

Mental health questionnaire

This form is to be completed only on request by Zurich Underwriting. To be completed by the life insured. To avoid delays, please check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy number/s



Policy type: ☐ Wealth Protection ☐ Active ☐ Sumo ☐ FutureWise

Your duty of disclosure

Before entering into a life insurance contract, we must be told anything that each of you as the proposed policy owner and the life to be insured (if a different person to the proposed policy owner) knows, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms.

The duty applies until we agree to provide the insurance. It also applies before the insurance contract is extended, varied or reinstated.

We do not need to be told anything that:

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

If you are the life to be insured (but not also the proposed policy owner), you not telling us something that you know, or could reasonably be expected to know, that may affect our decision to provide the insurance and on what terms, may be treated as a failure by the proposed policy owner to tell us something that they must tell us with the following consequences for the proposed policy owner.

If we are not told 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 we are not told anything that we are required to be told, and we would not have provided the insurance if we had been told, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if we had been told everything we should have been told. However, if the insurance contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the insurance contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if we had been told everything we should have been told. However, this right does not apply if the contract has a surrender value or provides cover on death.

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

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). 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.

1 Life insured details

Title		Surname	
Given names		Date of birth	/ /
Address		State	Postcode
Contact details	Work ()	Home ()	
	Mobile	Email	

2 Personal details

(a) Were you advised by your treating practitioner of a diagnosis or name for your condition?

☐ Yes ☐ No

If No, go to question (c)

If Yes, please check the following condition(s) you experienced and confirm age or date of diagnosis: (if more than one condition, please check all that apply)

<input type="checkbox"/>	Grief reaction, stressful life events or difficulties	Age	,	Or Date	/	/
<input type="checkbox"/>	Post natal depression	Age	,	Or Date	/	/
<input type="checkbox"/>	Depression (including major depression or dysthymia)	Age	,	Or Date	/	/
<input type="checkbox"/>	Anxiety (including panic disorder or generalised anxiety disorder)	Age	,	Or Date	/	/
<input type="checkbox"/>	Bipolar disorder	Age	,	Or Date	/	/
<input type="checkbox"/>	Obsessive compulsive disorder (OCD)	Age	,	Or Date	/	/
<input type="checkbox"/>	Post traumatic stress disorder (PTSD)	Age	,	Or Date	/	/
<input type="checkbox"/>	Schizophrenia or other psychotic disorder	Age	,	Or Date	/	/
<input type="checkbox"/>	Dissociative disorder (Including dissociative identity disorder)	Age	,	Or Date	/	/
<input type="checkbox"/>	Eating disorder (including anorexia or bulimia)	Age	,	Or Date	/	/
<input type="checkbox"/>	Attention Deficit or Hyperactivity Disorder (ADD/ADHD)	Age	,	Or Date	/	/
<input type="checkbox"/>	Personality disorder (including Borderline personality disorder)	Age	,	Or Date	/	/
<input type="checkbox"/>	Any other mental health condition not already mentioned What name was given to your condition? _____	Age	,	Or Date	/	/

(b) Have you experienced any of these conditions more than once?

☐ Yes ☐ No

If Yes, which condition did you experience more than once, and when did this happen?

(c) When did you first experience symptoms relating to your mental health?

Age , Or Date / /

(d) How have you been affected by your mental health?

Please select each which apply

<input type="checkbox"/>	Have taken time off work under the care of a doctor: When was the last time you were unable to work due to your mental health? What is the longest number of consecutive days you have been off work due to your mental health?	Age , Or Date / / Days
<input type="checkbox"/>	Have taken time off work under personal or employer sponsored leave: When was the last time you were unable to work due to your mental health? What is the longest number of consecutive days you have been off work due to your mental health?	Age , Or Date / / Days
<input type="checkbox"/>	My work or social relationships have been negatively impacted: When was the last time you were impacted in this way?	Age , Or Date / /
<input type="checkbox"/>	My ability to engage in my usual work and social activities have been negatively impacted: When was the last time you were impacted in this way?	Age , Or Date / /
<input type="checkbox"/>	My ability to function has been impacted by my mental health in other ways: Please describe how you have been impacted by your condition: When was the last time you were impacted in this way?	 Age , Or Date / /
<input type="checkbox"/>	My mental health has never impacted my ability to function or my relationships: When did you last experience symptoms of this condition?	Age , Or Date / /

2 Personal details (continued)

(e) Have you ever taken or been prescribed any medication for your mental health condition?

☐ Yes ☐ No

If Yes, please complete below (please check all that apply)

	Medication type	Date first prescribed	Are you still taking this?	Has this been prescribed more than once?
<input type="checkbox"/>	Antidepressants (e.g. Zoloft, Cipramil, Effexor, Lovan, Aropax)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Mood stabilisers (e.g. Lithium)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Antipsychotics (e.g. Clozaril, Seroquel, Zyrprexa, Risperdal)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Anticonvulsants (e.g. Epilim, Tegretol, Lamictal)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Sedatives / Hypnotics (e.g. Normison, Diazepam)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Stimulants (e.g. Ritalin, Concerta, Provigil)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Substance abuse related medications (e.g. Campral, Naloxone, Suboxone, Methadone)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other or unknown form of medication: Drug name: _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other or unknown form of medication: Drug name: _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other or unknown form of medication: Drug name: _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No Ceased / /	<input type="checkbox"/> Yes <input type="checkbox"/> No

(f) Have you ever received or been recommended any talk-based therapy such as counselling, CBT, other forms of mental health treatment or been referred to a psychiatrist?

☐ Yes ☐ No

If Yes, please complete below (please check all that apply)

	Treatment type	Date commenced / recommended	Are you still attending?	Date ceased (if applicable)
<input type="checkbox"/>	General counselling	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
<input type="checkbox"/>	Cognitive behaviour therapy (CBT) or Dialectical behaviour therapy (DBT)	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
<input type="checkbox"/>	Other forms of talk-therapy: Please specify: _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
<input type="checkbox"/>	Consultation with a psychiatrist	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

(g) Have you ever been treated in hospital for your mental health condition?

☐ Yes ☐ No

If Yes, when did this happen, what is the name of the hospital where you stayed, and how long was your admission

2 Personal details (continued)

(h) Have you ever thought of hurting yourself?

☐ Yes ☐ No

If Yes, please complete below

When did you last have these thoughts? Age , Or Date / /

Had you experienced these feelings previously?

☐ Yes ☐ No

If Yes, please describe how often you had experienced these feelings previously, and when you first had these thoughts:

Have you ever acted on those thoughts?

☐ Yes ☐ No

If Yes please provide details including when this has happened

(i) Provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted: From / / Most recent / /

(j) Have you consulted any other health professionals for this condition?

☐ Yes ☐ No

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted: From / / Most recent / /

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted: From / / Most recent / /

3 Declaration

The proposed life insured states as follows:

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

Name of life insured

Signature of life insured

Date

X

/ /

Any questions? Call 131 551

Please return the completed form 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 **life.newbusiness@zurich.com.au**

Save File

Print Form