Life Insurance Medical Examiner's Confidential Report

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DUTY OF DISCLOSURE

Before you enter into or become insured under an insurance contract with us, you and any life to be insured are required under the Insurance Contracts Act 1984 to provide us with the information we need to decide whether we'll accept your application for insurance, what terms will apply and what your premium will be. For the purposes of this Duty of Disclosure section, 'You' includes both the Policy Owner and the Life Insured.

You have this duty until we agree to insure you. You have the same duty before you extend, vary or reinstate an insurance contract. You do not need to tell us anything that:

- reduces the risk we insure you for
- is common knowledge
- we know or should know as an insurer, or
- we waive your duty to tell us about.

If the insurance is for the life of another person and that person does not tell us everything they should have, this may be treated as a failure by you to tell us something that you must tell us.

If you do 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 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 contract within three years of entering into it. If we choose not to avoid the contract, 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 contract has a surrender value, or provides cover on death, we may only exercise this right within three years of entering into the contract.

If we choose not to avoid the contract or reduce the amount you have been insured for, we may, at any time vary the contract 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 contract has a surrender value or provides cover on death.

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

PRIVACY

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which TAL collects, uses, secures and discloses your personal information is set out in the TAL Privacy Policy available at http://www.tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1800 666 136.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Reference Number

Name of life to be insured

DECLARATION

I understand and acknowledge that I am bound by the Duty of Disclosure. I declare that the information provided here is true and complete and I agree that this Declaration shall be held to form part of the application for insurance on my life now made to TAL.

Signature of life to be insured ✗ SIGN HERE Date DD / MM / YYYY

Witness ✗ SIGN HERE Date DD / MM / YYYY

2. POLICY DETAILS

Address

Occupation

Date of birth DD / MM / YYYY

3. IDENTIFICATION

If person is unknown to Examiner, please obtain photo identification and indicate method used:

Licence number

Passport number

Other (please state)

4. INFORMATION TO BE OBTAINED FROM APPLICANT

Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?
If yes, please provide details, naming conditions, dates, duration, date of recovery, name and address of the hospital or doctor at end of this section.

1. Any disease, disorder or condition relating to the heart and circulatory system including high blood pressure, raised cholesterol, heart murmur, stroke, brain haemorrhage, or embolism, chest pain or palpitations? Yes ☐ No ☐
2. Diabetes or raised blood sugar levels? Yes ☐ No ☐
3. Any disorder of the kidney, bladder or genitourinary system including prostate disorders, urinary tract infections, kidney stones, blood or protein in the urine? Yes ☐ No ☐
4. Any disorder of the digestive system, liver, oesophagus, stomach, gall bladder, pancreas or bowel including reflux, hernia, ulcers, haemochromatosis, colitis or Crohn's disease? Yes ☐ No ☐
5. Any cancer, leukaemia or tumour, lump, cyst or growth either malignant or benign (non-malignant)? Yes ☐ No ☐
6. Asthma, sleep apnoea, or any other respiratory, lung or breathing disorder? Yes ☐ No ☐
7. Head injury, epilepsy, fits, convulsions or chronic headaches? Yes ☐ No ☐
8. Numbness, tingling, altered sensation, tremor, fainting attacks, problems with balance or co-ordination, or any form of paralysis or multiple sclerosis? Yes ☐ No ☐
9. Any disorder of the eyes or ears, including blindness, blurred or double vision (other than sight problems corrected by glasses or contact lenses) or impaired hearing or tinnitus? Yes ☐ No ☐
10. Eczema, dermatitis, psoriasis or any other skin condition? Yes ☐ No ☐
11. Back or neck pain including muscular pain, strain, whiplash and sciatica? Yes ☐ No ☐
12. Any joint (eg wrist, elbow, shoulder, ankle, knee, hip), bone or muscle pain or disorder including RSI? Yes ☐ No ☐
13. Rheumatoid arthritis, other forms of arthritis, osteoporosis or gout? Yes ☐ No ☐
14. Any blood disorder including anaemia? Yes ☐ No ☐
15. Any thyroid disorder or lupus? Yes ☐ No ☐
16. Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, chronic fatigue, post natal depression or any other mental or nervous condition? Yes ☐ No ☐

4. INFORMATION TO BE OBTAINED FROM APPLICANT (CONTINUED)

Note: Questions 17 and 18 relate to females only. Males go to Question 19.

17. Any disorder of the cervix (including abnormal Pap smear), ovary, uterus, breast or endometrium, or are you currently pregnant? Yes ☐ No ☐

    If pregnant, please advise expected delivery date DD / MM / YYYY

18. Any complications of pregnancy or childbirth or a child with congenital abnormalities? Yes ☐ No ☐

19. Have you ever injected, smoked or otherwise taken recreational or non-prescription drugs, taken any drug other than as medically directed or received advice and/or counselling for excess alcohol consumption from any health professional? Yes ☐ No ☐

20. Have you ever tested positive for HIV/AIDS, Hepatitis B or C, or are you awaiting the results of such a test (other than for this application)? Yes ☐ No ☐

21. In the last 5 years have you engaged in any activity reasonably expected to having an increased risk or exposure to the HIV/AIDS virus? (This includes unprotected anal sex, sex with a sex worker or sex with someone you know, or suspect to be HIV positive). Yes ☐ No ☐

22. Have you in the last five years been absent from work or your usual duties for a period of more than five days through any illness or injury not previously disclosed in this application? Yes ☐ No ☐

23. **Apart from any condition already disclosed,** do you have any symptoms of illness, any physical defect, or any condition for which you receive medical advice or treatment? Yes ☐ No ☐

24. **Apart from treating any condition already disclosed,** have you in the last two years had medication prescribed (except contraceptives or antibiotics)? Yes ☐ No ☐

25. **Apart from investigating any condition already disclosed,** have you had any medical test (eg ECG, colonoscopy, endoscopy, gastroscopy or ultrasound)? Yes ☐ No ☐

26. **Apart from investigating any condition already disclosed,** have you ever had a genetic test where you received (or are currently awaiting) an individual result or are you considering having a genetic test (excluding genetic screening of a child during pregnancy)? Yes ☐ No ☐

27. **Apart from any condition already disclosed,** do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms? Yes ☐ No ☐

Please provide details if any questions 1-27 answered yes.

5. FAMILY HISTORY

1. Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 60? *(If family history is unknown, answer no)* Yes ☐ No ☐

Note: information is only required for 1st degree blood related family members, living or deceased.

If yes, please indicate against the following list:

☐ Heart disease (eg angina or heart attack) or stroke

☐ Cardiomyopathy

☐ Breast, cervical and/or ovarian cancer

☐ Bowel cancer or polyposis of the colon

☐ Any other type of cancer

☐ Diabetes Please specify if: Type 1 (early onset, insulin dependent) ☐ OR Type 2 ☐

☐ Alzheimer's disease

☐ Multiple sclerosis

☐ Motor neurone disease, Parkinson's disease, Polycystic kidney disease and/or Huntington's disease, mental illness and/or any other hereditary disorder (not previously listed in this section).

If yes, please advise relevant condition, number of relatives and age(s) affected. Also include details and results of any investigations performed on you as a result of this history.

Relationship	Medical Condition (ie breast cancer, heart attack)	Age when diagnosed	Age at death

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6. CONFIDENTIAL MEDICAL EXAMINATION (to be completed by examiner)

1. Do you know the Applicant? Yes ☐ No ☐
2. Have you ever attended the Applicant? Yes ☐ No ☐
3. Is the Applicant's build, appearance or behavior unusual? (eg including skin rashes, pigmentation) Yes ☐ No ☐
4. Are there any signs of past or present over-indulgence in tobacco, alcohol or of the misuse of drugs? Yes ☐ No ☐
5. Has the applicant ever smoked? Yes ☐ No ☐
   If yes, a Chest X-Ray is only required for Life insurance cover exceeding $15m where there is a current or past history of smoking.

7. MEASUREMENTS (to be taken by examiner)

1. Please provide Applicant's measurements below.

Height		cm	or		Feet	Inches
Weight		kg	or		Stone	Pounds
Chest Full inspiration:		cm	or		Inches	
Chest Full expiration:		cm	or		Inches	
Waist Circumference:		cm	or		Inches	
Hips Circumference:		cm	or		Inches	

2. Has there been any recent variation in weight? Yes ☐ No ☐
   If yes, please try to ascertain the cause, amount of weight loss and over what time period.

3. If the chest expansion is less than 5 cms, please comment as to cause.

8. RESPIRATORY SYSTEM

1. Is there any abnormality of the respiratory system to palpitation, percussion or auscultation? Yes ☐ No ☐
   If yes, please provide details.

2. Is there any sign of past or present respiratory disease? Yes ☐ No ☐
   If yes, please provide details.

9. CIRCULATORY SYSTEM

Questions 2-5 in this section to be completed by Doctors only (not paramedical examiners)

1. What is the rate and character of the pulse?

2. What is the position of the Apex beat of the heart?
   in the _____ interspace ____ cm from the mid-sternal line

3. Is there any evidence of cardiac enlargement? Yes ☐ No ☐
   If yes, please provide details.

4. Is there any abnormality in the heart sounds or rhythm? Yes ☐ No ☐
   If yes, please provide details.

5. Is any murmur present? Yes ☐ No ☐
   If yes, please describe fully including site, timing, intensity and transmission. Also, please indicate any effect of posture or respiration on the murmur.

6. What is the Blood Pressure? (Auscultatory method)
   Systolic _____ Diastolic _____ mm HG
   Systolic _____ Diastolic _____ mm HG
   Systolic _____ Diastolic _____ mm HG

   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.

7. Is there any abnormality of the peripheral arterial or venous circulation? Yes ☐ No ☐
   If yes, please provide details.

8. Do you consider the heart and vascular system to be abnormal? Yes ☐ No ☐
   If yes, please provide details.

9. Is the examinee now on treatment for hypertension? Yes ☐ No ☐
   If yes, and you have the required information, please state:

   A. Pre-treatment blood pressure level including date(s):

   B. Duration of treatment:

   C. Nature of treatment:

10. DIGESTIVE, ENDOCRINE AND LYMPH SYSTEMS

1. Is there any abnormality of tongue, mouth or throat? Yes ☐ No ☐
   If yes, please provide details.

2. Is there any palpable abnormality of the liver, spleen or other abdominal organs? Yes ☐ No ☐
   If yes, please provide details.

3. Is a hernia present? Yes ☐ No ☐
   If yes, please provide details.

4. Is there any abnormality of lymph glands in the neck, axillae or inguinal regions? Yes ☐ No ☐
   If yes, please provide details.

11. GENITO-URINARY SYSTEMS

1. Is there any genito-urinary abnormality? (eg stricture, prostate) Yes ☐ No ☐
   If yes, please provide details.

2. Does the urine contain:

   A. Protein (Albumin)? Yes ☐ No ☐

   B. Sugar? Yes ☐ No ☐

   C. Blood? Yes ☐ No ☐
   If yes, please indicate if applicant is menstruating.

   D. Other abnormalities? Yes ☐ No ☐
   If yes, please indicate what these are.

Positive specimen must be sent for MSU.

Female applicants only.

3. Is the applicant pregnant? Yes ☐ No ☐

   If yes, please provide expected delivery date DD / MM / YYYY

12. NERVOUS SYSTEM

1. Is there any defect of vision or abnormality of the eyes? Yes ☐ No ☐
   If yes, please provide details.

2. Is there any defect in hearing or speech? Yes ☐ No ☐
   If yes, please provide details.

   In cases of present or past ear discharge or deafness, state result of auriscopic examination.

3. Is there any evidence of mental abnormality? Yes ☐ No ☐
   If yes, please provide details.

4. Is there any evidence of disorder of the central or peripheral nervous system? Yes ☐ No ☐
   If yes, please provide details.

13. MUSCULO-SKELETAL SYSTEM AND SKIN

1. Is there any abnormality of the form or function of the joints? Yes ☐ No ☐
   If yes, please provide details.

2. Is there any abnormality of the form or function of the muscles or connective tissues? Yes ☐ No ☐
   If yes, please provide details.

3. Is there any abnormality of the form or function of the back or neck including the cervical and lumbar spine? Yes ☐ No ☐
   If yes, please provide details.

4. Is there any evidence of any disorder of the skin? Yes ☐ No ☐
   If yes, please provide details.

14. SUMMARY

1. Do you consider any medical attendant's reports or any special tests are required? Yes ☐ No ☐
   If yes, please provide details.

Note: no special tests are to be carried out in connection with the proposal for Insurance without TAL's authority

2. Do you consider the person examined to be likely to require any surgical operation? Yes ☐ No ☐
   If yes, please provide details.

3. Please comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement:

A. In the personal or family medical history:

B. Disclosed by your medical examination:

15. EXAMINER'S DETAILS

Name (block letters please)

Address

Phone number

Personal qualifications

TAL is bound by obligations imposed by privacy legislation. Information received or requested from you is handled in accordance with these obligations.

Signature of examiner ✗ SIGN HERE

Date DD / MM / YYYY

Please attach your invoice including your ABN to the forms you send to TAL.

SUBMITTING THIS FORM

Please return your completed form and any supporting documentation to:

TAL Life Limited
GPO Box 5380
Sydney NSW 2001

CONTACTING TAL

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