

Medical Examination Report

Information sheet

When to use this form

Use this form when we have asked you to have a medical examination with your own medical practitioner.

What you need to tell us

When you apply for insurance

When you apply for insurance, the insurer conducts a process called underwriting. It's how we decide whether we can cover you, 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 your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The Duty to Take Reasonable Care Not to Make a Misrepresentation

! Read this if you are applying for insurance as the policy owner, if you will be an insured person under a policy owned by someone else, or if you will be an insured person under a superannuation plan.

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

We may later investigate the answers given in your application, including at the time of a claim.

Where a **policy** owned by one person covers the life of another person, it's important that the other person does not make a misrepresentation when providing information to the insurer. If the other person does make a misrepresentation, then it may be treated as a failure by the owner of the **policy** in their Duty to Take Reasonable Care Not to Make a Misrepresentation. Therefore, you must take reasonable care not to make a misrepresentation when giving us information whether you're the owner of the **policy** or an **insured person** under it.

If you do not meet your legal duty

If you do not meet your Duty to Take Reasonable Care Not to Make a Misrepresentation, this 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.

If there is a failure to comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position it would have been in if the duty had been met. Therefore, if the person who answers our questions does not take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- we may **treat the contract (or your cover) as if it never existed**.
- we may **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told us everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.
- we may **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was;
- what the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will let you know our reasons and the information we rely on and give you an opportunity to provide an explanation.

If we decide to exercise one of these remedies, we will advise you of our decision and the process to have this reviewed or make a complaint if you disagree with our decision.

Guidance for answering our questions

When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question that we ask you.
- Do not assume that we will contact your doctor for any medical information.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it or check with us.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact us immediately.

Genetic test approach

You only need to tell us about any genetic testing you've had or have consented to have if the total combined sum insured with all life insurers for the insurance being applied for is over:

- \$500,000 life cover
- \$500,000 total and permanent disability cover (TPD)
- \$200,000 trauma / critical illness cover, or
- \$4,000 a month income protection cover, salary continuance cover or business expenses cover.

You can choose to tell us about a genetic test that you have had where the result was favourable. However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

Note: Resolution Life complies with the Moratorium on Genetic Tests. A copy of the moratorium is available in the Life Insurance Code of Practice cali.org.au/life-code.

Your privacy

Personal information

We may collect personal information directly from you or from your financial adviser.

We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it.

We may also collect and use any of your personal information, including sensitive information, collected and held by the Resolution Life Group if you authorise us to do so.

We may also use this information for related purposes — for example, enhancing customer service, product options and providing you with ongoing information about opportunities that may be useful for your financial needs through direct marketing. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the Resolution Life Group, or by your financial adviser. Please contact us if you do not want your personal information used for direct marketing purposes.

We usually disclose information of this kind to:

- other members of the Resolution Life Group
- your financial adviser or broker (if any)
- the owner of the plan (if applicable)

- external service suppliers who may be located in Australia or overseas, who supply administrative, financial or other services to assist the Resolution Life Group in providing Resolution Life Financial Services. A list of countries where these providers are likely to be located can be accessed via our Privacy Policy
- the Australian Transaction Reports and Analysis Centre (AUSTRAC) where required by our anti-money laundering compliance plan
- the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost super
- anyone you have authorised or if required by law.

Sensitive information

If sensitive information, such as health information, is collected in relation to this financial product, then additional restrictions apply. Resolution Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, Resolution Life, to assess your application for new or additional insurance. Resolution Life may also use this information for directly related purposes — for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims.

Resolution Life may disclose this type of health information to:

- your financial adviser or broker (if any)
- the Trustee or other members of the Resolution Life Group
- the owner of the plan (if applicable)
- Resolution Life's reinsurers
- 'doctors'
- any person Resolution Life considers necessary to help either assess claims or resolve complaints
- anyone you have authorised or if required by law.

If you are an 'insured person', aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

If you are an 'insured person', Resolution Life and/or their health screening provider may also speak to a third party for the sole purpose of arranging a health screening appointment.

This third party may include a spouse, family member, personal assistant, financial adviser or other relevant party.

Under the current Resolution Life Privacy Policy, you may access personal information about you held by the Resolution Life Group. The Resolution Life Privacy Policy sets out the Resolution Life Group's policies on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy, and information about how Resolution Life deals with such complaints.

The Resolution Life Privacy Policy can be obtained online at resolutionlife.com.au or by calling our Customer Service Centre on 133 731.

The product issuer, Resolution Life Australasia Limited ABN 84 079 300 379 (Resolution Life), is part of the Resolution Life Group. "AMP" and any other AMP trademarks are used by Resolution Life under licence from AMP Limited.

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Please keep this information sheet for your records —
don't return it with your completed form(s).

Medical Examination Report

Use this form when we have asked you to have a medical examination with your own medical practitioner.

Complete sections 3, 4 and 5 of the personal statement below in your own words prior to the medical examination. The medical examiner will discuss your answers with you and add any details considered appropriate.

Important: You must sign the declaration in the examiner's presence.

Please print in CAPITAL LETTERS and place a cross in any applicable boxes.

1. Plan details

Application/Plan number	Request ID (if applicable)
<input type="text"/>	<input type="text"/>

2. Personal details

Title	Date of birth	Gender
<input type="text"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Surname	Given name(s)	
<input type="text"/>	<input type="text"/>	
Residential address		
<input type="text"/>		
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact phone number	Mobile number	
<input type="text"/>	<input type="text"/>	
Email address		
<input type="text"/>		
Your occupation	Industry in which you work	
<input type="text"/>	<input type="text"/>	
Type of business being applied for:		
<input type="checkbox"/> Elevate	<input type="checkbox"/> Whole of life insurance	<input type="checkbox"/> Disability insurance
<input type="checkbox"/> Flexible Lifetime Protection	<input type="checkbox"/> Endowment insurance	<input type="checkbox"/> Personal or self-employed super
<input type="checkbox"/> Stand Alone Group	<input type="checkbox"/> CrisisCare insurance	<input type="checkbox"/> Investment plans with protection benefits
<input type="checkbox"/> Other super — please provide name of super scheme	<input type="text"/>	
<input type="checkbox"/> Other reason — please provide details	<input type="text"/>	

3. Family history

Has any first-degree blood related family member (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

- No, unknown/adopted — go to next question.
- Yes — please cross all that apply and provide the details further below:
 - Breast and/or ovarian cancer
 - Prostate cancer
 - Lynch syndrome, familial polyposis or bowel/colon cancer
 - Polycystic kidney disease, renal cell cancer or kidney cancer
 - Diabetes
 - Stroke
 - Heart attack
 - Cardiomyopathy
 - Haemochromatosis
 - Muscular dystrophy
 - Multiple sclerosis
 - Parkinson's disease
 - Motor neurone disease
 - Huntington's disease
 - Alzheimer's disease or any other type of dementia
 - Any other cancer or any other heart condition
 - Any hereditary disorder or condition that runs in families

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

4. Medical history

If you answer **Yes** to any conditions below, please provide details in the **Additional information** table, below.

To the best of your knowledge, have you ever had, been told you had, received advice or treatment for any of the following:

- a. High blood pressure, chest pain, high cholesterol, stroke or any heart or vascular disorder? No Yes
- b. Asthma, bronchitis, tuberculosis or any other lung disorder? No Yes
- c. Neurological disorder such as epilepsy, multiple sclerosis, paralysis, migraine, dizziness or neuritis? No Yes
- d. Kidney or bladder disorder such as kidney stones, nephritis or passing blood in the urine? No Yes
- e. Hepatitis, haemochromatosis, cirrhosis or any liver or gall bladder disorder? No Yes
- f. Diabetes, sugar in urine, thyroid or pancreatic disorder? No Yes
- g. Indigestion, ulcer, hernia, colitis, passing blood from the bowel or any other bowel disorder? No Yes
- h. Blood disorder, such as anaemia, haemophilia, leukaemia or received a blood transfusion? No Yes
- i. Cancer, cyst, skin lesion or tumour of any kind? No Yes
- j. Strained back, sciatica, whiplash, disc, vertebral or any other form of back or neck problem? No Yes
- k. Arthritis, rheumatism, gout, tendonitis, repetitive strain injury, chronic fatigue syndrome, fibromyalgia or any disorder of the joints or muscles? No Yes
- l. A mental health condition, including but not limited to depression, anxiety, panic attacks, stress or psychosis? No Yes
- m. Any other disorder or physical impairment, including any skin condition or impairment of sight or hearing? No Yes
- n. To the best of your knowledge, do you, or any of your current or past sexual partners, have HIV/AIDS; or are you experiencing any unexplained night sweats or unintentional weight loss; or do you engage/have you engaged in any activities reasonably accepted as having an increased risk of exposure to the virus? No Yes
- o. Have you within the last 3 years, taken any drugs or medication of any kind (whether prescribed or otherwise); had any preventative or prophylactic treatment (eg a mastectomy), undergone or intend undergoing any medical or surveillance tests (eg ultrasounds or colonoscopies), surgery either in Australia or overseas, or investigations: been referred to a specialist; suffered from any illness or injury not mentioned above; or been off work for more than 7 consecutive days due to any illness or injury? No Yes

Important: Please refer to the **genetic test approach** in the **information sheet** when answering this question.

4. Medical history (continued)

Females only

- p. Have you had an abnormal cervical screening or pap smear test, positive HPV test or mammogram; any gynaecological condition; complication with a past or current pregnancy or any breast lump (even if you have not seen a doctor about it)? No Yes
- q. Are you currently pregnant?
 No
 Yes — please provide the expected delivery date:

Additional information

Complete this table if you answered 'Yes' to any of the conditions above.

Question letter	Condition/ Test/ Reason	Date first started	Date of last symptoms	Degree of recovery %	Full details of treatment	Full name and address of doctor or hospital
		/ /	/ /			
		/ /	/ /			
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		/ /	/ /			
		/ /	/ /			
		/ /	/ /			

Note: If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

5. Habits

- a. Have you smoked any substance(s) within the last 3 years?
 No — go to question b
 Yes — please select which product(s) you use/have used and the enter the quantity consumed:
- Tobacco cigarettes/Cigars** Quantity per: day week month No. of years you had/have smoked
- Have you stopped smoking?
 No
 Yes — please provide month and year stopped month year

Other (Please specify below):

Quantity per: day week month No. of years you had/have smoked

Have you stopped smoking?
 No
 Yes — please provide month and year stopped month year

- b. Do you drink alcohol?
 No — go to section 6
 Yes — please advise:
- Average number of standard drinks¹ per: day week Other (please specify)
-

¹ Standard drink = 1 nip spirits, 1 wine glass of wine, sherry glass port/sherry, 10oz/250ml glass beer.

- Has this changed over the last 12 months?**
 No — go to section 6
 Yes — please provide details:
-

6. Declaration and signature

! This declaration is to be signed by the insured person in the presence of the medical examiner.

I acknowledge and declare:

- I understand that this personal statement forms part of my application for insurance.
- I have read and understood the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **Information sheet**, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy. I understand that if the questions are not answered truthfully, accurately and completely the insurance I have applied for may be avoided (treated as if it never existed) or altered and if I have made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted, and
- I have read the privacy information in the **Information sheet** and I agree to the various uses and exchanges of my personal information as set out in that section.

Insured person's name

Insured person's signature

Date

The insured person signed this agreement and declaration in my presence and discussed where I considered it appropriate.

Medical examiner's signature

Date

Confidential Medical Report

On the medical condition of:

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 Resolution Life's decision concerning the application 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.

A. Introduction

1. Are you acquainted with the examinee:

a. Professionally?

No Yes

b. Personally? If so, how long?

No Yes

2. Is there anything unfavourable in appearance, development or behaviour?

No Yes

3. Is there any indication of past or present abuse of alcohol or of the misuse of drugs?

No Yes

If you answer **Yes** to any of the above questions, please give details:

B. Measurements

1. Height (without shoes) cm or ft ins

2. Weight measured (clothed) kg or st lbs

3. Chest and abdomen at umbilicus (next to skin)

Chest Expiration cm Inspiration cm

Abdomen cm

4. If chest expansion is less than 5cm comment as to apparent cause and provide peak flow meter reading.

C. Respiratory system

1. Is there any abnormality of the respiratory system to palpitation, percussion or auscultation?

No Yes

2. Is there any sign of past or present respiratory disease?

No Yes

If you answer **Yes** to any of the above questions, please give details:

D. Circulatory system

1. What is the rate and character of the pulse? Pulse Rate per min. Character

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?

No Yes

4. Is there any abnormality in the heart sounds or rhythm?

No Yes

5. Is any murmur present?

No Yes

If **Yes**, describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.

D. Circulatory system (continued)

6. 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 are required at 5 and 10 minute intervals.

Reading 1: Systolic Diastolic

Reading 2: Systolic Diastolic

Reading 3: Systolic Diastolic

7. Is there any abnormality of the peripheral arterial or venous circulation?

No Yes

If **Yes** please give details:

8. Is there any abnormality of the heart or vascular system?

No Yes

If **Yes** please give details:

9. Is the examinee now on treatment for hypertension?

No Yes

If **Yes**, and if you have the required information, please state:

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

/

/

/

b. Duration of treatment

c. Nature of treatment

E. Digestive and lymphatic systems

1. Is there any abnormality of tongue, mouth, nose or throat?

No Yes

2. Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen?

No Yes

3. Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?

No Yes

4. Is a hernia present?

No Yes

If you answer **Yes** to any of the above questions, please give details:

F. Genito-urinary system

1. Is there any evidence of abnormality of the genito-urinary system?

No Yes

If **Yes** please give details:

2. Females – Is the examinee pregnant? If **Yes**, provide expected date of confinement No Yes

3. Examination of the urine (passed at time of examination).

No Yes

a. Albumin?

Note: If albumin is found, an early morning specimen should be examined and findings recorded before completing report.

b. Glucose?

c. Blood?

G. Nervous system

1. Is there any defect of vision or abnormality of the eyes?

No Yes

If **Yes** please give details:

G. Nervous system (continued)

2. Is there any defect in hearing or speech? No Yes

If **Yes** please give details:

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

3. Is there any evidence of:

- a. mental abnormality?

No Yes

If **Yes** please give details:

- b. any disorder of the central or peripheral nervous system?

No Yes

If **Yes** please give details:

H. Musculo-skeletal system and skin

1. Is there any abnormality of the form or function of:

- a. the joints?

No Yes

If **Yes** please give details:

- b. the muscles or connective tissues?

No Yes

If **Yes** please give details:

- c. the back or neck including the cervical and lumbar spine?

No Yes

If **Yes** please give details:

2. Is there evidence of any disorder of the skin?

No Yes

If **Yes** please give details:

I. Summary

1. Do you consider any medical attendant's reports or any special tests are required?

No Yes

If **Yes** please give details:

Note: No special tests are to be carried out in connection with the application for insurance without ResolutionLife's authority.

2. Do you consider the person examined to be likely to require any surgical operation? No

No Yes

If **Yes** please give details:

3. 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:

J. Payment of fee

Title	Surname		
<input type="text"/>	<input type="text"/>		
Given name(s)			
<input type="text"/>			
Residential address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone number	Mobile phone number		
<input type="text"/>	<input type="text"/>		
Email address			
<input type="text"/>			
Signature of medical examiner			Date signed
<input type="text" value="X"/>			<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Qualifications			
<input type="text"/>			

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 to us without delay.

Where to send this form

Email or mail this completed form (and any supporting documents) to:

Resolution Life Customer Service
GPO Box 5441
Sydney NSW 2001
askus@resolutionlife.com.au

Any questions?
133 731

Office/Adviser use only

Financial adviser name	
<input type="text"/>	
Financial adviser number	
<input type="text"/>	
Fee credited	Date fee credited
\$ <input type="text"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>