

# Medical Declaration Form Effective Nov 01, 2005

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

**Note: All travellers aged 86 years and over must go directly to pages 2 & 3, to complete and submit their application for medical cover.**

## Travellers under 86 years follow steps 1-3

Do you have a Pre-existing Medical Condition (PE Condition) for which you want to apply for additional cover? (Refer to definition below). If you have a PE Condition (and we decide to cover you), but you do not pay the Pre-existing Medical Premium, you will not be covered for any medical claim related to or associated with your condition.

For example, by not taking pre-existing medical cover, you will have to pay the high costs of overseas health care if you suffer an illness associated with your PE Condition.

## How do I obtain cover for my PE Condition/s?

Unlike some other travel insurance companies, we do not require everyone with a PE Condition to visit their doctor and supply a medical report. By following the steps below, you can see if you are automatically covered or if you need to make an application for cover. In most cases, you will only need to notify us of your PE Condition/s if you make a claim.

## Definition of Pre-Existing Medical Condition

The term PE Condition has a special meaning and is defined below. A Pre-Existing Medical Condition ("PE Condition") means:

- An ongoing medical or dental condition of which you are aware, or related complication you have, or the symptoms of which you are aware; OR
- A medical or dental condition that is currently being, or has been investigated, or treated by a health professional (including dentist or chiropractor); OR
- Any condition for which you take prescribed medicine; OR
- Any condition for which you have had surgery; OR
- Pregnancy.

Note: This definition applies to you, your travelling companion, any relative, or any other person.

## STEP 1 – Automatic Exclusion for some Pre-Existing Conditions

If you have any of the conditions or symptoms outlined below; we **cannot cover you** for any claim relating to or associated with the treatment of that PE Condition. You are **not required** to provide any further information about this condition, as it is automatically excluded from the policy.

Standard travel cover is available even though these conditions are automatically excluded from the policy.

- Neoplasia (cancer) of any kind.
- Any condition for which surgery is planned.
- You have had, or are on a waiting list for an organ transplant.
- You have been given a terminal prognosis for any condition with a life expectancy of under 24 months.
- You require home oxygen therapy.
- Chronic Renal Failure treated by haemodialysis or peritoneal dialysis.
- Chronic pain syndromes managed by a specialist pain management physician or clinic (including back pain).
- HIV infection with an AIDS defining illness.
- Mental illness as defined by DSM-V, including dementia, depression, anxiety, stress or other nervous condition.
- Therapeutic or illicit drug or alcohol addiction.
- Complications of a condition that required surgery in the past 6 months.
- Any condition that is currently under investigation to define a diagnosis.
- Any condition which has ever required spinal or brain surgery.
- Joint replacement surgery over 10 years ago.
- Pregnancy if all or part of your journey occurs when you are past the 26th week of gestation. (i.e. You are 26 weeks or more at the conclusion of your journey).

If NO, go to Step 2:

## STEP 2 – Automatic cover for some Pre-Existing Conditions

You are automatically covered for the PE Conditions below and **you do not need** to submit an application **or pay** an additional premium under the relevant standard Plan.

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| <ol style="list-style-type: none"> <li>Allergies – Any of the following:<br/>Allergic Rhinitis<br/>Anaphylaxis<br/>Bee Sting Allergy<br/>Chronic Sinusitis<br/>Dermatitis<br/>Eczema<br/>Food Intolerance<br/>Hay fever<br/>Latex Allergy<br/>Psoriasis<br/>Rhinitis<br/>Sinusitis<br/>Urticaria</li> <li>Acne</li> <li>Asthma</li> <li>Bells Palsy – idiopathic</li> <li>Benign Breast Cyst</li> <li>Benign Renal Cysts</li> <li>Bunions</li> <li>Carpal Tunnel Syndrome</li> <li>Cataracts</li> <li>Colonic Polyps</li> <li>Congenital blindness</li> <li>Congenital deafness</li> <li>Diabetes – Non Insulin Dependant providing you were diagnosed over 12 months ago and have not had any complications in the 12 months prior to the application for this policy. You must also have a Blood Sugar Level reading between 4 and 10.</li> <li>Dry Eye Syndrome</li> <li>Ear Grommets</li> <li>Epilepsy – If there are no underlying medical conditions (e.g. as result of brain tumours, head injury or strokes) and you are only on one (1) anti-convulsant medication and you have not had a</li> </ol> | <ol style="list-style-type: none"> <li>seizure in the last 12 months.</li> <li>Folate Deficiency</li> <li>Gastro Reflux</li> <li>Glaucoma</li> <li>Goitre</li> <li>Hashimoto's Disease</li> <li>Hiatus Hernia</li> <li>Hypercholesterolaemia (High Cholesterol) – Provided you do not also suffer from a known cardiovascular disease and/or diabetes</li> <li>Hypertension (High Blood Pressure) – Provided you do not also suffer from a known cardiovascular disease and/or diabetes</li> <li>Impaired Glucose Tolerance</li> <li>Incontinence</li> <li>Iron Deficiency Anaemia</li> <li>Macular Degeneration</li> <li>Meniere's Disease</li> <li>Menopause</li> <li>Nocturnal Cramps</li> <li>Ovarian Cysts</li> <li>Pernicious Anaemia</li> <li>Plantar Fasciitis</li> <li>Pregnancy up to 26 weeks gestation where no complications exist relating to this pregnancy, it is not a multiple pregnancy, and the pregnancy is not the result of assisted reproductive programs</li> <li>Raynaud's Disease</li> <li>Solar Keratosis</li> <li>Trans Urethral Resection of the Prostate (TURP)</li> <li>Trigeminal Neuralgia</li> <li>Trigger Finger</li> <li>Vitamin B12 Deficiency</li> </ol> |
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## STEP 3 – Pre-Existing Conditions Requiring Medical Assessment

**PLEASE READ THE LIST BELOW.** If the condition is **not described**, we **do not require** any further information and you **are not required** to complete the Pre-Existing Medical Declaration Form OR see your doctor. You are accepted for cover providing you pay the Pre-Existing Medical Premium.

If you have any condition described in this list, you are required to complete the Pre-Existing Medical Declaration (pages 2 & 3).

- Any condition for which you have been hospitalised in the 24 months prior to purchasing your policy.
- Any condition that requires ongoing treatment with prednisone or other immunosuppressant therapy (eg: arthritis, colitis, chronic respiratory disease etc).
- You have had angina (chest pain) within the past 6 months.
- You have had heart problems requiring coronary angiography, stents or bypass grafting (CABG) in the past 12 months or you had such procedures more than 3 years ago
- You have a Pacemaker or AICD (internal defibrillator).
- You have had a Cerebrovascular Accident (Stroke) or Transient Ischaemic Attack (TIA) in the past 24 months.
- HIV infection.
- Diabetes resulting in eye, kidney, nerve or vascular complications.
- Epilepsy due to an underlying medical conditions (e.g. as result of brain tumours, head injury or strokes) or if you are on two or more anti-convulsant medications, or you have had a seizure in the last 12 months.
- Cystic fibrosis.
- Any past history of Deep Vein Thrombosis (DVT) or Pulmonary Embolism.
- Joint replacement surgery over 10 years ago.
- Pregnancy up to 26 weeks which was the result of artificial reproductive techniques, OR which has had complications, OR is a multiple pregnancy. Expectant mothers should therefore consider whether they travel under this policy, particularly beyond the 20th week of Pregnancy.

If you have any condition described in Step 3, you will need to complete a Pre-Existing Medical Declaration Form, as outlined in Step 4 (over page).

If the condition is not outlined in Step 3, we do not require any further information and you **do not** need to complete a Pre-Existing Medical Assessment application Form or see your doctor. You are accepted for cover providing you pay the relevant Pre-existing Medical Premium.

SureSave Travel Insurance

Postal Address: PO Box 162 Toowong Queensland Australia 4066

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

Agency Name: \_\_\_\_\_ Consultant's Name: \_\_\_\_\_

Agency Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

# Medical Declaration Form Effective Nov 01, 2005

## Step 4: This page to be completed by the traveller.

**Please indicate the reason for completion of this form:**

I am older than 85 years of age and require a Travel Insurance policy.

**OR**

I have a medical condition which is described in Step 3 (Conditions Requiring Medical Assessment) and would like to apply for it to be covered.

We will advise you of the outcome of this assessment in writing within 1 business day **provided both pages of the form have been completed in full and signed.**

Applicant's Details **PLEASE USE BLOCK LETTERS** (a separate application must be completed for each passenger)

**NOTE: Where insufficient space, please attach a separate sheet to provide details**

1. Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Work Ph: \_\_\_\_\_ Home Ph: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

2. Male  Female  Date of Birth: / / Age now: Height: (m) Weight: (kg)

3. Countries to be visited: \_\_\_\_\_

4. (a) Departure Date: \_\_\_\_\_ (b) Return Date: \_\_\_\_\_

5. Cover required: Plan A  Plan C  Plan D  Plan J  Plan KA  Plan KB  Plan NZ1  Plan NZ2

6. Mode of Travel: Aircraft  Car  Coach  Ship

7. Are you intending to Ski: **Y**  **N**  Trek: **Y**  **N**

8. Total Cost of Pre-paid trip: AUD\$: \_\_\_\_\_

9. Have you: (a) Applied for cover for this journey with any other insurer? **Y**  **N**  If yes provide details: \_\_\_\_\_

**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 AU\$1000 in total? **Y**  **N**  If yes provide details: \_\_\_\_\_

10. Do you smoke? **Y**  **N**

11. Do you:

(a) require oxygen for your journey? **Y**  **N**  (b) require a wheelchair for the journey? **Y**  **N**

**Contact Persons**

12. If English is not your preferred language, 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: \_\_\_\_\_

**Passenger's Declaration:**

I confirm that all my answers are correct and complete. I have read and retained a copy of the Suresave 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: / /

Agency Name: \_\_\_\_\_ Consultant's Name: \_\_\_\_\_  
 Agency Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

# Medical Declaration Form Effective Nov 01, 2005

## Doctor's Declaration

This document provides 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 all relevant questions, and provide any "further details" if you believe they will affect our decision to offer cover.

### Patients Details (NOTE: A separate form must be completed for each patient)

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_ Date of Birth: / /

**13.** Are you the patient's usual Medical Practitioner?  Y  N  If not, do you have access to their medical records?  Y  N

If this application is for pregnancy only - please skip section 14.

**All references to time are with regard to the date of this medical assessment.**

**14.** Has your patient:

**(a)** Any condition that requires ongoing treatment with prednisone or other immunosuppressant therapy (eg: COAD, arthritis, colitis, chronic respiratory disease etc).  Y  N

**If yes:** Name of condition: \_\_\_\_\_

Current Medication and dosage: \_\_\_\_\_

Last exacerbation requiring hospital admission: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(b)** Experienced angina within the past 6 months.  Y  N  **If yes:** Frequency of Attacks: \_\_\_\_\_

Stable/Unstable: \_\_\_\_\_

Current Medication: \_\_\_\_\_

Is surgery planned?  Y  N  Further Details: \_\_\_\_\_

**(c)** Required coronary angiography, stents or bypass grafting (CABG)?  Y  N  **If yes:** Type of surgery: \_\_\_\_\_

Which arteries: \_\_\_\_\_

Date/s: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(d)** Had a Pacemaker or AICD (internal defibrillator) fitted?  Y  N  **If yes:** Type of device inserted: \_\_\_\_\_

Reason for insertion: \_\_\_\_\_

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: \_\_\_\_\_

**(e)** Had a Cerebrovascular Accident (Stroke) or Transient Ischaemic Attack (TIA) in the past 24 months?  Y  N  **If yes:** Date: \_\_\_\_\_

Current preventative medications: \_\_\_\_\_

Any resulting deficits: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(f)** Been diagnosed with diabetes mellitus?  Y  N  **If yes:** Type I or Type II: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Are there any kidney, nerve, or vascular complications? \_\_\_\_\_

Has there been an associated hospital admission in the past 12 months? \_\_\_\_\_

Further Details: \_\_\_\_\_

**(g)** Been diagnosed with HIV Infection?  Y  N  **If yes:** Latest CD4 count and date: \_\_\_\_\_

Any AIDS-defining illness? \_\_\_\_\_

Further Details: \_\_\_\_\_

**(h)** Ever been diagnosed with Deep Vein Thrombosis (DVT) or Pulmonary Embolism?  Y  N  **If yes:** Date: \_\_\_\_\_

Contributing factors: \_\_\_\_\_

Preventive measures for this journey: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(i)** Been diagnosed with Cystic fibrosis?  Y  N  **If yes:** Current medications, and dosage: \_\_\_\_\_

Last exacerbation requiring hospital admission: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(j)** Suffered from Epilepsy which:

**i.** is due to an underlying medical condition (e.g. as result of brain tumour or stroke)  Y  N  **If yes:** what is the underlying condition? \_\_\_\_\_

Further Details: \_\_\_\_\_

**ii.** Requires two or more anti-convulsant medications  Y  N  **If yes:** List medications and dosages: \_\_\_\_\_

Further Details: \_\_\_\_\_

**iii.** Has caused a seizure in the last 12 months.  Y  N  **If yes:** Date: \_\_\_\_\_

Further Details: \_\_\_\_\_

**(k)** Been hospitalised in the last 24 months for any other reason?  Y  N  **If yes:** Date & Details: \_\_\_\_\_

**15.** Is the patient currently pregnant?  Y  N  **If yes:** What is the due date? \_\_\_\_\_

Was conception via artificial reproductive techniques?  Y  N  Details: \_\_\_\_\_

Has the patient experienced any complications?  Y  N  Details: \_\_\_\_\_

Does the patient have any other medical conditions which could impact on the pregnancy?  Y  N  Details: \_\_\_\_\_

Is this a multiple pregnancy?  Y  N  Details: \_\_\_\_\_

**16.** In your opinion is your patient fit to undertake the proposed journey, without requiring any additional medical treatment in connection with any conditions currently under treatment?  Y  N

### 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: ( ) \_\_\_\_\_

# 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):

- (a) 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.

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