

## 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 amount 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, or which is medically documented or under investigation in the 12 months 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, or for which treatment, medication, preventative medication, advice, preventative advice or investigation have 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 of booking a particular trip.

Note:

- Where any condition, illness or disease is the subject of an investigation, that condition, illness or disease falls within this definition, regardless of whether or not a diagnosis of the condition, illness or disease has been made.
- This definition applies regardless of whether or not the condition, illness or disease displays symptoms.
- 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 on 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** - provided you are under 60 years of age and you have not required cortisone medication, except taken by inhaler or puffer, or hospitalisation for the past 12 months including as an outpatient.
- **Bell's palsy**
- **Benign breast cysts**
- **Bunions**
- **Carpal Tunnel syndrome**
- **Coeliac disease**
- **Congenital blindness/deafness**
- **Diabetes Mellitus Types 1 and 2** - where you have no known cardiovascular, hypertensive, vascular disease, no related kidney, eye or neuropathy complications
- **Epilepsy** - you have been seizure free for the past 12 months or do not require more than 1 anti-seizure medication
- **Goitre, hypothyroidism, Hashimoto's disease, Graves disease**
- **Hiatus hernia/Gastro-oesophageal reflux disease, Peptic ulcer disease**
- **High Cholesterol (Hypercholesterolaemia)**
- **High Lipids (Hyperlipidaemia)**
- **Insulin resistance, impaired glucose tolerance**
- **Incontinence**
- **Menopause**
- **Migraines except where you have been hospitalised in the past 12 months**
- **Nocturnal cramps**
- **Osteoporosis** - where there have been no fractures and you do not require more than 1 medication or suffer any back pain condition
- **Plantar fasciitis**
- **Raynaud's Disease**
- **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 representative, 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 amount payable; or
- will advise you that we are unable to insure for an existing medical condition; or
- 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, Elements and Inbound Travel Plans or after departure.	APPLICATION FORM on PDS	TRAVELLERS' MEDICAL APPRAISAL FORM	
		PART A	PART B
<b>INTERNATIONAL TRAVEL PLAN (Residents of Australia)</b>			
0 - 69 YEARS WITH EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
70 YEARS OR OVER REGARDLESS OF HEALTH	✓	✓	✓
<b>INTERNATIONAL TRAVEL PLAN (Non-residents of Australia)</b>			
0 - 59 YEARS WITH EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
60 YEARS OR OVER REGARDLESS OF HEALTH		NOT AVAILABLE	
<b>ANNUAL MULTI TRIP TRAVEL PLAN</b>			
0 - 69 YEARS WITH EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
70 YEARS OR OVER REGARDLESS OF HEALTH		NOT AVAILABLE	
<b>AUSTRALIAN TRAVEL PLAN (Residents of Australia)</b>			
ALL AGE GROUPS REQUIRING COVER FOR EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
<b>AUSTRALIAN TRAVEL PLAN (Non-residents of Australia)</b>			
0 - 59 YEARS WITH EXISTING MEDICAL CONDITION(S)	✓	✓ In some cases also Part B to be completed	✗
60 YEARS OR OVER REGARDLESS OF HEALTH		NOT AVAILABLE	

## 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) 8523 2961.

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

Travel Agent's Name & Address  
 Name: TRAVEL INSURANCE COVER  
 Address: PO BOX 1435  
 CROWS NEST NSW 1585  
 info@travelinsurancecover.com.au

QM1771 0310

## Part A - To Be Completed By Each Applicant

When complete fax Medical Appraisal Form to (03) 8523 2961

NOTE: IF INSUFFICIENT SPACE 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 of the Application Form regarding tests or investigations  Yes  No

Date of Birth  /  /  Postcode

Male  Female Height  Weight

Phone (Home/Mobile)  Phone (Work)

Email

Have you applied for travel insurance with QBE within the last 3 years?  Yes  No

Are you spending more than 72 hours in the USA, Canada, South or Central America or Antarctica?  Yes  No

What is the country or region you will be spending the majority of the trip?

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.

QM1771 0310

**Travel Agent's Name & Address**  
 Name: TRAVEL INSURANCE COVER  
 Address: PO BOX 1435  
 CROWS NEST NSW 1585

QM1771 0310

**APPLICANT DETAILS**

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.)

QM1771 0310



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

When complete fax the Application Form and this Medical Appraisal Form to: (03) 8523 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

TRAVEL INSURANCE COVER  
PO BOX 1435  
CROWS NEST NSW 1585

QMI771 0310

## 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.

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, or which is medically documented or under investigation in the 12 months 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, or for which treatment, medication, preventative medication, advice, preventative advice or investigation have 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 of booking a particular trip.

Note:

- Where any condition, illness or disease is the subject of an investigation, that condition, illness or disease falls within this definition, regardless of whether or not a diagnosis of the condition, illness or disease has been made.
- This definition applies regardless of whether or not the condition, illness or disease displays symptoms.
- 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 on your 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

Details

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

QMI771 0310

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