The Tele-Interview

Questions You May Be Asked

LIFESTYLE DETAILS

QUESTION	RESPONSE		
What is your Height?			
What is your Weight?			
Have you smoked any substance or used nicotine replacement products, including electronic cigarettes, in the last 12 months?	NO	YES Provide Details	Quantity Per Week? Cigarettes E-cigarettes Cigars / Cigarillos Pipe Smoking Hookah Gutka / Betel nut / Chewing tobacco Nicotine replacement products
Number of Standard Alcoholic Drinks you consume per week			
Have you had, or been recommended to have, Counselling or Treatment for Alcohol Use?	NO	YES Provide Details	

MEDICAL HISTORY

QUESTION	RESPONSE			
A cardiovascular condition such as: * raised blood pressure * raised cholesterol * heart attack * angina * chest pain * irregular heart beat * blood clot * stroke * transient ischaemic attack (TIA) / mini stroke * a heart valve problem * heart murmur * enlarged heart * lung embolism * aneurysm * haemorrhage * blood circulation problems * varicose veins * or any other cardiovascular disease or disorder?	NO	YES Provide Details	**What is the nature of this condition?**	
			Raised blood pressure / hypertension	
			Hypertension during pregnancy (females)	
			Raised cholesterol or triglycerides / hypercholestrolaemia	
			Heart attack / myocardial infarction	
			Angina	
			Chest pain	
			Palpitations	
			Blood clot / embolism	
			Deep vein thrombosis (DVT)	
			Any other cardiovascular disease or disorder not mentioned SPECIFY:	
Any cancer, tumour, lump, lesion or growth (even if you have not seen a doctor) such as: * a mole * sunspot * skin lesions that have changed colour, shape or size * skin cancers or cysts whether removed or not * skin conditions such as psoriasis, Marfan or Ehlers Danlos * syndrome * breast lump * leukaemia * Hodgkin's disease or lymphoma * or any other cancer, tumour or unidentified lump or growth of any kind?	NO	YES Provide Details	**What is the nature of this condition?**	
			Basal cell carcinoma (BCC)	
			Sunspot	
			Squamous cell carcinoma (SCC)	
			Mole/naevus	
			Dysplastic naevi	
			Melanoma	
			Skin cyst	
			Lipoma	
			Pilonidal cyst	
			Hydatid cyst	
			Psoriasis	
			Any other lesion, tumour or disorder not mentioned SPECIFY:	
Any respiratory disorder such as: * asthma * chronic bronchitis * chronic obstructive airways disease (COAD) * sleep apnoea * pneumonia * emphysema * cystic fibrosis * tuberculosis * or any other respiratory disease or disorder?	NO	YES Provide Details	**What is the nature of this condition?**	
			Asthma	
			Sleep apnoea	
			Pneumonia	
			Chronic bronchitis	
			Emphysema	
			Any other respiratory disorder not mentioned SPECIFY:	
Any mental health condition, for which you have consulted a doctor, received any treatment or counselling or taken medication, such as: * stress or anxiety * depression * chronic fatigue syndrome * bipolar disorder * schizophrenia * post traumatic stress syndrome * dementia * eating disorders * psychosis * or any other mental health disorder?	NO	YES Provide Details	**What is the nature of this condition?**	
			Stress	
			Anxiety	
			Depression	
			Post traumatic stress syndrome	
			Any other mental health disorder not mentioned SPECIFY:	

MEDICAL HISTORY - (Continued 1)

QUESTION	RESPONSE			
Any impairment of your sensory system such as: hearing, sight (other than corrected by glasses, contact lenses or corrective laser eye surgery), speech or any skin conditions: * hearing * sight or speech (other than corrected by glasses, contact lenses or corrective laser eye surgery)	NO	YES Provide Details	**What is the nature of this condition?**	
			Hearing loss	
			Tinnitus	
			Meniere's disease	
			Loss of sight	
			Cataract	
			Retinal Detachment or Tear	
			Glaucoma	
			Macular Degeneration	
			Eczema	
			Psoriasis	
			Any other condition or disorder of the sensory system not mentioned	
			SPECIFY:	
Any musculoskeletal disorder, deformity or injury affecting the joints, bones, muscles or any pain, strain or damage to the muscles, ligament or cartilage such as: * back or neck pain * disc disorder * sciatica * neck, back or joint surgery * arthritis * gout * spondylitis * carpal tunnel syndrome / repetitive strain injury (RSI) * polio * lupus (SLE) * amputations * or any other disorder of the muscles, joints, bones, neck or back?	NO	YES Provide Details	**What is the nature of this condition?**	
			Arthritis	
			Back pain	
			Disc disorder	
			Fractures of limbs and chest	
			Gout	
			Joint pain	
			Any other disorder of the muscles, joints, bones not mentioned	
			SPECIFY:	
An endocrine / glandular disorder such as: * diabetes or raised blood sugar * thyroid disorder / goitre * Addison's disease * pituitary gland disorder * glandular disorder (including glandular fever) or any other endocrine disease or disorder?	NO	YES Provide Details	**What is the nature of this condition?**	
			Type 1 diabetes	
			Type 2 diabetes	
			Gestational diabetes	
			Goitre	
			Hypothyroidism	
			Glandular fever	
			Any other endocrine /glandular disorder not mentioned	
			SPECIFY:	
A blood disorder (other than already disclosed) such as * anaemia * haemochromatosis * thalassaemia * blood clotting disorders * polycythemia or any other disease or disorder of the blood?	NO	YES Provide Details	**What is the nature of this condition?**	
			Anaemia	
			Haemochromatosis	
			Thalassaemia	
			Polycythemia	
			Any other disease or disorder of the blood not mentioned	
			SPECIFY:	

MEDICAL HISTORY - (Continued 2)

QUESTION	RESPONSE			
A neurological condition such as: * epilepsy / fainting / seizures * any head injury * multiple sclerosis * optic neuritis * encephalitis * Alzheimer's disease * Parkinson's disease * genetic conditions such as Huntington's disease * paralysis of any kind * tremors or any other disease or disorder of the nervous system?	NO	YES Provide Details	**What is the nature of this condition?**	
			Epilepsy / Seizures	
			Fainting	
			Concussion	
			Head injury	
			Multiple sclerosis	
			Motor neuron disease	
			Muscular dystrophy	
			Any other disease or disorder of the nervous system not mentioned	
			SPECIFY:	
Any disorder of the digestive system such as: * recurrent indigestion or reflux * Barrett's oesophagus * gall bladder problems * celiac disease * Crohn's disease or ulcerative colitis * irritable bowel syndrome * hernia * blood from the bowel * disorder of the liver or pancreas or any other disease or disorder of the digestive system?	NO	YES Provide Details	**What is the nature of this condition?**	
			Reflux / GORD / indigestion	
			Duodenal ulcer	
			Irritable bowel syndrome (IBS)	
			Ulcerative colitis	
			Gall stones	
			Gall bladder removal / cholecystectomy	
			Any other disease or disorder digestive system not mentioned	
			SPECIFY:	
A kidney, bladder, urinary tract disorder including any urinary symptoms such as: * kidney infection * horseshoe kidney * kidney stones * polycystic kidney disease * or any other disease or disorder of the urinary tract	NO	YES Provide Details	**What is the nature of this condition?**	
			Polycystic kidney disease	
			Kidney stone	
			Pyelonephritis	
			Cystitis	
			Incontinence	
			Any other disease or disorder of the urinary system	
			SPECIFY:	
Any urological disorder such as a disorder of the prostate or a lump or pain in your testis?	NO	YES Provide Details	**What is the nature of this condition?**	
			Benign prostate hypertrophy (BPH)	
			Removal of prostate	
			Prostate cancer	
			Transurethral resection (TURP)	
			Any other disease or disorder of the prostate or testis	
			SPECIFY:	
An abnormal PSA Test (Prostate Specific Antigen)?	NO	YES Provide Details	**What is the nature of this condition?**	
			SPECIFY:	

MEDICAL HISTORY - (Continued 3)

QUESTION	RESPONSE			
Have you ever tested positive for HIV or Hepatitis B or Hepatitis C, or are you awaiting the results of such a test?	NO	YES Provide Details	**What is the nature of this condition?**	
			Hepatitis type A	
			Hepatitis type B	
			Hepatitis B, resolved or immune	
			Hepatitis B, carrier or chronic infection	
			Hepatitis type C	
			Hepatitis type D	
			Hepatitis type E	
			HIV	
			Any other test or disorder related to the liver	
			SPECIFY:	
Have you ever used, taken or injected any Drugs or Medications NOT PRESCRIBED by a medical practitioner, Including recreational and designer drugs?	NO	YES Provide Details	**What is the nature of this condition?**	
			Cannabis (marijuana/dope)	
			Amphetamines (crystal meth, ice, etc.)	
			Anabolic steroids (gear, juice, etc.)	
			Barbiturates (downers, amytal, etc.)	
			Cocaine (coke, crack, etc.)	
			Ecstacy (MDMA, meth amphetamine, etc.)	
			Opiates (heroine, methadone, etc.)	
			Psychedelics (LSD, acid, mushrooms, etc.)	
			Solvents (Glue, aerosol, etc.)	
			Herbs (kavakava, poppy, etc.)	
			Sedatives (diazepam, tranks, etc.)	
			New psychoactive substances (herbal highs, bath salts, etc.)	
			Any other drugs or mediations not prescribed by a medical practitioner	
			SPECIFY:	
Have you ever or are you considering seeking medical advice, treatment, tests or surgery for a condition or symptom you have not told us about already? (e.g. consultation, x-ray, blood test, ECG, ultrasound)	NO	YES Provide Details	**What is the nature of this condition?** SPECIFY:	
Have you ever had a genetic test where you received (or are currently awaiting) an individual result or are you considering having a genetic test?	NO	YES Provide Details	**What is the Purpose?** SPECIFY:	

OCCUPATION

QUESTION	RESPONSE		
What is your employment status?	Employee		
	Self Employed		
	Employed by Own Company or Trust		
	Employed by Family Company >10% Shareholding		
	Employed by Family Company up to 10% Shareholding		
	Contractor		
	Casual Employment		
	Retired		
	Not Currently Employed		
	Full Time Home Duties		
How Many Hours Per Week do you work in your Main Occupation ?			
How many weeks do you work per year in your main occupation ?			
What percentage of your working week is working from home ?			
How long have you been in your current occupation (in months)?			
Do you intend to change your occupation, duties, hours worked, employment status or take extended leave within the next 12 months?	**NO**	**YES**	IF YES: Specify
Do you have a SECOND JOB?	NO	YES Provide Details	What is your second occupation?
			Please select your employment status of your second occupation:
			Employed
			Self Employed
			Silent Partner
			Military Reserves Forces
			Rural Fire Services / SES / Country Fire Authority
			Casual Work
			Freelance
			Does your second occupation include any hazardous activities or duties? (e.g. explosives, underwater diving, etc.) YES / NO
			IF YES SPECIFY:
			How many hours per week do you work in your second occupation?
			In what industry is your second occupation? (e.g. construction, mining, etc.)
			How long (in months) Have you been performing your second occupation?
			What is your expected annual income before tax from your second occupation in the current financial year?
			What are your duties of your second occupation? — Answer by Percentage
			Administration / Office %
			Manual duties %
			Supervision of manual work %
			Travelling %
			Other duties %
In the last five years have you been made, or are you currently being assessed to be; * Bankrupt, * Placed in receivership, * Administration or Liquidation?	NO	YES Provide Details	Have you been Fully Discharged? YES / NO
			If Discharged - Please Provide Date Discharged.
			Provide full details including date(s) of bankruptcy(ies) and reason(s).
			SPECIFY:

FINANCIAL

QUESTION	RESPONSE	
Do you expect to earn an annual income of at least $50000 from your main occupation in the current financial year? (This is your base salary before tax plus average annual performance bonus and commissions, fringe benefits and super contributions. It should not include income from a second occupation).	YES / NO	
	IF NO SPECIFY your expected annual income before tax from your main occupation in the current financial year:	
Does your bonus component contribute to more than 10% of your disclosed annual income?	YES / NO	
	IF YES: Please provide the amounts of annual bonus for the last 3 years.	
Does your annual income include any commissions of more than 20%?	YES / NO	
	IF YES: Please provide the amount and basis of the commissions (e.g. target rate including fixed percentage, target pay including split between fixed and variable remuneration, trailing commissions, etc.	
Please provide your annual income (this is your base salary plus any additional benefits such as super contributions and regular bonuses, commissions or fringe benefits) for:	Last financial year:	$
	The year before last financial year:	$
Other than your annual income, do you receive income from any other sources (such as investments, rental income or dividends)?	YES / NO	
	IF YES: On average how much do you receive from these sources each year? (investments, rental income or dividends)	
For how many days would your income continue if you became disabled or were otherwise unable to work?		

FAMILY HISTORY

QUESTION	RESPONSE		
Have any of your immediate family memebers (mother, father, brother, sister - living or dead) been diagnosed before the age of 60 with: *Cancer *Heart disease, (including cardiomyopathy) *Stroke *Polycycstic Kidney Disease *Huntingson's Disease *Alzheimer's or Dementia *Diabetes *Motor Neurone Disease *Multiple Sclerosis (MS) *Parkinson's Disease	NO	YES Provide Details	**What was their Relation to You?** Mother Father Sister Brother Identical Twin **What condition did they suffer from?** Breast Cancer Ovarian Cancer Colo-rectal Cancer (eg cancer of the colon or rectum) Other type of cancer Diabetes Heart Disease Cardiomyopathy Stroke Muscular Dystrophy Motor Neurone Disease Multiple Sclerosis (MS) Alzheimer's Disease Parkinson's Disease Huntingson's Chorea Familial Adenomatous Polyposis of the Colon Polycycstic kidney disease None of the above
When were they Diagnosed ? AGE:			

PASTIME ACTIVITIES

QUESTION	RESPONSE		
Do you now, or do you intend to take part in any hazardous pursuits or pastimes (e.g. flying, diving, material arts, parachuting, any kind of racing or competitive sports)?	NO	YES Provide Details	**What kind of activity do you take part in?**

DOCTOR DETAILS

QUESTION	RESPONSE			
Doctor's Name or Medical Centre that you have consulted				
Address				
Phone Number				
Date of last consultation:				
Please provide the reason(s) for your last consultation. OR Type "already disclosed" in the box if you have already told us about it.				
Have you been a patient of this doctor for less than two years?	NO	YES Provide Details	IF YES: Please provide the name and address of your previous doctor and when you last attended.	
			DR NAME	
			ADDRESS	
		DATE LAST VISITED		
Is there any additional information, that you wish for underwriters to consider in the underwriting assessment of your application?	NO	YES Provide Details		
If any type of medical or blood tests are required, has or will the advisor arrange these?	NO	YES Provide Details		