

# Joint/Musculoskeletal 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](http://www.zurich.com.au) or contact the Zurich Privacy Officer on 132 687 or email us at [privacy.officer@zurich.com.au](mailto: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 Joint/Musculoskeletal questionnaire

(a) Which joint(s) or areas of the body is/are affected?

(b) When did you first experience symptoms?

(c) What is, or was the cause of your symptoms/condition?

(d) What is, or was the diagnosis or nature of the disorder, including symptoms, e.g. muscular, soft tissue, ligament or other?

(e) Do you continue to experience symptoms?

Yes ☐ what was the date of your most recent symptoms?

how many episodes of symptoms do you experience per year?

how long do the symptoms normally last for?

No ☐ when did you last experience any symptoms of this condition?

how many episodes of symptoms have you experienced, and how long did the symptoms last for?

(f) Have you made a complete recovery?

Yes ☐ No ☐

If 'Yes', for how long have you been free of all symptoms?

## 2 Joint/Musculoskeletal questionnaire (continued)

(g) Are you currently undertaking treatment/therapy for this condition?

Yes ☐ → provide details of treatment/therapy below

No ☐ → have you ever undertaken treatment/therapy for this condition?

Yes ☐ → provide details below

No ☐ → go to (h)

| Type of treatment                               | Date commenced | Date ceased (if applicable) |
|-------------------------------------------------|----------------|-----------------------------|
| <input type="checkbox"/> Medication             | / /            | / /                         |
| Name Dosage                                     |                |                             |
| <input type="checkbox"/> Physiotherapy          | / /            | / /                         |
| <input type="checkbox"/> Chiropractor/Osteopath | / /            | / /                         |
| <input type="checkbox"/> Surgery                | / /            | / /                         |
| <input type="checkbox"/> Other - please advise  |                |                             |
|                                                 | / /            | / /                         |
|                                                 | / /            | / /                         |

(h) Have you undertaken any investigations, e.g. X-ray, CT scans or MRI?

Yes ☐ No ☐

If 'Yes', provide details

| Test | Date | Result |
|------|------|--------|
|      | / /  |        |
|      | / /  |        |
|      | / /  |        |

(i) Does this condition interfere with, or restrict your lifestyle activities or normal occupational duties?

Yes ☐ No ☐

If 'Yes', provide details

(j) Have you ever taken time off work as a result of this condition?

Yes ☐ No ☐

If 'Yes', advise when and for how long?

(k) Who was, or is your current treating doctor for this condition?

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted from / / Most recent / /

(l) Have you consulted any other health professionals for the condition/s? Yes ☐ No ☐ If 'Yes', provide details

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted from / / to / /

Doctor's/Clinic's name

Address

State

Postcode

Phone number

Dates consulted from / / to / /

### 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