Terminal Illness Medical Statement

To be completed by a medical practitioner.

The information provided in this form will be used to assist in determining all potential benefit entitlements available to the Policy Owner.

Please provide all detail you have available as this can assist in minimising the need for further information requests and allow a faster outcome for the Life Insured and Policy Owner.

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide your patient with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your patient with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Patient/claimant details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Address	Suburb	State	Postcode

Section 2. Patient history

1. Are you the patient's usual doctor?
   ☐ Yes ☐ No
   How long have you known the patient?

2. When did the patient first consult you for the present condition? / /

3. When did the present condition commence? / /

4. Please provide details of the patient's current diagnosis including; cause if relevant and how diagnosed. Please provide copies of the most recent diagnostic reports (scans, pathology, etc.) that confirm the current diagnosis and severity.

5. In your medical opinion, what is your patient's estimated life expectancy inclusive of all reasonable treatment options?

   ☐ < 12 months

   ☐ 12 to 24 months

   ☐ 24 to 36 months

   ☐ > 36 months

Section 2. Patient history (continued)

6. Does the patient have a prior medical history related to the present condition? ☐ Yes ☐ No

If Yes, please provide details.

Section 3. Other information

7. Are you completing claim forms on behalf of the patient for any other company in respect of this condition?

☐ Yes ☐ No

If Yes, please provide details.

8. Other comments (please use this space if required).

Section 4. Your details

Title	Given name(s)

Surname

Address	Suburb	State	Postcode

Phone no.	Qualifications

Signature of medical practitioner	Date *(dd/mm/yyyy)*
▶	

Please attach copies of any medical reports, medical certificates or test results you may have in your possession and return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auservices@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife Insurance Limited | Level 9, 2 Park Street, Sydney | NSW 2000
ABN 75 004 274 882 AFSL NO. 238 096