

81 Years and Over

Medical Declaration Form

Effective 1 May 2007

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

Travellers aged 81 years and over

If you are over 81 (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);
- (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 traveling companion or a relative.

* Pregnancy cover is explained on page 17 of the Product Disclosure Statement.

Your condition is not a Pre-existing Medical Condition if your medical condition 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, chiropractic treatment
8. Any mental illness as defined by DSM-IV including;
 - a) Dementia, depression, anxiety, stress or other nervous condition;
 - b) Behavioural diagnoses such as autism; and
 - 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) You have had a stroke or a Transient Ischaemic Attack (TIA) within the past 12 months
10. You have been given a terminal prognosis for any condition with a life expectancy of under 24 months
11. You require home oxygen therapy or you will require oxygen for the journey
12. You have Chronic Renal Failure treated by haemodialysis or peritoneal dialysis
13. You have been diagnosed with Congestive Heart Failure
14. You have full-blown AIDS (not an asymptomatic HIV infection)
15. You have had, or are on a waiting list for an organ transplant

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 infections are also excluded.

Agency Name: _____ Consultant's Name: _____
 Agency Phone No: _____ Fax: _____ 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): _____
 Total cost of trip per person – AUD\$: _____

4. 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: _____

5. Insurance Details

Cover required: Plan A-International Holiday Travel Plan J-Australia Only Plan KA-Australia Only Advance Purchase
 Plan KB-Australia Only Advance Purchase Plan NZ1-New Zealand Only Advance Purchase Plan NZ2-New Zealand Only Advance Purchase

PLEASE NOTE: Pre-existing Medical Condition Cover is not available on other plans.

Have you: (a) Applied for cover for this journey with any other insurer? **Y** **N** If yes, please provide details: _____

PLEASE NOTE: If your cover was denied or any special terms or conditions were applied, please supply a copy of the assessment forms.

(b) Ever made any medical travel insurance claims over AUD\$1,000 in total? **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 your 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: _____ Consultant's Name: _____
 Agency Phone No: _____ Fax: _____ Email: _____

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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.

1. Patient Details

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

2. Cognition

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

Details: 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**

3. 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:

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.

Transferring (i.e. moving on and off a chair or getting in and out of bed) **1** **2** **3** **4**

Meal preparation **1** **2** **3** **4**

Bathing and dressing **1** **2** **3** **4**

Medication administration **1** **2** **3** **4**

Housework (cleaning and washing) **1** **2** **3** **4**

Continence **1** **2** **3** **4**

Doctor's Stamp and Initial:

CONTINUES ON NEXT PAGE

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Personal Details

Surname: _____ Given Names: _____
Date of Birth: / / _____

4. 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-m). 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: _____

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

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

Further Details: _____

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: _____

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 DX: _____

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? **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)?

Condition: _____

Current Treatment: _____

Last exacerbation requiring hospital admission: _____

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 diagnosed with an HIV Infection? **Y** **N**

Latest CD4 count: _____ Date: / / _____

Any AIDS-defining illness? **Y** **N** Further details: _____

(k) Been a hospital patient in the last 24 months for any other reason (including day surgery and emergency department):

Y **N**

Date: / / _____

Reason: _____

Further details: _____

(l) 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: _____

DETAILS: _____

(m) 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 _____

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

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.

Doctor's Declaration:

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: _____

Agency Name:

Consultant's Name:

Agency Phone No:

Fax:

Email:

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Effective 1 May 2007

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.

Mondial Assistance

Postal Address: PO Box 162, TOOWONG QLD 4066

Phone: 1800 023 522 Fax: (07) 3305 7006

Email: 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

**For any questions please call our dedicated
Pre-existing Medical Team on 1800 023 522**

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Phone: 1800 023 522 Fax: (07) 3305 7006 Email: medical-assessments@mondial-assistance.com.au

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