

## Not Automatically Covered Existing Medical Conditions And Known Pregnancies

- If your condition is not a "Self Assessment" condition (see your Cover-More™ travel insurance brochure) you may be able to be covered by applying using this form.
- Existing Medical Condition cover is not available under any circumstances for certain conditions. These conditions include:
  - Back or Neck conditions
  - Food/drug allergies
  - The conditions named in "We Will Not Pay For" No.14 in our policy
  - Dental Conditions

## Not Automatically Covered Existing Medical Conditions And Known Pregnancies - Minimum Additional Premium (Pay Your Travel Agent If Accepted)

- These premiums apply for each person who has an Existing Medical Condition/Known Pregnancy which is not automatically covered and who wants to be covered for the condition.
- If you are travelling on a policy covering two adults and (if approved) you pay the additional premium to cover your Existing Medical Conditions/ Known Pregnancy, your family/travelling companion will also be covered for claims against the "amendment or cancellation costs" section arising from your condition/ pregnancy.
- The actual amount payable will sometimes be higher than the amounts shown below, which are minimums.
- **Options, Essentials and Daily Rate Business Policies** (includes any G.S.T. applicable)

Plan/ Area	Days						Weeks						Months									
	5	8	12	16	23	31	5	6	7	8	9	10	3	4	5	6	7	8	9	10	11	12
1	64	67	69	74	84	99	103	109	115	120	127	134	144	160	181	197	222	240	254	270	292	305
2	61	63	65	67	71	76	78	82	85	88	91	95	100	110	120	128	140	150	158	168	178	182
3	60	62	63	65	69	74	77	79	83	86	90	93	98	107	117	128	136	145	153	162	173	178
4	55	55	56	57	59	61	62	63	65	66	67	68	72	76	80	84	-	-	-	-	-	-
D, DA50	50	50	50	50	50	50	50	50	50	50	50	50	-	-	-	-	-	-	-	-	-	-

- **Annual Rate Business Policy** (includes any G.S.T. applicable): \$100  
You do not have to re-apply for cover for each journey. You must however advise us immediately of any change(s) to the medical condition(s).

## Important Information To Be Read Before Completing Overleaf

- You can only apply for cover through a travel agency which has attended to your travel arrangements.
- Once you have completed this form please fax or mail it to us. Within approximately two working days of receiving it a letter will be sent to you and/or our agent advising of our decision, or one of our nurses will telephone you. If you cannot be contacted by phone during normal business hours please phone us after two working days to follow up your application.

## Duty Of Disclosure

You have a legal duty of disclosure to us whenever you apply for, or change an insurance policy.

### What You Must Tell Us

You have a general duty to disclose to us everything that you know, or could reasonably be expected to know, is relevant to our decision whether to insure you, and, if we do, on what terms. However, your duty does not require you to disclose anything

- that reduces the risk to be undertaken by us;
- that is generally well known;
- that we know or, in the ordinary course of our business, ought to know; or
- in respect of which we have waived your duty.

### Your General Duty Applies To Changes

Your general duty applies in full when you change or reinstate the insurance policy.

### Your General Duty is Limited For New Policies

When you apply for a new policy your duty of disclosure applies, but you do not need to disclose something to us unless we specifically ask you about it. However, you must be honest in answering any questions we ask you. You have a legal duty to tell us anything you know, and which a reasonable person in your circumstances would include in answering the questions. We will use the answers in deciding whether to insure you and anyone else to be insured under the policy, and on what terms.

### If You Do Not Tell Us

If you do not answer our questions honestly or do not properly disclose to us, we may reduce or refuse to pay a claim or may cancel the policy. If you act fraudulently in answering our questions or not disclosing to us, we may refuse to pay a claim or treat the policy as never having existed.

## Please Answer YES Or NO To The Following Questions:

- I am 70 years of age or older, would like to purchase an international policy, but a premium for my age, destination and duration is **NOT** shown in the travel insurance brochure. YES  NO
- I wish to apply for Existing Medical Condition(s) and/or some Known Pregnancies cover, and if approved I am willing to pay the minimum extra premium shown on page 1 of this form. YES  NO
- I have haemophilia, a heart condition, lung condition (other than asthma satisfying the criteria under the "Self Assessment" section), dementia, reduced immunity (eg. as a result of medication or a medical condition) or a condition with a terminal prognosis. YES  NO

If you answered "Yes" to question 1 or 3 you must submit this form. We will advise whether we can provide a policy, and if so, on what terms.

If you only answered "Yes" to question 2 please continue to fill in this form if you wish to apply for cover for a condition that is not automatically covered.

If you answered "No" to all the above questions you do not need to complete this form. No cover will be provided for claims arising from any Existing Medical Condition(s) and/or Known Pregnancy which is not automatically covered.

## Applicant's Details

Please print clearly

Each applicant must complete a separate form

- |                              |                          |                          |
|------------------------------|--------------------------|--------------------------|
| Surname                      | Given Names              | Title                    |
| <input type="text"/>         | <input type="text"/>     | <input type="text"/>     |
| Address                      |                          | Postcode                 |
| <input type="text"/>         |                          | <input type="text"/>     |
| Home Phone                   | Work Phone               | Fax                      |
| ( ) <input type="text"/>     | ( ) <input type="text"/> | ( ) <input type="text"/> |
| Email (please print clearly) |                          |                          |
| <input type="text"/>         |                          |                          |
- We advise you of the outcome of this assessment in writing. How do you wish to receive it? (Email is quickest)  
Mail  Fax  Email
- Date of Birth Sex Height (m) Weight (kg)  

<input type="text"/> / <input type="text"/> / <input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
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- Have you smoked in the last 6 months? YES  NO
- Departure Date  /  /  Return Date  /  /
- What is the total value of this journey? \$
- Policy Type (Options/Business/Essentials etc.)
- Did you apply for cover for this journey from any other insurer? YES  NO   
(If yes, with which insurer)
- If your cover was denied, or if you had special terms and conditions placed on your policy, please include a copy of your other assessment forms with this application
- If you are pregnant, what is your estimated date of delivery?  /  /
- Do you play sport or exercise regularly? YES  NO   
(If yes, provide details below)
- If you suffer from epilepsy, have you had a fit in the last 2 years? YES  NO
- If you are currently receiving treatment (including medication) for your blood pressure what was your last recording? On what date was this recorded?  
 /  /
- Have you ever been diagnosed as having a heart condition? YES  NO
- Have you had a heart bypass or angioplasty? YES  NO   
*If you answered 'Yes' to question 16 or 17, please ensure your doctor completes page 4 of this form*
- If you suffer from diabetes, what was your last blood sugar level? On what date was this recorded?  
 /  /

## Contact People

- Issuing Agency  

.....	
Location .....	Phone (.....)
Consultant .....	Fax (.....)
Email .....	
- Specialist's Name  
 Phone ( )
- G.P.'s Name  
 Phone ( )
- If you do not have a good understanding of English, please provide the name and number of a person who can discuss your health with us  

Name .....
Relationship .....
Phone ( )

**Proposed Journey For Which Cover Is Sought Please list all destinations (If insufficient space is provided, please attach a list)**

23. Country	Length of Stay	Country	Length of Stay	Country	Length of Stay
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Details Of All Existing Medical Condition(s) (If insufficient space is provided, please attach a list)**

You must provide details of **ALL** Existing Medical Conditions of which you are aware and **ALL** medication taken, including any treatment or advice given by any doctor, physiotherapist, chiropractor, naturopath, etc. If you are unsure which Existing Medical Conditions you have, please have your doctor complete this section.

24. Medical Condition(s)	Date Diagnosed	Medication Taken	How often medication taken
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>

25. Is your current medication the same medication, strength and frequency as you were taking 3 months ago? YES  NO

**Medical Treatment (If insufficient space is provided, please attach a list)**

26. In the last 2 years have you had any medical problems while overseas? (If yes, provide details below) YES  NO

Date	Details
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

27. Have you been treated in hospital in the last 12 months? (If yes, provide details below) YES  NO

Date	Details
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

28. Have you visited a doctor in the last 90 days? (If yes, provide details below) YES  NO

Date	Details
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

**29. MEDICAL AUTHORITY AND DECLARATION**

I authorise any hospital or medical adviser who has attended to or examined me to furnish to the insurer or its representative any and all information in respect of treatment given for any condition related to this application. A photocopy or facsimile copy of this authority shall be considered as valid as the original.

I declare that I have read all the questions and answers and that all information provided in this application and any attachments is/will be truthful and no information has/will be withheld which may influence the insurer in its assessment of the proposed risk. I acknowledge my Duty of Disclosure as detailed on page 1. I have read the privacy information in the Product Disclosure Statement and consent to the collection, use and disclosure of my health information for the purposes outlined within it.

Signature of Applicant	Print Name	Date
<input type="text"/> X	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

30. I consent to you faxing the outcome of this assessment to the issuing agency. YES  NO

**Additional Information Required From Applicants Aged 70 Years Or Over**

31. If approved are you willing to pay the extra premium (shown on page 1 of this form) for Existing Medical Condition cover for the condition(s) you listed above on this form? YES  NO

If you answered 'No', cover will not be provided for any Existing Medical Condition unless it is a condition which is automatically covered.

32. Have you ever had a heart attack, chest pain, stroke or hip or knee replacement? YES  NO

If yes, please ensure you have provided details above.

# Cover-More™ Assessment Form – Heart Condition

Important: Please complete pages 2 and 3 before proceeding

To be completed by YOUR DOCTOR

Only To Be Completed If You Wish To Apply For Cover For A Heart Condition.

Once you have completed pages 2 and 3 this page must be completed (at your own cost) by your doctor

## Patient's Details

A separate form must be completed for each patient

33. Surname  Given Names  Date of Birth  /  /

34. Are you this patient's usual treating doctor YES  NO  How long have you known them?

35. Details of ALL Cardiac Conditions and Existing Medical Condition(s). You must also provide details of ALL medication taken and any treatment or advice given by any doctor (If insufficient space is provided please attach a list).

Cardiac and/or Related Existing Medical Condition(s)	Medication Taken	How often medication taken
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

36. Blood Pressure  Date of Reading  /  /  Heart Rate  Date of Reading  /  /  Cholesterol Level  Date of Reading  /  /

37. Is the current medication the same medication, strength and frequency as the medication prescribed 3 months ago? YES  NO

38. Has an Echocardiogram, Angiogram or stress test been performed? YES  NO   
*If Yes, please attach the results and findings of these or any other relevant tests.*

39. Have you attached the relevant results? YES  NO   
*If No, we may need to contact you to obtain further information.*

40. Does the patient suffer angina? YES  NO   
 If Yes, when was the last attack, what is the frequency of attacks and is the angina stable or unstable?

41. Has corrective surgery been performed? YES  NO   
 If Yes, what type/s, date/s and with what result?

42. Were any complications experienced after the procedure/s described above? YES  NO   
 If Yes, please provide details:

43. Which arteries were treated?

44. What is the patient's current INR level (if applicable)?

45. Has the patient been advised to have a valve repair or replacement? YES  NO

46. If Yes to question 45, has the patient had the procedure? YES  NO

**If Yes, please advise month and year:**

**If No, when is the patient likely to have the procedure?**

47. Has the patient ever been cardioverted? YES  NO   
 If Yes, please give indication:

48. Will the patient require follow-up for Cardiac Arrhythmia? YES  NO

49. Has the patient ever been diagnosed or treated for CCF / LVF / RVF/ Pulmonary Oedema? YES  NO

**General**  
 Please detail any special requirements of the patient whilst travelling on the proposed journey.

Please detail any other matters which you feel an insurer should be aware of in assessing the medical insurance risk of the patient.

**Declaration**  
 I hereby declare that the information detailed on this form and in attachments 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

(  ) (  )