

Raised cholesterol 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

Duty to take reasonable care not to make a misrepresentation

Your duty to take reasonable care not to make a misrepresentation is explained in the PDS and the Life Insured's Statement and it applies each time you provide us with information before we issue a policy.

Not meeting your legal duty can have serious impacts on your insurance. Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

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 Raised cholesterol details

(a) When were you first diagnosed with this condition? / /

(b) What was your original cholesterol result at that time?

(c) What was your most recent cholesterol result, and when was this taken?

Result
Date / /

(d) Is this result consistent with previous cholesterol checks? Yes ☐ No ☐

If 'No', provide details including your typical cholesterol result and reason for variance

(e) Are you currently taking medication for this condition?

No ☐ → have you been advised by your treating doctor that medication is required to control your condition?

Yes ☐

No ☐ → no treatment is required, go to (f)

Yes ☐ → provide details, go to (g)

Treatment/dosage

Date commenced treatment / /

2 Raised cholesterol details (continued)

(f) Have you ever taken medication for this condition?

No ☐ → go to (h)

Yes ☐ → provide details

Treatment/dosage

Date commenced treatment / /

Date ceased treatment / /

(g) Has your treatment (type of medication or dosage) changed within the last 12 months?

Yes ☐ No ☐

If 'Yes', provide details

Previous treatment/dosage

Reason for change

(h) Has your treating doctor advised you that your cholesterol is controlled and within normal limits?

Yes ☐ No ☐

If 'No', provide details

(i) How often has your treating doctor advised you to attend for review/check-ups in relation to your raised cholesterol?

☐ monthly ☐ quarterly ☐ every 6 months ☐ once a year ☐ other

(j). Provide details of the doctor treating you for this condition

Doctor's/clinic name

Address

State

Postcode

Phone number

3 Declaration

The proposed life insured states as follows:

1. I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
2. I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
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