

# 81 Years and Over

## Medical Declaration Form

Effective 30 June 2008

Important Information to read **before** completing this form:

### Travellers aged 81 years and over

If you are 81 years of age or over (at the date of application), we are unable to provide cover under this travel insurance policy unless you have received an offer from us in writing.

This document allows you to apply for:

- Travel Insurance coverage for a particular journey and
- Cover of Pre-existing Medical Conditions under that policy.

Our medical assessors will consider a series of factors in assessing your application including your age, destination, itinerary, duration of the journey, mode of transport, medical information supplied, and any other factors specifically relevant to your application.

Please be aware that our offer of cover may include limitations to the benefits of your policy. These include (but are not limited to):

- capping your maximum claimable benefit and
- increasing your excess and
- excluding specific medical conditions

We retain the absolute right to decline cover.

#### To apply for cover:

1. Read the Pre-existing Medical Condition information below, detailing the situations and medical conditions for which cover is never available, and ensure that this is acceptable to you.
2. Complete page 2 of this document.
3. Have pages 3 and 4 completed by your regular doctor.
4. Forward pages 2, 3 and 4 to us for assessment. We will provide you with the outcome of your assessment within 1 business day, provided that all pages are completed in full and signed.

### Pre-existing Medical Conditions

**Please read this section carefully.**

*Travel Insurance only provides cover for emergency overseas medical events that are unforeseen. Medical conditions that were pre-existing at the time of the policy being issued are not covered, unless they are a condition that we expressly agree to cover.*

*If you have a pre-existing medical condition that is not covered, we will not pay any claims arising from, related to or associated with that condition. This means that you may have to pay for an overseas medical emergency which can be prohibitive in some countries.*

#### What is a Pre-existing Medical Condition?

A Pre-existing Medical Condition means:

- (a) an ongoing medical or dental condition of which you are aware, or related complication you have, or the symptoms of which you are aware;
- (b) A medical or dental condition that is currently being, or has been investigated, or treated by a health professional (including dentist or chiropractor) at any time in the past, prior to policy purchase;
- (c) Any condition for which you take prescribed medicine;
- (d) Any condition for which you have had surgery;
- (e) Any condition for which you see a medical specialist; or
- (f) Pregnancy. \*

This definition applies to you, your Travelling Party, a Relative or any other person.

\* Pregnancy cover is explained on page 15 of the Product Disclosure Statement.

Your condition is not a Pre-existing Medical Condition if it arose after the date of issue of your policy.

### Pre-existing Medical Conditions which are automatically excluded

We will not pay any costs or expenses arising directly or indirectly from any of the following Pre-existing Medical Conditions, e.g. cost of medical care while overseas, or cost of cancellation of your travel plans due to a change in health.

1. Any type of cancer that you have previously been diagnosed with, or secondaries from that cancer
2. Any condition for which surgery/treatment/procedure is planned
3. Any condition which arises from signs or symptoms that you are currently aware of, but:
  - a) You have not yet sought a medical opinion regarding the cause; OR
  - b) You are currently under investigation to define a diagnosis; OR
  - c) You are awaiting specialist opinion
4. Any condition for which you have undergone surgery in the past 6 weeks
5. Any condition for which you have ever required spinal or brain surgery
6. Any condition which has caused a seizure in the past 12 months
7. Any chronic or recurring pain (including back pain) requiring regular medication or other ongoing treatment such as physiotherapy or chiropractic treatment
8. Any mental illness as defined by DSM-IV including:
  - a) Dementia, depression, anxiety, stress or other nervous condition; OR
  - b) Behavioural diagnoses such as autism; OR
  - c) A therapeutic or illicit drug or alcohol addiction
9. Any cardiovascular disease (see example) if you have
  - a) Experienced angina (chest pain) within the past 6 months; OR
  - b) Had a stroke or a Transient Ischaemic Attack (TIA) within the past 12 months; OR
  - c) Been diagnosed with Congestive Heart Failure
10. Any condition for which you have been given a terminal prognosis, with a life expectancy of under 24 months
11. Any respiratory condition (see examples) for which you require home oxygen therapy or for which you will require oxygen for the journey
12. Chronic Renal Failure which is treated by haemodialysis or peritoneal dialysis
13. Full-blown AIDS (not an asymptomatic HIV infection)
14. Organ transplantation, previous organ transplantation, or any condition for which you are awaiting organ transplantation.

#### Examples of two common Pre-existing Medical Conditions are set out below:

##### Cardiovascular disease:

Medical conditions involving the heart and blood vessels are collectively called cardiovascular disease (CVD). All such conditions are interrelated. If you have ever needed to see a specialist cardiologist, or been diagnosed with a form of CVD such as (but not limited to):

- 1 Aneurysms
- 2 Angina
- 3 Cardiomyopathy
- 4 Cerebrovascular Accident (Stroke)
- 5 Disturbances in heart rhythm (cardiac arrhythmias)
- 6 Previous heart surgery (including valve replacements, bypass surgery, stents)
- 7 Myocardial infarction (heart attack)
- 8 Transient Ischaemic Attack

and you do not purchase adequate cover for CVD, you may not be covered for any claims relating to the heart/cardiovascular system (including heart attacks and strokes). If any of these conditions are expressly excluded from the policy, all CVD is excluded.

##### Chronic Lung Disease:

If you have ever been diagnosed with a chronic lung disease including (but not limited to) Emphysema and Chronic Bronchitis, Bronchiectasis, Chronic Obstructive Airways Disease (COAD) or Chronic Obstructive Pulmonary Disease (COPD) and you do not purchase adequate cover for your respiratory disease, you may not be covered for any claims relating to a new airways infection. If a chronic lung condition is expressly excluded under your policy, all new respiratory infections are also excluded.

Agency Name: \_\_\_\_\_ Agency Phone No: (0 ) \_\_\_\_\_ Consultant's Name: \_\_\_\_\_  
 Fax: (0 ) \_\_\_\_\_ Email: \_\_\_\_\_

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### This page to be completed by the traveller.

We will advise you of the outcome of this assessment in writing within 1 business day *provided pages 2, 3 and 4 of this form have been completed in full and signed.*

**PLEASE USE BLOCK LETTERS** (a separate application must be completed for each passenger).

**PLEASE NOTE: Where there is insufficient space, please attach a separate sheet to provide details.**

#### 1. Personal Details

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_ Title: \_\_\_\_\_  Male  Female Date of Birth: / /  
 Are you an Australian Citizen or Permanent Resident? **Y**  **N**

**PLEASE NOTE: Pre-existing medical cover is only available to Australian Citizens or Permanent Residents**

#### 2. Contact Details

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_  
 Work Phone No: \_\_\_\_\_ Home Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_ Email: \_\_\_\_\_

#### 3. Trip Details

Departure Date: / / Return Date: / /  
 Countries to be visited: \_\_\_\_\_  
 Mode of Travel:  Aircraft  Car  Coach  Ship  Train  
 Type of Accommodation:  Paid accommodation  Staying with friends or relatives  
 Are you travelling:  Alone  With a companion (their relationship to you): \_\_\_\_\_  
 Approximate total cost of trip per person - AUD\$: \_\_\_\_\_

#### 4. Insurance Details

Cover required: Plan A - Comprehensive  Plan B - Australia Only   
 Have you ever made any medical travel insurance claims over AUD\$1,000 in total? **Y**  **N**  If yes, please provide details: \_\_\_\_\_  
 Have you applied for travel insurance for this journey through another insurer or company? **Y**  **N**  If yes, please provide details: \_\_\_\_\_

#### 5. Health at Home

Do you: (a) Drive a car? **Y**  **N**  Frequency:  Daily  Weekly  Monthly  
 (b) Use public transport? **Y**  **N**  Type:  Bus  Train  Taxi  Ferry Frequency:  Daily  Weekly  Monthly  
 (c) Exercise/participate in a sporting activity (e.g. lawn bowls)? **Y**  **N**   
 Activity: \_\_\_\_\_ Frequency:  Daily  Weekly  Monthly  
 Activity: \_\_\_\_\_ Frequency:  Daily  Weekly  Monthly  
 (d) Participate in a leisure activity (e.g. Bridge, gardening)? **Y**  **N**   
 Activity: \_\_\_\_\_ Frequency:  Daily  Weekly  Monthly  
 Activity: \_\_\_\_\_ Frequency:  Daily  Weekly  Monthly  
 Have you ever smoked? **Y**  **N**  If yes, please provide details: \_\_\_\_\_

#### 6. Contact Persons

If English is not your preferred language or you wish to nominate a person to speak on you behalf, please provide the name and number of a person who can discuss your medical status with our qualified clinical staff.  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone No: \_\_\_\_\_

#### 7. Passenger's Declaration:

I confirm that all my answers are correct and complete. I have read and retained a copy of the Product Disclosure Statement (PDS). I have not withheld any information likely to affect my application for cover. I authorise any doctor, hospital, clinic or any other person to give Mondial Assistance any medical information (past and current). A photocopy of the authorisation is valid as the original. I have read the Product Disclosure Statement and I consent to the correct use and disclosure of my personal information by Allianz or Mondial Assistance to such persons and for such purposes stated in the Privacy Policy. I agree not to be covered for any Pre-existing Medical Conditions unless disclosed in this form and Mondial Assistance has agreed to cover those conditions.

Passenger's Signature: \_\_\_\_\_ Date: / /

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Agency Name: \_\_\_\_\_ Agency Phone No: (0 ) \_\_\_\_\_ Consultant's Name: \_\_\_\_\_  
 Fax: (0 ) \_\_\_\_\_ Email: \_\_\_\_\_

## 81 Years and Over Medical Declaration Form Effective 30 June 2008

### Doctor's Declaration

Pages 3 and 4 to be completed by your doctor. Any resulting costs incurred are the responsibility of the traveller.

**PLEASE NOTE: A separate form must be completed for each patient. PLEASE USE BLOCK LETTERS.**

Dear Doctor,

Your patient is seeking travel insurance from our company. The aim of these questions is to establish their general health and wellbeing, and their fitness to travel. All references to time are with regard to the date of this medical assessment.

### 8. Patient Details

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_ Date of Birth: / / Current Height: (m) Current Weight: (kg)

### 9. Cognition

(a) Does the patient suffer from any neurological or cognitive impairment? **Y**  **N**

If yes, please indicate the reason:  Acquired or Traumatic Brain Injury  Transient Global Amnesia

Alzheimer's Disease  Dementia  Memory Loss  Post-CVA Damage

Other (please specify): \_\_\_\_\_

(b) In the past 2 years, has the patient experienced:

Dizziness **Y**  **N**  Falls **Y**  **N**  Loss of consciousness **Y**  **N**

### 10. Daily Living

(a) Which of these best describes the patient's living situation?

Alone in their own home  In their own home – with a companion or family members  In residential/Hostel care  In full time nursing care

Other (please specify): \_\_\_\_\_

(b) Does the patient experience any difficulty walking? **Y**  **N**

If yes, please indicate which aid/assistance is required:  Regular rests  Walking stick  Walking frame  Wheelchair  Motorised wheelchair

Other (please specify): \_\_\_\_\_

And reason for difficulty:  Unsteadiness  Paralysis  Shortness of breath

Musculoskeletal pain  Sensory changes  Neurological impairment

Other (please specify): \_\_\_\_\_

(c) Does the patient experience any difficulty communicating? **Y**  **N**

If yes, please indicate the reason for difficulty:  Requires interpreter  Difficulty due to hearing impairment

Receptive/Expressive dysphasia  Dysarthria  Cognitive Impairment

Other (please specify): \_\_\_\_\_

(d) Please indicate the level of assistance that the patient requires with the following tasks, using the scale to the right

|  |                            |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|----------------------------|
| Transferring (i.e. moving on and off a chair or getting in and out of bed) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Meal preparation   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Bathing and dressing   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Medication administration  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Housework (cleaning and washing)   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Continence   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

#### LEGEND

- 1** Completely independent
- 2** Performs with some assistance from others\*
- 3** Largely performed by others\*
- 4** Completely dependent on others\*

\*Where 'others' includes relatives, paid carers, meals on wheels, community nurses, domestic help.

Doctor's Stamp and Initial:

Passenger's Name: \_\_\_\_\_

Date of Birth: / / \_\_\_\_\_

**11. Medical History**

Doctor,

These questions provide the medical information on which we base our decision to accept or decline pre-existing medical cover for your patient's intended travel. The following questions are designed to compile factual information about the traveller's risk of claim, based on their risk profile.

Please answer **YES** or **NO** to the questions (a-l). If the answer is **YES**, complete all questions in that section.

There is space provided for further information if you believe that it will affect our decision to offer cover.

Does the patient:

(a) Have Diabetes Mellitus? **Y**  **N**

If yes: Type I or Type II: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Currently controlled with: Diet only  Insulin injections  Insulin pump

Other medication:  Please specify: \_\_\_\_\_

Are there any eye, kidney, nerve, or vascular complications? **Y**  **N**

Details: \_\_\_\_\_

Has there been an associated hospital admission in the past 12 months? **Y**  **N**

(b) Require treatment for:

i. Hypertension **Y**  **N**  ii. Hypercholesterolaemia **Y**  **N**

(c) Have a history of Ischaemic Heart Disease? **Y**  **N**

Have they experienced angina within the past 6 months? **Y**  **N**

If yes: Frequency of attacks: \_\_\_\_\_

Date of last attack: / / \_\_\_\_\_

Current Medication: \_\_\_\_\_

Is there any history of myocardial infarction? **Y**  **N**

Dates: \_\_\_\_\_

Further details: \_\_\_\_\_

Have they undergone Coronary Angiography, Stents or Bypass Grafting (CABG)? **Y**  **N**

Type of surgery: \_\_\_\_\_

Which arteries? \_\_\_\_\_

Date/s: / / Further details: \_\_\_\_\_

Have they experienced any angina since that procedure? **Y**  **N**

(d) Have a history of Cerebrovascular Accident (Stroke) or Transient Ischaemic Attack (TIA)? **Y**  **N**

Date: / / \_\_\_\_\_

Current preventative medications: \_\_\_\_\_

Further details: \_\_\_\_\_

(e) Have a history of cardiac rhythm disorder? **Y**  **N**

Name of arrhythmia: \_\_\_\_\_ Date of diagnosis: / / \_\_\_\_\_

Current medication: \_\_\_\_\_

Has a Pacemaker or AICD (internal defibrillator) been fitted? **Y**  **N**

Type of device inserted: \_\_\_\_\_

Date of insertion: / / \_\_\_\_\_

When was the last assessment of the device made by a cardiologist – or is an assessment planned before commencing the trip? / / \_\_\_\_\_

Further details: \_\_\_\_\_

(f) Have Heart Failure or have any history of Heart Failure? **Y**  **N**

Further details: \_\_\_\_\_

(g) Ever been diagnosed with Deep Vein Thrombosis (DVT) or Pulmonary Embolism? **Y**  **N**

Contributing factors: \_\_\_\_\_

Date: / / \_\_\_\_\_

Preventive measures for this journey: \_\_\_\_\_

Further details: \_\_\_\_\_

(h) Have a chronic respiratory condition (such as Asthma, CF, Chronic Bronchitis, Bronchiectasis, Emphysema, COAD, COPD)? **Y**  **N**

Condition: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Last exacerbation requiring hospital admission: \_\_\_\_\_

Does the passenger require home oxygen therapy? **Y**  **N**

Does the passenger require oxygen for the journey? **Y**  **N**

(i) Any other condition that requires ongoing treatment with prednisone or other immunosuppressant therapy (eg: arthritis, colitis, multiple sclerosis etc)? **Y**  **N**

Name of condition: \_\_\_\_\_

Current medication and dosage: \_\_\_\_\_

Last exacerbation requiring hospital admission: \_\_\_\_\_

Further details: \_\_\_\_\_

(j) Been a hospital patient in the last 24 months for any other reason (including day surgery and emergency department)? **Y**  **N**

(If one of these attendances was for a routine colonoscopy, please indicate whether the result was normal)

Date: / / \_\_\_\_\_

Reason: \_\_\_\_\_

Further details: \_\_\_\_\_

(k) Have they seen any specialists in the past year for a condition or disease not yet described? **Y**  **N**

Type of specialist: \_\_\_\_\_

Major diagnosis: \_\_\_\_\_

Type of specialist: \_\_\_\_\_

Major diagnosis: \_\_\_\_\_

Type of specialist: \_\_\_\_\_

Major diagnosis: \_\_\_\_\_

(l) Are you aware of any other symptoms, conditions or disease not yet described? **Y**  **N**

| Medical condition | Current medication/treatment |
|-------------------|------------------------------|
| 1                 |                              |
| 2                 |                              |
| 3                 |                              |
| 4                 |                              |
| 5                 |                              |

**12. Doctor's Declaration:**

Travel overseas, particularly by commercial aircraft, places significant stress on individuals with a medical condition which may result in decompensation. This fact must be taken into account when completing the medical declaration.

In your opinion is your patient medically fit to undertake the proposed journey without suffering a medical episode? **Y**  **N**

I hereby declare that the information detailed on this form is accurate and complete and that no information has been withheld which may influence the insurer.

Signature of Physician: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: / / \_\_\_\_\_

Qualifications: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Doctor's Stamp and Initial:

81 and Over

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# 81 Years and Over Medical Declaration Form

Effective 30 June 2008

## Privacy Policy

We (Allianz and our agent Mondial Assistance) require your informed permission to collect, use and disclose your personal information for the following purposes:

- (a) Assessing your request for travel insurance in respect of your known medical conditions;
- and**
- (b) Arranging and managing your travel insurance if we accept risk. In the course of undertaking our functions and activities as stated above, it may be necessary to collect from and disclose to the following third parties your personal information (including sensitive information and health information):
  - (c) Medical practitioners;
  - (b) Health service providers;
  - (c) Hospitals and clinics;
  - (d) International assistance providers; and
  - (e) Any other person we deem necessary.

Except as stated above or as otherwise required or authorised by law, we will not collect, use or disclose your personal information to any other third party without your prior knowledge or consent. Collection of your personal information is governed by the Privacy Act 1988 (Cth) and/or with your consent. You are permitted to access your information held by us and should contact our Privacy Officer if you wish to do so or if you have any questions about the way we handle your personal information. If necessary personal information is not provided, we will be unable to do business with you.

**For any questions please call our dedicated  
Pre-existing Medical Team on 1800 22 7771**

**Mondial Assistance**

**Postal Address: PO Box 162, TOOWONG QLD 4066**

**Phone: 1800 22 7771 Fax: (07) 3305 7006 Email: [medical-assessments@mondial-assistance.com.au](mailto:medical-assessments@mondial-assistance.com.au)**

This insurance is arranged and managed by ETI Australia Pty Ltd, trading as Mondial Assistance, ABN 52 097 227 177, AFSL 245631 and is issued and underwritten by Allianz Australia Insurance Limited, ABN 15 000 122 850, AFSL 234708