd/mm/yyyy) [ / / ]

7. What were your cholesterol readings at that time? Fields for Cholesterol, Triglycerides, LDL Cholesterol, and HDL Cholesterol.

8. How has your doctor described your cholesterol control?  Excellent  Good  Poor  Other

If **other**, please provide details

Empty text input box for details.

9. When is your next cholesterol check up?.....Date (dd/mm/yyyy) [ / / ]

**Declaration**

I, the life to be insured, declare that I have read and understood my duty to take reasonable care not to make a misrepresentation and that the statements and answers provided in this questionnaire are true, accurate and complete. I understand that the information I provide on this form in conjunction with any other statements made in connection with this application for life insurance will be used by OnePath Life, to decide whether to extend life insurance cover to the policy owner in respect of my life.

I acknowledge and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Product Disclosure Statement and OnePath Life's Privacy Policy, which is available at onepathinsurance.com.au/about-us/privacy-policy or by calling Customer Services on 133 667.

If I have provided 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.

Name of life to be insured [Text input box]

Signature (sign clearly within the box) [Signature box with 'X' and Date (dd/mm/yyyy) [ / / ]]

**Postal address**  
OnePath Life  
Locked Bag 994  
North Sydney NSW 2059