Life Insurance

Epilepsy and Seizure Questionnaire

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Please complete the questionnaire and return to TAL.

1. DUTY OF DISCLOSURE

Before you enter into or become insured under an insurance contract with us, you and any life to be insured are required under the *Insurance Contracts Act 1984* to provide us with the information we need to decide whether we'll accept your application for insurance, what terms will apply and what your premium will be. For the purposes of this Duty of Disclosure section, 'You' includes both the Policy Owner and the Life Insured.

You have this duty until we agree to insure you. You have the same duty before you extend, vary or reinstate an insurance contract. You do not need to tell us anything that:

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

If the insurance is for the life of another person and that person does not tell us everything they should have, this may be treated as a failure by you to tell us something that you must tell us.

If you do not tell us 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 you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within three years of entering into it. If we choose not to avoid the contract, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the contract has a surrender value, or provides cover on death, we may only exercise this right within three years of entering into the contract.

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

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

2. PRIVACY

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which TAL collects, uses, secures and discloses your personal information is set out in the TAL Privacy Policy available at http://www.tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1800 666 136.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

2. PRIVACY (continued)

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following.

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

3. PERSONAL DETAILS

Reference number

Name of life to be insured

Date of birth DD / MM / YYYY

4. QUESTIONNAIRE

1. When did you first become aware of this condition?

2. Is there a cause or another condition associated with this condition (e.g. head injury, stroke, brain lesion, pneumonia etc)?

☐ No ☐ Yes → Please provide details.

3. What type of seizure/s have you experienced?

☐ Absence or petit mal seizure (e.g. temporary unconsciousness)

☐ Atonic seizure (e.g. collapse to ground due to lack of muscle tone)

☐ Myoclonic seizure (e.g. brief muscle jerks)

☐ Tonic seizure (e.g. sudden stiffening of muscles)

☐ Tonic-clonic seizure (e.g. collapse due to sudden stiffening of muscles followed by jerking limbs)

☐ Focal or partial seizure (e.g. involuntary movement or stiffening of a limb, nausea, altered consciousness)

☐ Other → Please provide details.

4. QUESTIONNAIRE (continued)

4. Are symptoms:

☐ Improving

☐ Worsening

☐ Stable

5. How often have you experienced symptoms (e.g. daily, monthly, once only)?

6. When did you last experience symptoms?

7. Were symptoms triggered by anything (e.g. alcohol, caffeine, stress, sleep, driving)?

☐ No ☐ Yes → Please provide details.

8. How have these symptoms impacted your daily functioning?

9. Have you had a test or investigation in relation to this condition?

☐ No ☐ Yes → Please provide details.

	TEST 1	TEST 2	TEST 3
a) Type of test or investigation (e.g.blood test, EEG, CT scan, MRI etc)			
b) First done (date – month and year)			
c) How often required (e.g. once only, monthly, annually etc)			
d) Last done (if more than once) (date – month and year)			
e) Result/s			
f) Who has a copy of this test result (doctor or hospital name, myself)			

4. QUESTIONNAIRE (continued)

10. Have you had any treatment in relation to this condition?

☐ No ☐ Yes → Please provide details.

	TREATMENT 1	TREATMENT 2	TREATMENT 3
a) Treatment type (e.g. medication, surgery, therapy etc)			
b) Treatment details (e.g. name of medication used, dosage, type of surgery or therapy etc)			
c) First used (date – month and year)			
d) How often required (e.g. daily, once, monthly etc)			
e) Last used (date – month and year)			
f) Any change in treatment in last 12 months?			

11. Has any other treatment or investigation been discussed or considered?

☐ No ☐ Yes → Please provide details.

12. Have you ever had a complication related to this condition e.g. status epilepticus, anxiety, depression, cognitive impairment?

☐ No ☐ Yes → Please provide details.

13. Has this condition ever affected your ability to perform your usual work duties?

☐ No ☐ Yes → Please provide details including dates of time off work and details of any light or modified duties or hours worked.

4. QUESTIONNAIRE (continued)

14. Is this a condition that you have fully recovered from and will no longer need further consultation with a doctor or a health practitioner?

☐ Yes → How long you have been fully recovered?

☐ No → What is your degree of recovery and future treatment plan?

15. Please supply the name and address of all doctors, health practitioners or hospitals consulted for this condition.

NAME OF DOCTOR, HEALTH PRACTITIONER OR HOSPITAL	WHEN LAST CONSULTED FOR THIS CONDITION?	ADDRESS
	DD / MM / YYYY	
	DD / MM / YYYY	
	DD / MM / YYYY	

16. Please provide any other information you think will be helpful to us in assessing your application.

5. DECLARATION

I understand and acknowledge that I am bound by the Duty of Disclosure. I declare that the information provided here is true and complete and I agree that this Declaration shall be held to form part of the application for insurance on my life now made to TAL.

Signature of life to be insured ✗

Date DD / MM / YYYY

SUBMITTING THIS FORM

Please return your completed form and any supporting documentation to:

TAL Life Limited
GPO Box 5380
Sydney NSW 2001

CONTACTING TAL

groupriskadmin@tal.com.au
1800 666 136
+61 (0)2 9465 2065
tal.com.au

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