Many conditions are automatically covered, please refer to the Existing Medical Condition section of the Product Disclosure Statement.

Who Needs To Complete This Form?

People travelling to New Zealand or within Australia who want cover for:
- Anxiety, depression, mental or nervous disorders
- Terminal conditions
- Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or any derivative of either

People travelling to Europe, the Middle East, Asia, South West Pacific or Norfolk Island who want cover for:
- Anxiety, depression, mental or nervous disorders
- Cancer *
- Cerebrovascular conditions (e.g. stroke, transient ischaemic attack (TIA))
- Dementia/Alzheimer’s disease
- Diabetes *
- Heart conditions
- Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or any derivative of either
- Hypertension *
- Kidney conditions
- Liver conditions
- Organ transplant
- Peripheral vascular disease
- Reduced immunity (e.g. as a result of medical treatment or a medical condition)
- Respiratory or lung conditions *
- Terminal conditions
- Conditions for which you:
  - are under investigation or on a treatment waiting list
  - have changed your medication in the last 60 days
  - have been treated by a medical practitioner in the last 90 days

*No assessment is required if you satisfy the requirements outlined under the section “Conditions We Automatically Cover For Free” section of the PDS.

People travelling to the Americas or Africa who:
- Want cover for any condition that is not listed under the section “Conditions We Automatically Cover For Free” in the PDS.
- Have previously been diagnosed with a heart condition, a lung condition (not including asthma if you are under 60 years of age), or reduced immunity (e.g. as a result of medical treatment or a medical condition). In this case, you must submit this form. We will then advise whether a policy can be issued and if so, on what terms.

All travellers 75 years or over who want cover for:
- Any condition that is not listed under the section “Conditions We Automatically Cover For Free” in the PDS.

International travellers 70 years or over:
- Where a quote for a policy is not available online for your age, area and duration of your trip.

Pregnant travellers if:
- The policy has not been issued and;
- There have been complications with this or any previous pregnancy; or
- The conception was medically assisted (including hormone therapies and IVF).

If none of the above are relevant to you and you still think you may need to apply, please call Customer Service for more information on 1300 728 015.

Travellers with back or neck conditions should not apply as Existing Medical Condition cover is not available under any circumstances for these conditions.

How Much Will The Extra Cover Cost?

International Single Trip Policies
You can find the Existing Medical Condition premiums in the letter provided with your assessment outcome. These premiums apply to each person who wants to be covered for an Existing Medical Condition or pregnancy which is not listed as automatically covered in the PDS. If your condition required approval, the premium occasionally may be higher than these rates.

Domestic Single Trip Policies
We will advise any cost applicable in our assessment outcome letter or please call 1300 728 015 for a quote.

Annual Multi-Trip Policies
We will advise any cost applicable in our assessment outcome letter or please call 1300 728 015 for a quote. You do not have to re-apply for cover for each journey. You must however advise us immediately of any change to your medical condition(s).
Medical Assessment Form

I am completing this form because:

- I wish to apply for an Existing Medical Condition (not automatically covered - see page 1) and if approved I am willing to pay the additional premium. Yes ☐ No ☐
- I am travelling to the Americas/Africa and have previously been diagnosed with a heart condition, lung condition (excluding asthma if you are under 60 years old) and/or reduced immunity (e.g. as a result of medical treatment or a medical condition). Yes ☐ No ☐

If you answered ‘No’ to both points above, you do not have to complete this form, however, you will not be covered for your pre-existing medical condition/s.

Your Details

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male ☐</th>
<th>Female ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Height (m)</td>
<td>Weight (kg)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Address</td>
<td>Post Code</td>
<td>Email Address</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Hours Phone</td>
<td>Mobile</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your Travel And Policy Details

<table>
<thead>
<tr>
<th>Departure date</th>
<th>Return date</th>
<th>Number of people in your travelling party</th>
<th>Total value of this journey per person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Single Trip ☐</td>
<td>Annual Multi-Trip ☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did you apply for cover for this journey from any other insurer? Yes ☐ No ☐

If Yes and your cover was denied or restricted, please note you must also attach a copy of your assessment form that you provided to them along with this form.

General Health Information

Have you smoked in the last 6 months? Yes ☐ No ☐

If you are pregnant, what is your expected date of delivery? □

If you are currently receiving treatment (including medication) for your blood pressure, what was your last recording? On what date was this recorded?*

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Date diagnosed</th>
<th>Medication taken</th>
<th>How often medication taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you suffer from a kidney/renal condition what was your last creatinine level? On what date was this recorded? Please attach latest kidney function blood results (e.g creatinine/urea levels in last 6 months)*

If you suffer from diabetes what was your last blood sugar level? On what date was this recorded?*

<table>
<thead>
<tr>
<th>Is your current medication the same medication, strength and frequency as you were taking 60 days ago?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been treated in hospital in the last 12 months? If yes, please give reasons for treatment.</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

Details Of All Existing Medical Conditions And Treatment (every question must be answered)

Medical condition: [details]

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Date diagnosed</th>
<th>Medication taken</th>
<th>How often medication taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is your current medication the same medication, strength and frequency as you were taking 60 days ago? Yes ☐ No ☐

Have you been treated in hospital in the last 12 months? If yes, please give reasons for treatment. Yes ☐ No ☐
Medical Assessment Form

Details Of All Existing Medical Conditions And Treatment continued... (every question must be answered)

Have you had medical treatment or visited a doctor in the last 90 days? If yes, please give reasons for visits. Yes ☐ No ☐

Date: ___________ Details: ____________________________________________________________

Are you currently awaiting medical review, treatment or investigation? If yes, please provide details below. Yes ☐ No ☐

Date: ___________ Details: ____________________________________________________________

Do you intend to seek medical treatment overseas? Yes ☐ No ☐

Are you travelling against medical advice? Yes ☐ No ☐

Have you been diagnosed with a terminal condition or metastatic condition? Yes ☐ No ☐

Have you received medical advice that a condition you are suffering from may be terminal? Yes ☐ No ☐

For heart condition applications, your doctor must complete page 4.

Medical Authority And Your Declaration

How would you like to receive the outcome of this assessment? Email ☐ Post ☐

I authorise any hospital or medical advisor who has attended to or examined me to provide 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 fax copy of this authority shall be considered as valid as the original.

I declare that all information provided in this application and any attachments is truthful and no information has been withheld which may influence the insurer in its assessment of the risk. I acknowledge my Duty of Disclosure as detailed in the PDS. 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: ___________

If someone has completed this form on your behalf, please provide their details here. By doing this you are providing consent for us to talk to them about your application.

Name: ___________________________ Relationship: ___________________________ Phone: (____) ___________

Doctor’s Details And Declaration

To be completed if your doctor has filled in any part of this form on your behalf:

I hereby declare that the information detailed on pages 2-3 of this form and any 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: (____) ___________

How To Submit This Form

By fax: 02 8362 9368

By mail:
Australia Post Travel Insurance
Medical Assessments
c/o Travel Insurance Partners Pty Ltd.
PO Box 168
North Sydney
NSW 2060

Scan and Email:
auspost-assessments@travelinsurancepartners.com.au

Call us on:
1300 728 015 or email us on:
auspost@travelinsurancepartners.com.au

Any Questions?
### Medical Assessment Form – HEART CONDITIONS

**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)

<table>
<thead>
<tr>
<th>Given name</th>
<th>Surname</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Are you this patient’s usual doctor?  
Yes ☐  No ☐  How long have you known them?  

Please detail all Cardiac Conditions, Current Medical Conditions and Ongoing Medical Conditions below. You must also provide details of all current medication taken and any treatment or advice given by any doctor (if insufficient space is provided please attach a list).

<table>
<thead>
<tr>
<th>Cardiac, Current Medical Conditions and Ongoing Medical Conditions</th>
<th>Date diagnosed</th>
<th>Medication taken</th>
<th>How often medication taken</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>Date of reading</th>
<th>Heart rate</th>
<th>Date of reading</th>
<th>Cholesterol level</th>
<th>Date of reading</th>
</tr>
</thead>
</table>

Is the current medication the same medication, strength and frequency as the medication prescribed 60 days ago?  
Yes ☐  No ☐

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.

Does the patient suffer angina?  
Yes ☐  No ☐  If yes, when was the last attack? what is the frequency? and is the angina stable or unstable?

Has corrective surgery been performed?  
Yes ☐  No ☐  If yes, what type/s, date/s and with what result?

Were any complications experienced after the procedure/s described above?  
Yes ☐  No ☐  If yes, please provide details

Which arteries were treated?

What is the patient’s current INR level (if applicable)?

Has the patient been advised to have a valve repair or replacement?  
Yes ☐  No ☐  If yes, has the patient had the procedure?  
Yes ☐  No ☐  If yes, when?

If no, when is the patient likely to have the procedure?  

Has the patient ever been cardioverted?  
Yes ☐  No ☐

If yes, please give indication

Will the patient require follow-up for Cardiac Anhythmia?  
Yes ☐  No ☐

Has the patient ever been diagnosed or treated for CCF/LVF/RVF/Pulmonary Oedema?  
Yes ☐  No ☐

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 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  

Qualifications

Phone  

Date

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