

Please Ensure You Read This Information Before Completing This Form

We WILL NOT PAY any claim if you are aged 70 years or over at the time the Certificate of Insurance is to be issued or a claim arising as a result of, or exacerbated by, or consequential upon your existing medical condition UNLESS you have applied for cover, we have agreed to cover you and you have paid any additional premium we ask for. You MUST apply for cover and cover must be approved by us in writing prior to the issue of a Certificate of Insurance if:

- you have an existing medical condition; or
- you are a resident of Australia and are 70 years of age or over; or
- you have answered yes to the question in the application regarding undergoing or have undergone or been referred for any tests or investigations into any undiagnosed or suspected medical condition.

An existing medical condition is:

- any chronic or ongoing (whether chronic or otherwise) medical or dental condition, illness or disease of which you were aware or should reasonably have been aware, and which is medically documented or under investigation prior to the issue of the Certificate of Insurance; or
- any physical, mental illness or medical condition (including pregnancy), defect, illness or disease of which you were aware or should reasonably have been aware, and for which treatment, medication, preventative medication, advice, preventative advice or investigation has been received or prescribed by a medical or dental adviser in the 60 days prior to the issue of the Certificate of Insurance and in the case of the Annual Multi Trip Travel Plan also within 30 days prior to booking a particular trip.

Note:

- Where any condition is the subject of an investigation, that condition falls within this definition, regardless of whether a diagnosis of the condition has been made.
- This definition applies to you, your travelling party, your relatives, your business colleague(s), or any other person you have a relationship with whose state of health could impact your travel plans.

The Following Medical Conditions Do Not Require You To Apply For Cover

Provided the following existing medical conditions are stable and you or anyone else to be covered are not waiting for treatment, on a hospital waiting list or awaiting results of medical tests or investigation in relation to any of these conditions cover is provided without medical application

- **Acne**
- **Allergies** - such as allergic rhinitis, chronic rhinitis, hayfever, sinusitis, anaphylaxis, dermatitis, eczema, psoriasis, urticaria, food intolerance, latex allergy
- **Anaemia** - including iron deficiency anaemia, B12 deficiency, folate deficiency, pernicious anaemia
- **Asthma** - not requiring cortisone medication or hospitalisation for the past 12 months including as an outpatient
- **Bell's palsy**
- **Benign breast or renal cysts**
- **Bunions**
- **Carpal Tunnel syndrome**
- **Cataracts, dry eye syndrome, glaucoma, macular degeneration**
- **Coeliac disease**
- **Colonic polyps**
- **Congenital blindness/deafness**
- **Diabetes Mellitus Types 1 and 2** - where you have no known cardiovascular, hypertensive, vascular disease and no related kidney, eye or neuropathy complications
- **Epilepsy** - you have been seizure free for the past 12 months and do not require more than 1 anti-seizure medication
- **Goitre, hypothyroidism, Hashimotos disease, Graves disease**
- **Gout**
- **Hiatus hernia/Gastro-oesophageal reflux disease, Peptic ulcer disease**
- **High Cholesterol (Hypercholesterolaemia)**
- **High Lipids (Hyperlipidaemia)**
- **Insulin resistance, impaired glucose tolerance**
- **Incontinence**
- **Meniere's disease, Tinnitus**
- **Menopause**
- **Migraines** except where you have been hospitalised in the past 12 months
- **Nocturnal cramps**
- **Osteoporosis** - whereby there has been no fractures and you do not require more than 1 medication
- **Plantar fasciitis**
- **Raynaud's Disease**
- **Sleep apnoea**
- **Stable High Blood Pressure (Hypertension)**
- **Trigeminal neuralgia**
- **Trigger finger**
- **Routine screening tests where no underlying disease has been detected.**

One Travellers Medical Appraisal Form per applicant needs to be completed and submitted, via our Distributor, for review by us. Once reviewed we:

- may offer you insurance; and
- may provide cover for an existing medical condition on either a full or restricted basis. A Travellers Appraisal Number will be issued and you will be advised of the additional premium payable; or
- will advise you that we are unable to insure for an existing medical condition;
- may offer altered terms and conditions to the policy.

IF OFFERED, COVER FOR AN EXISTING MEDICAL CONDITION MUST BE TAKEN UP WITHIN 14 DAYS OF THE APPROVAL DATE AND A TRAVELLERS APPRAISAL NUMBER MUST APPEAR ON YOUR CERTIFICATE OF INSURANCE.

What Forms Need To Be Completed To Apply For Cover?

Not available to Australian Cancellation And Additional Expenses, VFR and Inbound Travel Plans or after departure	APPLICATION FORM on PDS	TRAVELLERS' MEDICAL APPRAISAL FORM	
		PART A	PART B
INTERNATIONAL TRAVEL PLAN			
0 - 69 YEARS REQUIRING COVER FOR EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
70 YEARS OR OVER REGARDLESS OF HEALTH	✓	✓	✓
ANNUAL MULTI TRIP TRAVEL PLAN			
0 - 69 YEARS REQUIRING COVER FOR EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
70 YEARS OR OVER REGARDLESS OF HEALTH		NOT AVAILABLE	
AUSTRALIAN TRAVEL PLAN			
ALL AGE GROUPS REQUIRING COVER FOR EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗

Destination

This is the maximum duration we will consider to cover you for each of the listed destinations.

	USA, CANADA, SOUTH AND CENTRAL AMERICA AND ANTARCTICA.	CONTINENTAL EUROPE, MIDDLE EAST, JAPAN AND AFRICA.	UK, ASIA AND TAHITI.	PACIFIC REGION AND INDONESIA.
UNDER 70 YEARS OF AGE	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS
BETWEEN 70 - 74 YEARS	3 MONTHS	4 MONTHS	12 MONTHS	12 MONTHS
BETWEEN 75 - 79 YEARS	3 MONTHS	3 MONTHS	6 MONTHS	6 MONTHS
80 YEARS AND OVER	4 WEEKS	8 WEEKS	3 MONTHS	3 MONTHS

Privacy

If you would prefer for your application and Travellers Medical Appraisal Form to be processed directly, mark the form "Confidential" and fax to our Medical Appraisal Department on (03) 8805 2961.

NOTE: IF THERE IS INSUFFICIENT SPACE ON THIS FORM ATTACH A SEPARATE SHEET.

Travel Agent's Name & Address
 Name:
 Address:

Part A - To Be Completed By Each Applicant

When complete fax Medical Appraisal Form to (03) 8805 2961

NOTE: IF THERE IS INSUFFICIENT SPACE ON THIS FORM ATTACH A SEPARATE SHEET.

Title Full Name

I am applying for cover for an existing medical condition. Yes No
 I have answered Yes to Question 2 on page 3 of the application form regarding tests or investigations Yes No

Date of Birth / / Postcode

Male Female Height Weight

Phone (Home/Mobile) Phone (Work)

Email

Country/ies to be visited

Flights Cruises Snow Sports Trekking Trip Value \$

Travel Dates / / to / /

Agency Name Consultant Name

Agency Phone Agency Fax

Have you booked your travel arrangements through this Agency? Yes No
 Policy Selected International Australian Annual Multi Trip

In most cases if you answer the questions fully and accurately we will be able to process your application for travel insurance on the information supplied. In certain circumstances we may ask you to have our Doctor's Declaration completed by your usual Medical Practitioner before cover can be assessed.

GENERAL HEALTH QUESTIONS

Can you walk 50 metres unaided? Yes No

Do you require a wheelchair for the trip? Yes No

Are you currently a smoker? Yes No

If you have quit smoking, how many years since you last smoked?

Do you need oxygen, CPAP or have any other special travel requirements? Yes No

If yes to any of the above please give details:

Have you been hospitalised in the past 3 years for any reason? Yes No
 Date and details including treatment

Have you;

Suffered from any form of heart condition? Yes No

Suffered from any vascular condition, stroke or TIA? Yes No

Suffered from any form of cancer or malignancy? Yes No

Suffered from any respiratory conditions (including asthma)? Yes No

Suffered from any psychiatric conditions including stress, anxiety, depression or any other mental condition? Yes No

Are you;

Travelling to obtain medical treatment? Yes No

Suffering from a terminal condition or registered with palliative care? Yes No

Suffering from metastatic cancer or secondaries? Yes No

Awaiting any medical tests/investigations or treatment? Yes No

Suffering from any other medical condition? Yes No

Pregnant? Yes No

A. HEART CONDITIONS

What is the heart condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

Please give details, including dates of any of the following: Bypass surgery, angioplasty or stenting, valve replacements or any other corrective heart surgery.

Please give details, including dates of any of the following: Heart attack, heart failure, cardiomyopathy, ventricular failure or valve disease.

Please give details of any proposed surgery, tests or treatment.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

B. VASCULAR CONDITIONS

What is the vascular condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology, angiograms or pathology for this condition in the past 2 years please give details and results if known.

Please give details, including dates of carotid artery surgery, angioplasty, stenting or any other corrective surgery.

Please give details, including dates including the dates of stroke, TIA (transient ischemic attack), peripheral vascular disease or aneurysm, pulmonary embolus, deep vein thrombosis (clot).

Please give details of any claudication (pains in the legs due to vascular disease) or lower limb ulcers.

Please give details of any proposed surgery, tests or treatment.

Dates and details of hospitalisation for vascular condition.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

Travel Agent's Name & Address

Name:
Address:

APPLICANT DETAILS

Title Full Name

[Title] [Full Name]

C. RESPIRATORY CONDITIONS

What is the respiratory condition?
[]

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.
[]
[]

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.
[]
[]

Please give details of bronchitis or chest infections that occur with asthma.
[]
[]

How often and when did you last require antibiotics?
[]
[]

Please give details of how often and when did you last require cortisone (prednisolone).
[]
[]

Please give details of any proposed surgery, tests or treatment.
[]
[]

Please give a brief history of the condition and how it affects you.
[]
[]

What is your treatment? Please include all medications you are currently taking.
[]
[]

D. PREGNANCY

Are you currently pregnant? Yes No Due Date [] / [] / []

How many weeks will you be when you travel? []

Was the pregnancy assisted by artificial reproductive techniques, eg IVF? Yes No
If yes please give details

[]
[]

Please give details if you have had previous miscarriages.
[]
[]

Please give details if you have suffered any pregnancy related complications either in this or in previous pregnancies.
[]
[]

Please give details of any special recommendations made by your doctor in regard to this trip.
[]
[]

E. CANCER

What is the condition?
[]

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.
[]
[]

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

[]
[]

Please give details of any proposed surgery, tests or treatment.
[]
[]

Please give a brief history of the condition and how it affects you.
[]
[]

What is your treatment? Please include all medications you are currently taking.
[]
[]

F. MEDICAL CONDITION

What is the condition?
[]
[]

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.
[]
[]

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.
[]
[]

Please give details of any proposed surgery, tests or treatment.
[]
[]

Please give a brief history of the condition and how it affects you.
[]
[]

What is your treatment? Please include all medications you are currently taking.
[]
[]

G. UNDIAGNOSED OR SUSPECT CONDITION

Please give details of any tests, investigations, doctors visits or referrals to specialists you would like to disclose.
[]
[]

Please give details if any of these tests, investigations, doctors visits or referrals have been completed.
[]
[]

Please give details if you know the results.
[]
[]

Please give details if you have been told the purpose of the tests, investigations, doctors visits or referrals to specialists.
[]
[]

What possible diagnosis has the doctor told you could be the outcome of the above investigations etc?
[]
[]

Declaration: I have read and retained a copy of the PDS. I consent to the collection, use and disclosure of my health information for the purposes outlined in the Privacy section of the PDS. I agree that I will not be covered for any Existing Medical Condition unless the insurance company has agreed to insure those conditions. I agree that cover will not include replacement medication or maintaining a course of treatment commenced before the trip. I understand that should cover be given for any Existing Medical Condition, it will be for UNEXPECTED TREATMENT ONLY.

Signature [] Date [] / [] / []

(The signatory must be 18 years of age or over and is authorised to sign on behalf of all named persons.)



Doctors Declaration Part B - To Be Completed By Applicant's Doctor

When complete fax the Application Form and this Medical Appraisal Form to: (03) 8805 2961

PART B must be completed by your usual medical practitioner if:

- you are 70 years of age or over and wish to purchase an International Travel Plan; or
- after we reviewed part A we requested more information.

Travel Agent's Name & Address

APPLICANT DETAILS

Title Full Name

Date of Birth / /

Your patient has asked you to complete this form as part of their travel insurance application. Please disclose all medical conditions as failure to disclose a condition means that your patient has no cover for the undisclosed condition.

Existing medical condition(s) means:

- any chronic or ongoing (whether chronic or otherwise) medical or dental condition, illness or disease of which you were aware or should reasonably have been aware, and which is medically documented or under investigation prior to the issue of the Certificate of Insurance; or
- any physical, mental illness or medical condition (including pregnancy), defect, illness or disease of which you were aware or should reasonably have been aware, and for which treatment, medication, preventative medication, advice, preventative advice or investigation has been received or prescribed by a medical or dental adviser in the 60 days prior to the issue of the Certificate of Insurance and in the case of the Annual Multi Trip Plan also within 30 days prior to booking a particular trip.

Note:

- Where any condition is the subject of an investigation, that condition falls within this definition, regardless of whether or not a diagnosis of the condition has been made.
- This definition applies to the traveller, their travelling party, and their relatives, business partner or any other person whose state of health could impact their travel plans.

What are the patients active medical conditions?

Details of treatment and medications

Details of past medical history

Details of any hospitalisations you know the patient to have had

Has your patient had ANY history of:

- Hypertension? / .
- Portal Hypertension? / .
- Angina? Frequency of attacks
- Heart Failure? CCF LVF Cardiomyopathy IHD Angiography Valvular Disease Stenting C.A.G.S Other

• Diabetes? Type

Diabetes Complications?

• Respiratory condition(s)? Asthma Bronchitis COAD COPD

Has your patient ever required oxygen? Yes No
Any other conditions or disease?

Is there any planned surgery test or treatment? Yes No
Please give details

Does your patient have any undiagnosed or suspected condition(s)? Yes No
Please give details of any tests/investigations/referrals that have been completed

Have you told your patient the purpose of the tests/investigation or referrals? Yes No
Please give details

What possible diagnosis have you told your patient/the family could be the outcome of the above investigations etc?

In your opinion is the patient fit to undertake the trip without requiring any additional medical attention in connection with any condition currently under treatment? Yes No
Have you provided a medical referral to any overseas medical practitioner or hospital?
 Yes No Why?

Is your patient suffering from a terminal condition? Yes No

Is your patient suffering from a metastatic condition? Yes No

Has your patient been referred to palliative care, district nursing or other home assistance?

Does your patient need other special requirements for the trip? Yes No

Is your patient travelling to seek medical advice? Yes No

Is your patient attending any specialists e.g. cardiologists etc? Yes No

If so, provide copies of recent review

Any other comments/details you wish to add?

Doctor's Signature Phone ()

Doctor's Name

Address

Postcode

Qualifications Date / /

Email

Fax ()