



Travellers Medical Appraisal Form For Non Travelling Relative/Business Partner

Enquires: Customer Service Centre on 1300 791 948 or (02) 9701 6500

Please Ensure You Read This Information Before Completing This Form

The Travellers Medical Appraisal Form must be **CLEARLY COMPLETED IN BLOCK LETTERS**. Return completed forms to our Distributor.

Existing Medical Condition Of A Non Travelling Relative Or Business Partner

(Not available to Deposit Protection, Australian Cancellation And Additional Expenses, VFR or Inbound Travel Plans, after departure or to non residents of Australia.)

Provided your non travelling relative or business partner is under 80 years of age at the time the Certificate of Insurance is to be issued you can apply to cover their existing medical condition if their state of health could disrupt your travel plans even though they are not travelling with you.

Complete your application form and this form and submit for approval, via our Distributor. If cover is approved you will be advised of any additional premium payable and of any special terms imposed.

If you do not select this additional benefit there will be no cover if your trip is cancelled, cut short or disrupted as a result of your non travelling relative's or business partner's existing medical condition.

An Existing Medical Condition is:

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.

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 you, your travelling party, your relatives, your business colleague, or any other person you have a relationship with whose state of health could impact your travel plans.

Once we have reviewed this form:

- We may offer you insurance; and
- We may provide cover for an existing medical condition. A Travellers Appraisal Number will be issued and you will be advised of the additional amount payable; or
- We will advise you that we are unable to insure for an existing medical condition

IF OFFERED, COVER FOR AN EXISTING MEDICAL CONDITION MUST BE TAKEN UP WITHIN 14 DAYS OF THE APPROVAL DATE.

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 1300 327 275.

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



Non Travelling Relative/Business Partner Medical Appraisal Form

Cover optional however not available on Deposit Protection, Australian Cancellation And Additional Expenses, VFR or Inbound Travel Plans, after departure or to non residents of Australia, or if Non Travelling Relative or Business Partner is 80 years of age or over.

When completed fax to: 1300 327 275

Part A To Be Completed By You, The Traveller

Travel Agent's Name and Address

Consultant's Name

Phone () Fax ()

Name of persons travelling Relationship

Phone Work () Home/Mobile ()

Email

Country/ies to be visited

Travel Dates / / to / / Trip Value \$

Policy Selected International Australian

Travel Plan Selected (Refer to the PDS)

Part B To Be Completed By Non Traveller

Title Full Name

Postcode

Height Weight Date of Birth / /

Have you been hospitalised or attended an Emergency Department in the past 12 months? Yes No

Details Date / /

List details of your visit(s) to a Doctor including a Specialist over the past 12 months;

Reason Date / /

Reason Date / /

Reason Date / /

List any treatment or medication you have had in the past 12 months?

Have you ever had Cancer? Yes No

Treatment Date / /

Have you ever had Heart Disease? Yes No

Treatment Date / /

Do you smoke Cigarettes? Yes No If Yes, how many per day?

Declaration: I consent to the collection, use and disclosure of my health information for the purpose of assessment and provision of travel insurance to my relative or business partner. I authorise any hospital or medical adviser who has attended to, or examined me, to disclose any or all information regarding the treatment given for any condition related to the declaration Signature Date / /

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

Part C Doctor's Declaration

Are you the patient's usual Medical Practitioner? Yes No If so, how long?

List the nature and extent of Existing Medical Condition(s) (refer to front page) in the past 12 months.

Condition First Consulted / /

Medication Last Consulted / /

Condition First Consulted / /

Medication Last Consulted / /

Condition First Consulted / /

Medication Last Consulted / /

Condition First Consulted / /

Medication Last Consulted / /

What other medication has this patient taken in the last 12 months? (e.g. chemotherapy, Ab's etc)

Has your patient had ANY history of: • Hypertension? / .

• Angina? Last Attack / / Frequency of attacks

• Heart Failure? CCF LVF Cardiomyopathy IHD Angiography Stenting C.A.G.S Other

• Diabetes? Type

• Respiratory condition(s)? Asthma Bronchitis COAD COPD

Details

Any other conditions or disease? Details

Are any of the conditions mentioned under review or unstable? If so, give details

Is your patient currently in hospital/nursing home? Yes No

Are you aware of any recent deterioration, changes, planned surgery or reviews that may require the passenger to cancel the trip? Yes No

Details

Is your patient suffering from a terminal condition? Yes No

Details

Is your patient suffering from a malignant condition? Yes No

Details

Is there any planned surgery or treatment in the future? Yes No

Details

Any other comments/details you wish to add?

Doctor's Signature Phone ()

Doctor's Name

Address Postcode

Qualifications Date / /

Email Fax ()