Underwriting

Medical examination form

Questions 1, 2 and 3 of Section 1 are to be completed by the life insured prior to the examination. The medical examiner will discuss the answers with you and add any details considered appropriate.

Section 2 is to be completed by the medical examiner.

Please avoid delays by checking that all questions have been answered fully and where appropriate use BLOCK LETTERS.

Policy number(s)

Section 1

Your duty of disclosure

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer’s decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of life insurance.

Your duty of disclosure however does not require disclosure of a matter:

• that diminishes the risk to be undertaken by the insurer
• that is common knowledge
• that your insurer knows or, in the ordinary course of business ought to know
• if compliance with your duty in relation to that matter is waived by the insurer.

Your duty of disclosure continues until the insurer has informed you as to whether the insurer accepts or declines your application. This means that you must advise the insurer of any changes to the information included in your application up until the date that the insurer confirms in writing that the application has been accepted or declined.

In particular, you should advise Zurich of any changes in medical or physical conditions, and of any visits to medical service providers.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Your privacy

Zurich is bound by the National Privacy Principles. 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.

Adviser name

Adviser number
# Life insured details

<table>
<thead>
<tr>
<th>Title</th>
<th>Surname</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

**Given names**

<table>
<thead>
<tr>
<th>Date of birth</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

**Address**

<table>
<thead>
<tr>
<th>State</th>
<th>Postcode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Contact numbers**

<table>
<thead>
<tr>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Present occupation**

<table>
<thead>
<tr>
<th>Industry in which you work</th>
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<tbody>
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</tbody>
</table>

The medical examiner is requested to ensure that a clear and complete answer is given to each of the following questions.

## Personal habits

(a) Have you smoked tobacco or any other substance within the last 12 months?  
Yes ☐ No ☐

If “Yes”, please provide type and quantity per day

(b) Do you now or have you ever consumed alcohol?  
Yes ☐ No ☐

If “Yes”, how many standard drinks do you consume on average per week

(c) Have you ever reduced or been advised to reduce your tobacco or alcohol consumption?  
Yes ☐ No ☐

Type, previous amount, duration:

Reason for reduction, cessation:

(d) (i) Have you used or injected yourself with any drug not prescribed by a doctor?  
Yes ☐ No ☐

If “Yes”, please provide details

(ii) Have you ever had an alcohol dependency?  
Yes ☐ No ☐

If “Yes”, please provide details

(e) Do you take any medication, drugs, stimulants, sedatives or tranquillisers or have you done so within the last 5 years?  
Yes ☐ No ☐

If “Yes”, please provide details
## Medical history

If you answer ‘Yes’, to any of the following questions, please provide full details including question number, date, condition, name and address of doctors/hospitals, treatment, results, length of time off work.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Details as requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Any heart or vascular disorder, high blood pressure, raised cholesterol, chest pain, rheumatic fever?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Indigestion, hernia, gastric or duodenal ulcer?</td>
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<tr>
<td>(c) Bowel disease?</td>
<td></td>
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<tr>
<td>(d) Coughing of blood or passage of blood from the bowel or in the urine?</td>
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<tr>
<td>(e) Hepatitis, haemochromatosis, any liver disease, gall bladder disease or abnormal liver function tests?</td>
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<tr>
<td>(f) Anaemia, leukaemia, haemophilia, or other blood disorder?</td>
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<td>(g) Kidney or bladder disorder (including renal colic, calculi, nephritis, pyelitis or cystitis)?</td>
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<td>(h) Cancer, tumour, cyst or growth of any kind?</td>
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<tr>
<td>(i) Thyroid or prostate disorder?</td>
<td></td>
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<td>(j) Arthritis, gout?</td>
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<tr>
<td>(k) Tendonitis, tenosynovitis, “RSI” or regional pain syndrome?</td>
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<td>(l) Any impairment of sight, hearing or speech?</td>
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<td>(m) Any skin disorder?</td>
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<tr>
<td>(n) Any congenital abnormality?</td>
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<td></td>
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<tr>
<td>(o) Any sexually transmitted disease or hepatitis?</td>
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<td></td>
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<tr>
<td>(p) Any positive antibody test for HIV?</td>
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<tr>
<td>(q) Any other disability, illness or injury?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(r) Have you had any blood test, urine test or bowel screening?</td>
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<tr>
<td>(s) Have you had an ECG, X-ray, CT or MRI scan?</td>
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<tr>
<td>(t) Have you had any other test?</td>
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<tr>
<td>(u) Asthma, bronchitis or other lung complaint?</td>
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<td></td>
<td></td>
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<tr>
<td>(v) Epilepsy, fainting attacks or fits of any kind?</td>
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<td></td>
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<tr>
<td>(w) Paralysis or stroke?</td>
<td></td>
<td></td>
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<tr>
<td>(x) Depression, stress, anxiety, panic attacks, behavioural disorder or other mental or nervous condition?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Medical history (continued)

If you answer ‘Yes’, to any of the following questions, please provide full details including question number, date, condition, name and address of doctors/hospitals, treatment, results, length of time off work

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Details as requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>(y)</td>
<td></td>
<td>Lethargy, chronic fatigue, chronic pain syndrome, glandular fever or fibromyalgia?</td>
</tr>
<tr>
<td>(z)</td>
<td></td>
<td>Diabetes?</td>
</tr>
<tr>
<td>(a1)</td>
<td></td>
<td>Any disease of, or injury to, the neck or spine including back strain, disc disorder, lumbago, fibrositis, sciatica, neuritis or other non-specific back pain?</td>
</tr>
<tr>
<td>(b1)</td>
<td></td>
<td>Any injury, deformity or disease involving any joint or limb?</td>
</tr>
<tr>
<td>(c1)</td>
<td></td>
<td>Do you contemplate seeking any examination, advice or treatment (including medical or surgical) in the near future?</td>
</tr>
</tbody>
</table>

Family medical history – all to complete

Please indicate if any parent, brother or sister, living or deceased, has had any of the following:

- Diabetes
- Cancer
- Cystic fibrosis
- Heart disease
- Polycystic kidneys
- Mental disorder
- Stroke
- Muscular dystrophy
- Huntington's chorea or any hereditary disease

If ‘Yes’, please complete the following schedule of family history

<table>
<thead>
<tr>
<th>Living</th>
<th>Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>State of health (if not good, state reason)</td>
</tr>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
</tr>
</tbody>
</table>

Declaration

The proposed life insured states as follows:

1. I have read and understood all of the statements, questions and answers in the form. In particular, I acknowledge my duty of disclosure to Zurich as described on page 1.
2. Each statement that I have made to Zurich or any other person in relation to my application for insurance and in this form is true and correct.
3. I acknowledge that Zurich will rely on statements in this form in deciding whether 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 (ie. 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 form to verify any aspect of it. In the same way, I authorise any person named in this form to disclose any information they may possess about me to Zurich.

Signature of life insured

Signature of medical examiner

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

If you have any queries please contact your financial adviser, call Zurich on 131 551 or email: risksuspense.management@zurich.com.au
Underwriting

Medical examination form

The 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.

Zurich’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. This form must be posted direct to Zurich immediately on completion of examination.

Please avoid delays by checking that all questions have been answered fully and where appropriate use block letters.

Section 2

1. Introduction

(a) Are you acquainted with the examinee

Yes ☐ No ☐

If ‘Yes’, please give details ☐ Professionally ☐ Personally

(b) Is there anything unfavourable in appearance, development or behaviour?

Yes ☐ No ☐

If ‘Yes’, please provide details

(c) Is there any indication of past or present abuse of alcohol or of the misuse of drugs

Yes ☐ No ☐

If ‘Yes’, please provide details

2. Measurement

Please fill in the following particulars. Measurements must be actual wherever possible

(a) Height without shoes? cm

Weight (clothed) kg

Chest expiration (next to skin) cm

Inspiration cm

Abdomen at umbilicus (next skin) cm

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

3. Respiratory system

(a) Is there any abnormality of the respiratory system to palpation, percussion or auscultation?

Yes ☐ No ☐

If ‘Yes’, please provide details

(b) Is there any sign of past or present respiratory disease?

Yes ☐ No ☐

If ‘Yes’, please provide details
## Circulatory system

<table>
<thead>
<tr>
<th>(a) What is the rate and character of the pulse?</th>
<th>Pulse rate</th>
<th>Character</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) What is the position of the apex beat of the heart?</td>
<td>In the intercostal space</td>
<td>from mid-sternal line cm</td>
</tr>
<tr>
<td>(c) Is there any evidence of cardiac enlargement?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’ please provide details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Is there any abnormality in the heart sounds or rhythm?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’ please provide details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Is there any murmur present?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’, describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) 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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>Diastolic</td>
<td>mm Hg</td>
</tr>
<tr>
<td>Systolic</td>
<td>Diastolic</td>
<td>mm Hg</td>
</tr>
<tr>
<td>Systolic</td>
<td>Diastolic</td>
<td>mm Hg</td>
</tr>
<tr>
<td>(g) Is there any abnormality of the peripheral arterial or venous circulation?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’, please provide details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(h) Is there any abnormality of the heart and vascular system?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’, please provide details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Is the examinee now on treatment for hypertension?</td>
<td>Yes ○</td>
<td>No ○</td>
</tr>
<tr>
<td>If ‘Yes’, please provide details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-treatment blood pressure level including dates (if known)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature of treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Digestive and lymphatic systems

(a) Is there any abnormality of the tongue, mouth or throat?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(b) Is there any abnormality or evidence of disease of any abdominal organ, including liver and and spleen?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(c) Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(d) Is a hernia present?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

### Genito-urinary systems

(a) (i) Urine examination (the urine should be passed at the time of examination if not, please state circumstances)  
   Does the urine contain:  
   (i) Albumin  
      Yes ☐  No ☐  
      If ‘Yes’, please provide details  
   
   (ii) Glucose  
      Yes ☐  No ☐  
      If ‘Yes’, please provide details  
   
   (iii) Blood  
      Yes ☐  No ☐  
      If ‘Yes’, please provide details  

   (ii) If albumin is found, an early morning specimen should be examined and findings recorded here before completing the report  

(b) Is there any evidence of abnormality of the genito-urinary systems?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(c) FEMALES – Is the examinee pregnant?  
   Yes ☐  No ☐  
   If ‘Yes’, please advise expected date of confinement / /  

### Nervous system

(a) Is there any defect or abnormality of the eyes?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(b) Is there any defect in hearing or speech (in cases of present or past ear discharge or deafness, state result of auriscopic examination)?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

(c) (i) Is there any evidence of mental abnormality?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details  

   (ii) Is there any evidence of disorder of the central or peripheral nervous system?  
   Yes ☐  No ☐  
   If ‘Yes’, please provide details
Musculo-skeletal system and skin

(a) Is there any abnormality of the form or function of
(i) the joints? Yes ☐ No ☐
   If ‘Yes’, please provide details

(ii) the muscles or connective tissues? Yes ☐ No ☐
   If ‘Yes’, please provide details

(iii) the back or neck including the cervical and lumbar spine? Yes ☐ No ☐
   If ‘Yes’, please provide details

(b) Is there any evidence of any disorder of the skin? Yes ☐ No ☐
   If ‘Yes’, please provide details

Summary

(a) Do you consider any medical attendant’s reports 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 ☐ No ☐
   If ‘Yes’, please provide details

(b) Do you consider the person examined to be likely to require any surgical operation or future medical treatment? Yes ☐ No ☐
   If ‘Yes’, please provide details

(c) Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement:
   (i) In the personal or family medical history

   (ii) Disclosed by your medical examination
Declaration
To my knowledge I declare that the information provided is true and correct

Name
Qualifications
Address

State Postcode
Contact number
Your fee $

Signature of medical examiner Date
✗ / /

Any questions? Call 131 551
Please return the completed form and invoice 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 **risksuspense.management@zurich.com.au**, or
By fax, to **02 9995 3822**.