

4. Other than those conditions stated in question 3, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- a. Heart murmur or any other heart or blood vessel disorder?Yes No
 - b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder?Yes No
 - c. Tuberculosis or any other lung or respiratory system disorder?Yes No
 - d. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system?Yes No
 - e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancrea?Yes No
 - f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? Yes No
 - g. Sleep apnoea or any sleeping disorder?Yes No
 - h. Thyroid disorder or any other glandular disorder?Yes No
 - i. Any sickness, injury or physical impairment not previously mentioned?Yes No
5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)?Yes No
6. Have you ever had or are you considering having a genetic test?Yes No
7. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation?.....Yes No
8. Other than already stated, during the last 3 years have you been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist or any other health care professional, been in hospital, had any operation or had any tests or investigations (eg, x-ray, ECG etc)?Yes No
9. Has your mother or father, or any brother or sister had breast, ovarian, colon or other cancer, diabetes, high blood pressure, heart problems, stroke, mental disorder, haemochromatosis, Huntington's disease, muscular dystrophy, familial adenomatous polyposis, polycystic kidney, osteoporosis, Creutzfeldt-Jakob disease or any other hereditary disease?.....Yes No

If 'yes', please provide details in the following table.

Family member (relationship to you)	Condition/sickness (for cancer/heart disease, specify type)	Age at onset (approx)	Age at death (if applicable)

10. Females only

- a. (i) Have you ever had an abnormal pap smear or breast ultrasound or mammogram?Yes No
- If 'yes', please provide details of test(s), result(s) and date(s).
- (ii) Have you had any follow up tests beyond the initial test mentioned in a(i)? Yes No
- If 'yes', please provide details of test(s), result(s) and date(s).
- b. Are you currently pregnant?Yes No
- (i) If 'yes', due date / / / / /
- (j) Have there been or are there expected to be any complications?Yes No
- If 'yes', please provide details.

If you answered 'yes' to 4, 5, 6, 7 or 8 please provide details.

Question no. Sickness, injury or tests

Test results

Date commenced / / / / / Time off work Degree of recovery (%)

Date of last symptoms / / / / / Treatment received

Full name and address of doctor or hospital

State Postcode

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Date of last symptoms Treatment received

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State Postcode

7. Habits (must be completed, except when a medical examination is required)

Office use only 10

1. Have you ever smoked tobacco or any other substance, or, in the last 12 months, used any nicotine replacement therapy product?Yes No

If 'yes', type (eg, cigarettes, gum, patches)? Daily quantity?

How many years? Date ceased? if applicable

Other

2. Do you drink alcohol?Yes No

If 'yes', please advise number of standard drinks per week? Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs?Yes No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol?.....Yes No

If you answered 'yes' to question 3 or 4, please provide details in the following table

Question no.	Date from	Date to	Type of usage (alcohol, heroin etc)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		

8. Doctor's details (must be completed)

Office use only 11

If you don't have a usual doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your usual doctor

Address Postcode

Work phone () Fax ()

2. How long have you been a patient of this doctor? Date of last consultation | d | d | / | m | m | / | y | y | y | y |

Reason and outcome of last consultation

3. If you've been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address Postcode

Please provide date, reason and outcome of last consultation(s).

9. HIV (must be completed)

Office use only 12

1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV? **Yes** **No**

2. In the last 3 years have you or do you intend to:

a. Work as or engage in sexual intercourse with a prostitute? **Yes** **No**

b. Engage in male to male anal sexual activity? **Yes** **No**

c. Have sexual intercourse with an intravenous drug user? **Yes** **No**

d. Have sexual intercourse with someone you suspect or know to be HIV positive? **Yes** **No**

If you have answered 'yes' to any of the above, our underwriters will contact you for further information.

10. Activities (must be completed)

Office use only 13

1. In the last 12 months have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity eg, football, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (eg, Qantas)? Yes No

If 'yes', please answer the activities questionnaire on page 8.

2. Type of activity?

3. Do you want to be considered for cover whilst taking part in this activity? Yes, please complete Section 11 No

Underwater diving

a. Type (scuba, hookah etc) b. What are your qualifications for this activity?

c. How long have you been doing this? d. How often do you do this?

e. Are you professional or amateur?

f. Maximum depth of dives Metres g. Average depth of dives Metres

h. Geographical location

i. Do you dive in wrecks, potholes or caves? Yes No

j. Have you ever had a diving accident or diving sickness? (eg, blackout, needed decompression etc) Yes No

k. Do you intend to change the scope of your license/participation? Yes No

If 'yes' to i – k, please provide details.

Motor sports

a. Type (car, bike etc) b. Events (speedway, off road etc)

c. How long have you been doing this? d. How often do you do this?

e. Are you professional or amateur?

f. Category (eg, touring cars)	Class (eg, AA/D)	Vehicle & type of fuel	Engine capacity	No. of vehicles in event	Max speed km/hour
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

k. Do you intend to change the scope of your license/participation? Yes No

If 'yes', please provide details.

Flying – power-driven aircraft or conventional glider

a. What type of flying do you do (private, agricultural, ultralight etc)?

b. Total number of hours flown as a pilot? Hrs Number of hours in the past 12 months? Fixed Wing Hrs Helicopter Hrs

c. Number of hours expected in the next year? Fixed Wing Hrs Helicopter Hrs

d. Geographical location

e. What class license do you hold?

f. Do you intend to change the scope of your license? Yes No

If 'yes', please provide details.

Abseiling, caving, mountaineering, rock climbing

a. Activity

b. How long have you been doing this? c. How often do you do this?

d. Geographical location

e. Maximum altitude/depth f. Equipment used

g. Maximum grade of climb h. Type (top roping etc)

Other activity

a. Describe activity b. What are your qualifications for this?

c. How long have you been doing this? d. How often do you do this?

e. Geographical location f. Are you professional or amateur?

12. Special health questionnaires

Skin Lesion/Skin Cancer/Sun Spot

1. How many skin lesions, skin cancers or sun spots have you had treated?

2. Please provide details of each of the above in the table below. If more than 3, provide details on a separate page.

	Lesion 1	Lesion 2	Lesion 3
a) Where on the body was it located: eg, arm, nose, scalp.			
b) Was the lesion benign or malignant?			
c) What was the diagnosis? ie the name advised by your doctor eg, melanoma, BCC, keratosis etc.			
d) What was the date of diagnosis, biopsy, or treatment?			
e) How was it treated?* See examples of treatment types below.			

***Examples of treatment types:** Excised (surgically removed), curettage (removal with a scraping instrument), cryotherapy (freezing off), diathermy (burning off), topical cream eg, Efudix/Aldara or photodynamic therapy.

3. Have you been advised to have regular skin checks? Yes No
If 'yes', please advise by whom and the frequency.

4. What was the date and result of your last skin check and the name and address of the doctor or clinic consulted?

Name & address

Date / / / / / /

5. Has any further follow-up or treatment been recommended? Yes No
If 'yes', please provide details.

6. Do you have or can you obtain a copy of any pathology reports which relate to the skin lesion(s)/cancer(s) or sun spot(s) treated? Yes No
If 'yes', please attach a copy to this application.

7. Does your regular doctor, skin specialist or skin clinic have details regarding the lesion(s)/cancer(s) or sun spot(s)? Yes No

If 'yes', please indicate which one and provide the name and address if it's not your usual doctor.

If 'no', please provide the name and address of the doctor who has full details.

Name & address

8. Do you have any skin lesions for which you are considering consulting a doctor or seeking medical advice or treatment? Yes No
If 'yes', please provide details.

Hypertension (High Blood Pressure)

1. When were you first diagnosed with hypertension? [d | d | / | m | m | / | y | y | y | y |]

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	
/ /	

3. Have you taken regular or occasional medication for this condition? Yes No

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two readings/tests, including dates and any change to your treatment

Date	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
/ /		
/ /		

5. Have you had an electrocardiogram (ECG), Blood Pressure monitor or any other heart test? Yes No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Do you have any complications as a result of hypertension? Yes No

If 'yes', please provide details

7. Does your regular doctor have details of this condition? Yes No

If 'no', please provide the name and address of the doctor who has full details

High Cholesterol

1. When were you first diagnosed with high cholesterol/triglycerides? [d | d | / | m | m | / | y | y | y | y |]

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	
/ /	

3. Have you taken regular or occasional medication for this condition? Yes No

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two cholesterol test results, including dates and any change to your treatment

Date	Result (If unsure, answer 'unsure')	If treatment was changed, give details
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	

5. Have you had an electrocardiogram (ECG), blood pressure monitor or any other heart test? Yes No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Does your regular doctor have details of this condition? Yes No

If 'no', please provide the name and address of the doctor who has full details

Asthma

- Date asthma first diagnosed / /
- How often do you experience symptoms? eg, wheezing, breathlessness, chest tightness.
- When did you last experience symptoms?
 / /
- Are you woken during the night with symptoms?..... Yes No
If 'yes', how often and date of last occurrence.
- Have you ever been off work due to your asthma? Yes No
If 'yes', please advise when and for how long.
- What is your current treatment? Include type of medication and dosage.
- Have you ever required use of oral steroids? Yes No
If 'yes', please advise when and for how long.
- Have you ever been in hospital or received emergency treatment for asthma? Yes No
If 'yes', please advise when, for how long and where.
- Do you ever measure your peak flow? Yes No
If 'yes', please advise your highest and lowest readings in the past 6 months.
- Have you ever consulted a specialist for this condition? Yes No
If 'yes', please advise name and address of doctor and date of last consultation.
- Does your regular doctor have details of this condition? Yes No
If 'no', please provide name and address of doctor who has full details.
- Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Anxiety/Depression/Nervous disorder

- Nature of condition and underlying cause.
- Describe your symptoms.
- Date symptoms commenced. / /
 - Are you still experiencing symptoms? Yes No
 - If 'no', when did you last experience symptoms?
 / /
- Have you had any recurrence of this condition? Yes No
If 'yes', please advise when and how many times.
- Have you taken regular or occasional medication for this condition? Yes No
If 'yes', please advise type, dosage and frequency.
- Are you still taking this medication? Yes No
If 'no', please advise date ceased / /
- Have you had any other treatment (eg, counselling, hospitalisation, ECT)?..... Yes No
If 'yes', please advise type, dates, hospital and name and address of treating doctor.
- Have you ever been off work or had your normal daily activities restricted in any way due to this condition?..... Yes No
If 'yes', please advise when and for how long.
- Have you any ongoing effects or restriction in your activities of any kind?..... Yes No
If 'yes', please provide details.
- Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? Yes No
If 'yes', please advise dates and name and address of all persons consulted.
- Please provide details of your most recent visit for this condition. Include date, name and address of the doctor or health professional consulted.
- Does your regular doctor have details of this condition? Yes No
If 'no', please provide name and address of doctor who has full details.

