Supplementary Personal Statement

Mental health questionnaire

1 September 2011

OnePath Life Limited (OnePath Life)
ABN 33 009 657 176 AFSL 238341
OnePath Custodians Pty Limited (OnePath Custodians)
ABN 12 008 508 496 AFSL 238346 RSE L0000673
OnePath MasterFund
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GPO Box 4129, Sydney NSW 2001

Group Risk Administration
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Instructions

- Print in black or blue ink.
- All questions must be completed by the life insured. Please attach a separate page if you require more space for an answer.

Details of life insured

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname First name

Maiden name (if applicable) Date of birth (dd/mm/yyyy) / /

Plan name

Member number

No. and street (home)

Suburb/Town State Postcode

Phone Home Work

Mobile

Email

Gender ☐ Male ☐ Female

Marital status ☐ Single ☐ De facto ☐ Married ☐ Widow/Widower

Smoker ☐ Yes ☐ No

1. Please tick the conditions you have had (or currently have), or received treatment for:

☐ Anxiety including generalised anxiety, panic or phobia disorder
☐ Depression including major depression or dysthymia
☐ Alcohol or other substance abuse or addiction
☐ Schizophrenia or any other psychotic disorder
☐ Eating disorder including anorexia nervosa or bulimia
☐ Manic depressive illness or bi-polar disorder
☐ Post traumatic stress
☐ Stress, sleeplessness or chronic tiredness

If **other**, please provide details:

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Details of life insured – continued

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

4. Are you currently symptom free? ☐ Yes ☐ No

If **yes**, please provide date(s) of last symptoms.

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details.

7. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details.

Treatment (e.g. tranquilisers, sedatives, ECT, counselling)	Date commenced	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? ☐ Yes ☐ No

If **yes**, please provide details.

10. Have you been referred for consultation with a psychiatrist or psychologist? ☐ Yes ☐ No

If **yes**, please provide details:

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

11. Have you been admitted to hospital or any other care facility? ☐ Yes ☐ No

If **yes**, please provide details:

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / / Doctor(s) consulted

12. Does your usual doctor have details of this condition(s) ☐ Yes ☐ No

Declaration

The duty of disclosure was set out in your original application to us. The duty of disclosure provides that you need to tell us anything that is relevant to our decision to insure you. Your duty of disclosure continues until the contract of life insurance has been accepted and the policy issued by OnePath Life. Please make sure you answer all applicable questions completely and truthfully.

I, the life insured, declare that the answers to the questions on this Supplementary Personal Statement are true and complete to the best of my knowledge. I understand that the information I provide on this form in conjunction with any other statements made in connection with this application for life insurance will be used by OnePath Life, to decide whether to extend life insurance cover to the policy owner in respect of my life.

Name of Life Insured

Signature ✗

Date (dd/mm/yyyy) / /

Head office

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