Underwriting Pre-assessment Form

Use this form to collect client pre-assessment information for underwriting purposes. This form must only be completed by a financial adviser or adviser support staff.

Note: effective 1 April 2020, only existing Resolution Life customers will be eligible to apply for Elevate Insurance cover.

Genetic test approach

You only need to tell us about any genetic testing you've had or have consented to have if the total combined sum insured with all life insurers for the insurance being applied for is over:

- $500,000 life cover
- $500,000 total and permanent disability cover (TPD)
- $200,000 trauma / critical illness cover, or
- $4,000 a month income protection cover, salary continuance cover or business expenses cover

You can choose to tell us about a genetic test that you have had where the result was favourable. However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.
Note: Resolution Life complies with the Moratorium on Genetic Tests. A copy of the moratorium is available in the Life Insurance Code of Practice **cali.org.au/life-code**.

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

1. Adviser contact details

Adviser number

Adviser name

Email address

Contact phone number

Mobile number

2. Client details

Title

Date of birth D D M M Y Y Y Y

Surname

Given name(s)

Gender

☐ Male ☐ Female

Residential address

Suburb

State

Postcode

Contact phone number

Mobile number

Email address

3. Insurance benefit(s) required for client

What type of insurance benefit(s) are required for your client (select **all** that apply)?

	Sum insured
☐ Life insurance benefit	$
☐ TPD	$
☐ Own occupation	
☐ Trauma	$
☐ Income protection	$
☐ Business expenses	$

4. Client general health information

a. Smoker status? ☐ Non smoker ☐ Smoker

b. What is your client's height? cm

c. What is your client's weight? kg

d. Does your client have any major illness in their family history?

☐ No

☐ Yes—please provide details below:

e. Has your client ever had surgery or been hospitalised?

☐ No

☐ Yes—please provide details below:

4. Client general health information (continued)

f. Does your client require regular follow up with any doctor, chiropractor, psychologist etc?

- ☐ No
- ☐ Yes—please provide details below:

g. Has your client suffered from or previously had any of the following conditions (select **all** that apply):

> ! Please complete the relevant **medical questionnaire** in section **5** for each condition that you select.

- ☐ Diabetes
- ☐ Skin lesion
- ☐ Cancer
- ☐ Mental health Back/
- ☐ Neck/Joint pain
- ☐ Cholesterol/ Hypertension
- ☐ Sleep apnoea
- ☐ Rheumatoid/ psoriatic arthritis, ankylosing spondylitis
- ☐ Other— if you've selected this please provide the following details:

Note: If your client has more than one medical condition, please provide answers to questions (i) to (xii) in section **9. Other information**.

i. Name of disorder

ii. What area(s) of the body, organs or system is affected?

iii. Date of diagnosis D D M M Y Y Y Y **or** Age of diagnosis

iv. Please list the current symptoms, frequency and severity for the condition?

v. Date of last symptoms D D M M Y Y Y Y **or** Age of last symptoms

vi. What is the cause of the symptoms or what can exacerbate the symptoms?

vii. What treatment did your client use for the condition (include medication name, dose and any changes to that treatment)?

4. Client general health information (continued)

viii. Has your client had any time off work due to the condition?

- ☐ No
- ☐ Yes—please provide details:

ix. Has this condition restricted your client's daily activities?

- ☐ No
- ☐ Yes—please provide the frequency and duration of the restriction:

x. Has your client had any complications or secondary illness due to this condition?

- ☐ No
- ☐ Yes—please provide details:

xi. Has your client been advised to have, attend to or arrange any follow up investigations, tests or consultations with a specialist?

- ☐ No
- ☐ Yes—please provide details:

xii. Has your client provided medical information and have you attached it to this form?

- ☐ No
- ☐ Yes

5. Medical questionnaire

Diabetes

a. What was your client's age at diabetes diagnosis?

b. How was your client's diabetes treated (eg insulin, oral medication, diet, other treatment or no treatment)?
Note: Please provide the medication name if applicable.

c. What was your client's last HbA1C result?

d. What date was your client's last HbA1C result completed?
D D M M Y Y Y Y

5. Medical questionnaire (continued)

e. Did your client have any related complications (eg eyes, kidneys, circulation etc)?

- ☐ No
- ☐ Yes—please provide details below:

Skin lesion

a. What type of skin lesion did your client have removed?

b. How many skin lesions has your client had removed in the last five years?

c. Was the lesion frozen/lasered off or removed with the use of a cream?

d. If the lesion was surgically removed, was the pathology result benign or normal?

Note: If the result was malignant please also complete the **Cancer** section in this form.

e. Does your client require any follow ups?

- ☐ No
- ☐ Yes—how often?

f. What reasons were provided for your client to have follow ups?

Cancer

a. What date was your client diagnosed with cancer?

D D M M Y Y Y Y

b. What type of cancer was your client diagnosed with?

c. Where is the site of the cancer?

d. Was this confirmed to be malignant or benign?

e. Does your client require any regular follow ups?

- ☐ No
- ☐ Yes—how often?

f. What type of treatment was your client given (eg surgery, radiation therapy, chemotherapy)?

5. Medical questionnaire (continued)

g. What was the date of your client's last treatment?

D D M M Y Y Y Y

h. Do you have a copy of your client's pathology results?

- ☐ No
- ☐ Yes—please provide details of grade or staging:

Mental health

a. What type of mental health condition has your client had?

b. Has the cause of their condition been identified?

c. How often did/does your client have symptoms?

d. What date did your client's condition begin?

D D M M Y Y Y Y

e. What is the date of your client's last symptoms?

D D M M Y Y Y Y

f. Please provide details of all treatments your client has had:

g. Is your client still taking medication for their condition?

- ☐ No
- ☐ Yes—please provide details:

h. Has your client ever been absent from work or has their lifestyle been restricted in any way as a result of this condition?

- ☐ No
- ☐ Yes—please provide details:

i. Has your client ever been hospitalised for this condition?

- ☐ No
- ☐ Yes—please provide details:

j. Has your client ever attempted suicide?

- ☐ No
- ☐ Yes—how long ago?

5. Medical questionnaire (continued)

Cholesterol/Hypertension

a. Is your client **currently** being treated for cholesterol or hypertension?

☐ Yes—please provide current treatment details:

☐ No—please provide previous treatment details (including date treatment ceased)?

b. When did your client have their cholesterol/blood pressure checked?

D D M M Y Y Y Y

c. What were the results of the cholesterol/blood pressure tests?

Back/neck/joint pain

a. Where is the client's pain or what joint is affected?

b. Does your client have current symptoms?

☐ No—what date did your client last have symptoms?

D D M M Y Y Y Y

☐ Yes—please provide details of current symptoms:

c. How frequent are/were your client's symptoms?

d. Did your client have the symptoms investigated?

☐ No

☐ Yes—please provide details below:

e. Has your client had time off work?

☐ No

☐ Yes—please provide details below:

f. What type of treatment has your client had for their current and or past symptoms (include frequency)?

5. Medical questionnaire (continued)

Rheumatoid/psoriatic arthritis, ankylosing spondylitis

a. What part of your client's body is affected by rheumatoid/psoriatic arthritis, ankylosing spondylitis?

b. What age was your client diagnosed with the condition?

c. Is your client suffering from any symptoms?

☐ No

☐ Yes—when did they last suffer from symptoms for this condition?

d. Please provide details of the treatment taken by your client:

e. Does your client have any complications (eg eyes, kidneys, circulation etc)?

☐ No

☐ Yes—please provide details:

Sleep apnoea

a. What date was your client's condition diagnosed?

D D M M Y Y Y Y

b. What type of sleep apnoea does your client have?

☐ Mild ☐ Moderate ☐ Severe

c. Please provide details of the recommended treatment (eg CPAP, dental splint, surgery etc):

d. Does your client use their recommended treatment?

☐ No

☐ Yes

6. Sports and pursuits information

a. What sport or pursuits does your client take part in?

b. How often does your client participate in this sport or pursuit (eg hours per week, or number per month/year)?

c. What are the maximum height/depth and or speed for the sport or pursuit?

6. Sports and pursuits information (continued)

d. Is the sport or pursuit competitive?

- ☐ No
- ☐ Yes

e. Does your client hold licences or qualifications for the sport or pursuit?

- ☐ No
- ☐ Yes—provide licence/qualification details:

7. Client financial information

What is your client's employment status?

- ☐ Employed — go to the **Employed** section.
- ☐ Self-employed — go to the **Self-employed** section.

Employed

! Your client needs to provide details (**for the last two years**) of their base salary, commission, bonuses and regular overtime.

Please cross below to confirm you've provided and attached (to this form) the required documentation for your client (**for the last two years**):

- ☐ Base salary details
- ☐ Bonus details
- ☐ Commission details
- ☐ Overtime

Self-employed

a. How long has your client been self-employed?

Months Years

b. What percentage of the business is owned by your client?

%

c. Does your client's spouse have any ownership in the business?

- ☐ No
- ☐ Yes—is your client's spouse actively involved in the business?
  - ☐ No ☐ Yes

! Your client needs to provide details (**for the last two years**) of their business gross income, expenses, wages paid to them from expenses for all entities (ie profit and loss statements and tax returns).

Please cross the list below to confirm you've provided and attached (to this form) the required documentation for your client (**for the last two years**):

- ☐ Profit and loss statements
- ☐ Tax returns

8. Client occupation information

a. If your client is employed please cross the type of working arrangement they have:

- ☐ Permanent full time
- ☐ Permanent part time
- ☐ Casual
- ☐ Contractor

b. What is your client's occupation?

c. What are the main duties and percentages of time (for each duty) of your client's occupation?

Duties	(%)

d. Where does your client perform these duties (eg home, office, on-site, off-shore, at heights etc) and what is the percentage of time spent for each duty?

Location	(%)

e. Does your client hold any professional or trade qualifications relating to their current role?

- ☐ No
- ☐ Yes—please provide details below:

f. How many hours per week does your client work in this occupation?

Hours per week

g. How many weeks per year does your client work in this occupation?

Weeks per year

9. Other information

Where to send this form

Email or mail this completed form (and any supporting documents) to:

Resolution Life Customer Service
GPO Box 5441
Sydney NSW 2001

Any questions?
133 731

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