MLC Limited
ABN 90 000 000 402
AFSL 230694

Application No.

Standard Medical Examination Form

Part 1
Personal Statement by the Life to be Insured

Part 2
Confidential Medical Report to MLC Limited for Insurance Cover

What you must tell us

Your Duty of Disclosure

- Under the Insurance Contracts Act 1984 you have a duty to complete this application honestly and to disclose to MLC everything you know, or could reasonably be expected to know, which might affect MLC's decision to provide this insurance, and what premiums and conditions will apply.
- If you fail to comply with this duty, MLC may (as permitted by law) cancel your policy or reduce the amount of cover.
- Your Duty of Disclosure continues until the Contract of Life Insurance has been accepted by the insurer and a policy is issued. It also applies if you seek to extend, vary or reinstate the Contract.

Standard Medical Examination Form

Part 1 – Personal Statement by the Life to be Insured

Application Number

Name of Financial Adviser authorising examination

Division | Financial Adviser No. | Phone No. ( )

Special instructions for the Medical Examiner
(to be completed by the Financial Adviser)

☐ Resting ECG required ☐ Exercise ECG required

☐ Please make particular comment on:

Personal statement made in connection with a proposal for insurance on the life of:

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname (Family name) *PLEASE PRINT*

Given name(s)

Address

Postcode

Date of Birth / /

Occupation and Industry

Occupational duties

Complete sections 1, 2 & 3 of the personal statement below in your own words prior to the examination. The Medical Examiner will discuss your answers with you and add any details considered appropriate. Sign the declaration on page 3 in the Examiner's presence.

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

1 Habits

1A a) Do you drink alcohol?

No ☐

Yes ☐ Number of standard drinks:
Per day or Per week

Note: One standard drink = 1 glass of beer/wine/nip of spirit

b) If no, have you ever drunk alcohol?

No ☐

Yes ☐ Number of standard drinks:
Per day or Per week

Note: One standard drink = 1 glass of beer/wine/nip of spirit

Date ceased / / Reasons ceased

1B a) Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

No ☐

Yes ☐ What type eg. cigarettes, gum, patch?

Daily quantity?

b) If no, have you ever smoked tobacco or any other substance or used any nicotine-containing product?

No ☐

Yes ☐ What type eg. cigarettes, gum, patch?

Daily quantity? Date ceased / /

Reasons ceased

2 Medical History

2A Do you have or have you ever had any of the following?
If you answer 'Yes' to any item in this question please give details at Question 3.

	Item Code	No	Yes
Heart complaint, high blood pressure or high cholesterol?	a	☐	☐
Epilepsy or any neurological disorder?	b	☐	☐
Stroke or vascular disorder?	c	☐	☐
Asthma or any other lung complaint?	d	☐	☐
Diabetes, bowel, kidney or bladder disorder?	e	☐	☐
Alcohol or drug dependence?	f	☐	☐
Professional advice to reduce alcohol consumption?	g	☐	☐
Migraine, persistent headache or chronic fatigue?	h	☐	☐
Disorder of the reproductive system (eg. prostate, ovary), abnormal Pap smear or sexually transmitted disease?	i	☐	☐
Cancer or leukaemia?	j	☐	☐
Haemophilia or blood disorder?	k	☐	☐
Liver disorder, hepatitis or test indicating past or present hepatitis infection?	l	☐	☐
Any allergies, skin disorders or disorder of the eyes, ears, nose or throat?	m	☐	☐
Cyst, mole or skin lesion requiring medical advice or treatment	n	☐	☐
Any other operation, disability, illness, or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned?	o	☐	☐
Strained back, sciatica, whiplash, spondylitis or any other back, neck or spinal problem?	p	☐	☐
Disorder of the joints or muscles, arthritis, gout or repetitive strain injury?	q	☐	☐
Treatment or counselling for depression or any nervous, anxiety, stress or mental health condition?	r	☐	☐

2B Other than already stated, have you in the last 5 years:

Taken any prescribed medication on a regular or ongoing basis (other than for colds or flu)?	a	☐	☐
Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?	b	☐	☐
Do you NOW have any other disability, illness injury or symptoms not already mentioned?	c	☐	☐
Do you contemplate seeking any advice, test, investigation or treatment?	d	☐	☐

Males: ***Go to Question 4A***

Females only

Have you had any complications of pregnancy or childbirth?

No ☐

Yes ☐

Are you currently pregnant?

No ☐

Yes ☐ Date Due / /

3 Did you answer 'Yes' to any item in question 2

No ☐

Yes ☐ Give full and accurate details below of each instance.

Question number & Item Code (*see above*)	Disability, Illness, injury, condition or test	Test results	When did it start?	When did it cease?	Type of treatment	How long off work?	Have you completely recovered?	Name and address of Institution and attending person

4 Family History

4A Have any of your parents, brothers or sisters (living or dead) suffered from any of the following, **under the age of 60 years?**

- Cancer (specify type and site)
- Heart disease
- Kidney disease
- Stroke
- Diabetes

No ☐

Yes ☐ Give details below

Medical condition	Number of family members affected	If 'cancer', state type and site

4B Have any of your parents, brothers or sisters (living or dead) **ever** suffered from any of the following?

- Huntington's disease
- Cystic fibrosis
- Any other hereditary disorder
- Muscular dystrophy
- Familial polyposis

No ☐

Yes ☐ Give details below

Medical condition	Number of family members affected

5 Doctors Details / Last Consult

Doctor's name or medical centre

Address

Postcode

Business Telephone

( )

How long have you been attending this practice? yrs mths

Pleas provide details of your last check-up or consultation

Date of last consultation / /

Reason for last check-up or consultation

Result

Medication prescribed, referral given or tests ordered

Declaration

I declare that my answers to the questions in this Personal Statement are true and complete.

I agree that MLC is authorised to obtain any information from any medical practitioner that they possess in relation to the insurance.

I understand that this Personal Statement forms part of my proposal for insurance.

Signature of Life to be Insured

X Date / /

I declare that the signature of the Life to be Insured was signed in my presence and that I have discussed the personal statements made by the Life to be Insured where appropriate.

Signature of Medical Examiner

X Date / /

Standard Medical Examination Form

Part 2 – Confidential Medical Report to MLC Limited for Insurance Cover

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 company'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.

6 Introduction

6A Are you acquainted with the examinee:

a) Professionally?

No ☐

Yes ☐ For how long?

b) Personally?

No ☐

Yes ☐ For how long?

6B Is there anything unfavourable in appearance, development or behaviour?

No ☐

Yes ☐ Please give details

6C Is there any indication of past or present abuse of alcohol or the misuse of drugs?

No ☐

Yes ☐ Please give details

7 Measurements

Give the following measurements:

7A Height (without shoes) cm

7B Weight (clothed) kg

7C BMI

7D Chest and abdomen at umbilicus (next to skin)

Chest Expiration cm

Chest Inspiration cm

Abdomen cm

7E If chest expansion is less than 5cm, comment as to the apparent cause or provide peak flow meter reading if available.

8 Respiratory System

8A Is there any abnormality of the respiratory system to palpation percussion or auscultation?

No ☐

Yes ☐ Please give details

8B Is there any sign of past or present respiratory disease?

No ☐

Yes ☐ Please give details

9 Circulatory System

9A What is the rate and character of the pulse?

Pulse rate ____ per minute

Character ____

9B What is the position of the apex beat of the heart?

In the ____ interspace ____ cm

from the mid-sternal line

9C Is there any evidence of cardiac enlargement?

No ☐

Yes ☐ Please give details

9D Is there any abnormality in the heart sounds or rhythm?

No ☐

Yes ☐ Please give details

9E Is any murmur present?

No ☐

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

9F 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.

Systolic	Diastolic
mm Hg	mm Hg
Systolic	Diastolic
mm Hg	mm Hg
Systolic	Diastolic
mm Hg	mm Hg

9G Is there any abnormality of the peripheral arterial or venous circulation?

No ☐

Yes ☐ Please give details

9H Do you consider the heart and the vascular system to be **abnormal**?

No ☐

Yes ☐ Please give details

9I Is the examinee now on treatment for hypertension or hypercholesterolaemia?

No ☐

Yes ☐ If known, please advise

a) Pre-treatment level including dates

b) Duration of treatment

c) Nature of treatment

10 Digestive and Lymphatic Systems

10A Is there any abnormality of tongue, mouth or throat?

No ☐

Yes ☐ Please give details

10B Is there any abnormality or evidence of disease of any abdominal organ, including liver or spleen?

No ☐

Yes ☐ Please give details

10 Digestive and Lymphatic Systems continued

10C Is there any abnormality of the lymph nodes in the neck, axillae or inguinal regions?

No ☐

Yes ☐ Please give details

10D Is a hernia present?

No ☐

Yes ☐ Please describe fully

11 Genito-urinary System

11A Examination of the urine:

The urine should be passed at the time of the examination. If not, please state the circumstances.

If Albumin is found, an early morning specimen should be examined and findings recorded before completing the report.

a) Albumin

b) Glucose

c) Blood

11B Is there any evidence of abnormality of the genito-urinary system?

No ☐

Yes ☐ Please give details

11C **Females only**

Is the examinee pregnant?

No ☐

Yes ☐ Expected date of confinement / /

12 Nervous System

12A Is there any defect of vision or abnormality of the eyes?

No ☐

Yes ☐ Please give details

12B Is there any defect in hearing or speech?

No ☐

Yes ☐

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

12C Is there any evidence of mental abnormality?

No ☐

Yes ☐ Please give details

12D Is there any evidence of any disorder of the central or peripheral nervous system?

No ☐

Yes ☐ Please give details

13 Musculo-skeletal System and Skin

13A Is there any abnormality in the form or function of the joints, muscles or connective tissue?

No ☐

Yes ☐ Please give details

13B Is there any abnormality in the form or function of the back or neck including the cervical and lumbar spine?

No ☐

Yes ☐ Please give details

13C Is there any evidence of any disorder of the skin?

No ☐

Yes ☐ Please give details

14 Summary

14A 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)**

No ☐

Yes ☐ Please give details

14B Do you consider the person examined to be likely to require any surgical operation?

No ☐

Yes ☐ Please give details

14C Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement:

a) in the personal medical history

b) disclosed by your medical examination

Dated at _____ on / /

Signature of Medical Examiner

X

Name of Medical Examiner (BLOCK LETTERS)

Qualifications

Address

Postcode

Telephone No.

Please include a GST Tax Invoice with your report to allow payment.

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 without delay to: MLC Limited
Attention: HNM
PO Box 200
North Sydney NSW 2059

Where to get help

MLC Service Centre
For more information call the MLC Service Centre on 132 652 or contact your Financial Adviser.

Website
For details on MLC's range of products and services visit our website at **mlc.com.au**

OFFICE USE ONLY

Amount	Date	Authorised
$		

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