

# Medical Declaration Form (Under 81 years of age) 28 July 2011

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

## 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.

See pages 9 to 14 of the PDS for more details.

### 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) at any time in the past, prior to policy purchase;
- (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. \*

The above definition applies to you, your Travelling Companion, a Relative or any other person.

\* Pregnancy cover is explained in page 9 of the Product Disclosure Statement.

Your condition is not a Pre-existing Medical Condition if it arose after the date of issue of your policy.

### How do I obtain cover for my Pre-existing Medical Condition?

If you are aged 81 years or over, this Medical Declaration Form does not apply to you. You must complete the '81 Years and Over Medical Declaration Form' available from your travel agent or online at [www.chitravelinsurance.com.au/downloads/medical\\_forma81.pdf](http://www.chitravelinsurance.com.au/downloads/medical_forma81.pdf). We have the absolute right to accept or decline cover, or impose special conditions such as an Excess or reduced benefits.

If you have a Pre-existing Medical Condition and you want cover for that condition, read the following information. **If you have any questions regarding Pre-existing Medical Conditions, please contact us on 1800 227 771.**

### Group 1 - 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 or chiropractic treatment
8. Any mental illness as defined by DSM-IV including:
  - a) Dementia, depression, anxiety, stress or other nervous condition; or
  - b) Behavioural diagnoses such as autism; or
  - c) A therapeutic or illicit drug or alcohol addiction
9. Any cardiovascular disease or cerebrovascular disease (see example) if you have:
  - a) Experienced angina (chest pain) within the past 6 months; or
  - b) Had a stroke (cerebrovascular accident or CVA) or a Transient Ischaemic Attack (TIA) within the past 12 months
10. Any cardiac or respiratory condition (see examples) if you:
  - a) require home oxygen therapy; or
  - b) will require oxygen for the Journey; or
  - c) have been diagnosed with Congestive Heart Failure
11. Chronic Renal Failure which is treated by haemodialysis or peritoneal dialysis
12. Any AIDS defining illness or any condition associated with immunocompromise
13. Organ transplantation, previous organ transplantation, or any condition for which you are awaiting organ transplantation
14. Any condition for which you have been given a terminal prognosis for any condition with a life expectancy of under 24 months

Travel insurance is available to you, however there is no provision to claim for any of the medical conditions as listed in the above Group 1.

### Group 2 - Pre-existing Medical Conditions which are automatically covered - no additional premium is payable.

You are automatically covered if your Pre-existing Medical Condition is described below, provided that you have **not** been hospitalised (including Day Surgery or Emergency Department attendance) for that condition in the past 18 months.

We do not require any further information or a Medical Declaration Form if your condition is described in this list, and has not caused hospitalisation in the past 18 months:

- |  |   |
|--|---|
| 1. Acne  | 16. Folate Deficiency   |
| 2. Allergies limited to Rhinitis, Chronic Sinusitis, Eczema, Food Intolerance, Hay Fever                               | 17. Gastric Reflux  |
| 3. Asthma - providing that you   | 18. Goitre  |
| a) have no other lung disease, and   | 19. Glaucoma  |
| b) are less than 60 years of age at the date of policy purchase.   | 20. Graves' Disease   |
| 4. Bell's palsy  | 21. Hiatus Hernia   |
| 5. Benign Positional Vertigo   | 22. *Hypercholesterolaemia (High Cholesterol) - provided you do not also suffer from a known cardiovascular disease and/or diabetes |
| 6. Bunions   | 23. *Hyperlipidaemia (High Blood Lipids) - provided you do not also suffer from a known cardiovascular disease and/or diabetes      |
| 7. Carpal Tunnel Syndrome  | 24. *Hypertension (High Blood Pressure) - provided you do not also suffer from a known cardiovascular disease and/or diabetes       |
| 8. Cataracts   | 25. Hypothyroidism, including Hashimoto's Disease   |
| 9. Coeliac disease   | 26. Impaired Glucose Tolerance  |
| 10. Congenital Blindness   | 27. Incontinence  |
| 11. Congenital Deafness  | 28. Insulin Resistance  |
| 12. *Diabetes Mellitus (Type I) - providing you:   | 29. Iron Deficiency Anaemia   |
| a) were diagnosed over 12 months ago, and  | 30. Macular Degeneration  |
| b) have no eye, kidney, nerve or vascular complications, and   | 31. Meniere's Disease   |
| c) do not also suffer from a known cardiovascular disease, hypertension, hyperlipidaemia or hypercholesterolaemia, and | 32. Migraine  |
| d) are under 50 years of age at the date of policy purchase,   | 33. Nocturnal cramps  |
| 13. *Diabetes Mellitus (Type II) - providing you:  | 34. Osteopaenia   |
| a) were diagnosed over 12 months ago, and  | 35. Osteoporosis  |
| b) have no eye, kidney, nerve or vascular complications, and   | 36. Pernicious Anaemia  |
| c) do not also suffer from a known cardiovascular disease, hypertension, hyperlipidaemia or hypercholesterolaemia      | 37. Plantar fasciitis   |
| 14. Dry eye syndrome   | 38. Raynaud's Disease   |
| 15. Epilepsy - providing there has been no change to your medication regime in the past 12 months                      | 39. Sleep apnoea  |
|  | 40. Solar keratosis   |
|  | 41. Trigeminal Neuralgia  |
|  | 42. Trigger finger  |
|  | 43. Vitamin B12 Deficiency  |

**\* Diabetes (Type I and Type II), Hypertension, Hypercholesterolaemia and Hyperlipidaemia are risk factors for cardiovascular disease.**

**If you have a history of cardiovascular disease, and it is excluded under your policy, cover for these conditions is also excluded.**

If hospitalisation has occurred, or your condition does not meet the description, cover is not automatic. You are required to submit a completed Medical Declaration Form, as explained in Group 3.

### Group 3 - Pre-existing Medical Conditions about which we need further information - require approval and an additional premium is payable

If your Pre-existing Medical Condition does not fall within Group 1 or 2 and you would like to apply for cover for your Pre-existing Medical Condition, we will require you to complete pages 2 and 3 of this form and forward it to us for consideration. We will respond within 1 business day.

Be aware if you have a Pre-existing Medical Condition and you do not:

- (i) apply for and are accepted for cover; and
  - (ii) pay the relevant additional premium for the condition,
- we will not pay any claims related to the Pre-existing Medical Condition. Refer to the PDS under **"Your Policy Cover"** (pages 37 to 52) and **"General Exclusions Applicable to all Sections"** (pages 53 to 55).

**You cannot apply for cover for conditions outlined in Group 1.**

**Examples of three (3) common Pre-existing Medical Conditions are set out on page 4.**

Agency Name: NORTH TRAVEL INSURANCE

Agency Phone No: (0) 02 8569 0238

Consultant's Name: WEB

Fax: (0) 02 8569 0238

Email: emc@northtravelinsurance.com.au

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### Disclosure of Pre-existing Medical Conditions

This form should be completed by the traveller. If you do not feel comfortable, or confident answering the medical questions on page 3, you should request the assistance of your usual doctor. (Any resulting costs incurred are the responsibility of the traveller).

#### Before continuing, please confirm:

I am less than 81 years of age. (If you are 81 years of age or over, please ask your travel agent for the correct form)

#### AND

I have a Pre-existing Medical Condition and would like to apply for it to be covered.

(if not, please reread page 1, or pages 9 to 14 of the PDS, to check whether you need to complete this form)

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.**

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

**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 a Resident of Australia? **Y**  **N**

**PLEASE NOTE: Pre-existing medical cover is only available to permanent Residents of Australia.**

#### 2. Contact Details

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

Work Phone No: \_\_\_\_\_ Home Phone No: \_\_\_\_\_

Fax No: \_\_\_\_\_ Email: \_\_\_\_\_

#### 3. Insurance Details

Cover required:

**Multiple Journey:**  Plan D Frequent Traveller Date of commencement / /

**OR**

**Single Journey:**

Plan A Comprehensive

Plan B Australia Only

**Please Note: Pre-existing Medical Condition Cover is not available on other plans.**

**Departure Date:** / / **Return Date:** / /

**Countries to be visited:**

Mode of Travel: Aircraft  Car  Coach  Ship  Train

Are you intending to: Ski  Snowboard  Trek (journey on foot with backpacks over a number of days)  Hike (one or more isolated long distance walks)

Approximate total cost of trip per person – AUD\$:

#### 4. Health Details

Height: \_\_\_\_\_ (cm) Weight: \_\_\_\_\_ (kg)

Have you ever smoked? **Y**  **N**  Still a smoker? **Y**  **N**  If yes: How many per day?

If no: How long ago did you cease smoking?

Have you ever made any medical travel insurance claims over AUD\$1,000 in total? **Y**  **N**  If yes, please provide details:

Have you applied for travel insurance for this journey through another insurer or company? **Y**  **N**  If yes, please provide details:

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**Traveller's name:** \_\_\_\_\_

**Date of Birth:**     /     /

This document provides information on which we base our risk assessment decision (i.e. to accept or decline Pre-Existing Medical Conditions) and should be completed by the traveller. If you do not feel comfortable, or confident answering the below medical questions, you should request the assistance of your usual doctor. Any resulting costs incurred are the responsibility of the traveller. Where there is insufficient space to complete an answer, please provide additional pages with the travellers' name and date of birth noted.

**5. Medical History**

Please answer 'Yes' or 'No' to all questions (a – p) in this section. If you answer 'Yes', to any of the questions, please complete all details in that question. Additionally refer to page 4 of this Medical Declaration Form.

**a)** Have you ever had a blood clot, such as a Deep Vein Thrombosis (DVT) or Pulmonary Embolism? **Y**  **N**   
 If yes: Date:     /     /     Reason for clot (eg pregnancy, after surgery, aeroplane journey): \_\_\_\_\_  
 What are your planned preventive measures for this journey? \_\_\_\_\_

**b)** Do you have HIV infection? **Y**  **N**   
 If yes: Latest CD4 count: \_\_\_\_\_ Date of latest CD4 count:     /     /

**c)** Have you ever been diagnosed with a chronic lung disease (including Emphysema and Chronic Bronchitis, Bronchiectasis, COAD (Chronic Obstructive Airways Disease) or COPD (Chronic Obstructive Pulmonary Disease), Cystic Fibrosis, Asbestosis or Asthma)? **Y**  **N**   
 If yes: Name of condition? \_\_\_\_\_ What medication do you currently take for this condition? \_\_\_\_\_  
 Date you were last in Hospital/Emergency Department with this condition:     /     /  
 Are bronchodilators or inhaled steroids used? **Y**  **N**   
 Further details: \_\_\_\_\_  
 Do you require home oxygen therapy? **Y**  **N**   
 Will you require oxygen for the journey? **Y**  **N**

**d)** Do you have Diabetes Mellitus? **Y**  **N**   
 If yes: Date of Diagnosis:     /     /     Currently controlled with: Diet only  Insulin injections  Insulin pump  Other medication   
 Please specify medication: \_\_\_\_\_  
 Do you have any resulting problems with your: Eyes:  Kidneys:  Legs (e.g. loss of feeling, ulcers):  If yes, please provide details: \_\_\_\_\_

**e)** Do you take medication for Hypertension (high blood pressure)? **Y**  **N**  List medications: \_\_\_\_\_

**f)** Do you take medication for Hypercholesterolaemia (high cholesterol)? **Y**  **N**  List medications: \_\_\_\_\_

**g)** Have you ever had Angina (chest pain)? **Y**  **N**  If yes: When was your last attack:     /     /  
 Frequency of attacks: \_\_\_\_\_ What treatment do you take for it? \_\_\_\_\_

**h)** Have you ever had a heart attack (myocardial infarct)? **Y**  **N**   
 If yes: Date of heart attack:     /     /

**i)** Have you ever had coronary angiography, stents or bypass grafting (CABG)? **Y**  **N**   
 If yes: Name of procedure and date:     /     /  
 Have you experienced any angina since that procedure? **Y**  **N**

**j)** Have you ever had a stroke (CVA) or mini-stroke (TIA)? **Y**  **N**   
 If yes: Name of event and date:     /     /

**k)** Have you ever been diagnosed with a heart arrhythmia such as atrial fibrillation? **Y**  **N**  List medications: \_\_\_\_\_  
 If yes: Name of condition: \_\_\_\_\_ Date of Diagnosis:     /     /

**l)** Do you have a Pacemaker or AICD (internal defibrillator)? **Y**  **N**   
 If yes: 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?     /     /

**m)** Do you take any other medication for your heart, or to thin your blood? **Y**  **N**   
 e.g. Warfarin (also known as Coumadin, Jantoven, Marevan, and Waran)  
 If yes: List medications: \_\_\_\_\_

**n)** Have you ever been diagnosed with epilepsy? **Y**  **N**   
 If yes: Have you experienced a seizure in the last 12 months? **Y**  **N**   
 Have there been any changes to your seizure medication in the last 12 months? **Y**  **N**

**o)** Have you been hospitalised (including day surgery), or attended the Emergency Department in the past 24 months? **Y**  **N**   
 If yes, please provide details: (If one of these attendances was for a routine colonoscopy, please indicate whether the result was normal)  

Date of event	Reason for attendance
1     /     /	.....
2     /     /	.....
3     /     /	.....

**p)** Please provide details of any other Pre-existing Medical Conditions (as defined on page 1 of this document) not yet mentioned:

Medical condition	Current medication/treatment
1	.....
2	.....
3	.....
4	.....
5	.....

Were any of these conditions newly diagnosed in the last 3 months? **Y**  **N**   
 If yes, please provide details: \_\_\_\_\_

**6. 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 Allianz Global 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 Allianz Global 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 Allianz Global Assistance has agreed to cover those conditions.

Passenger's Signature: \_\_\_\_\_

Date:     /     /

**7. Doctor's Declaration:**

**Optional- Required only if the answers have been provided by your doctor.**

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 this Medical Declaration.

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

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: \_\_\_\_\_

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## Additional Options

*Prolonged travel, particularly at altitude in commercial aircraft, places increased stress upon the cardiovascular and respiratory systems via a number of different mechanisms. Despite patients being stable in their normal environment our experience over many hundreds of thousands of cases is that there is a quantifiable risk associated with your planned trip based on a risk assessment of your past medical history for your cardiovascular or respiratory conditions.*

*We offer your medical practitioners an opportunity to provide evidence regarding the risk of deterioration during travel. The insurer will then assess the application based on this expert advice. Any decision will be based heavily on this advice so we would ask that the opinion offered is considered. This is especially important should in the future the patient suffer an adverse event during the planned travel.*

In particular, where the applicant has any of the following issues:

- A past history of Deep Vein Thrombosis (DVT) or Pulmonary Embolism,
- A chronic lung disease (including Emphysema and Chronic Bronchitis, Bronchiectasis, COAD (Chronic Obstructive Airways Disease) or COPD (Chronic Obstructive Pulmonary Disease), Cystic Fibrosis, Asbestosis and Asthma is present,
- Diabetes (Type I or II) where any nerve, eye or vascular complications has occurred,
- Heart problems requiring angiography, stents or bypass grafting (CABG) in the past 12 months or such procedures were performed more than 10 years ago,
- A Cerebrovascular Accident (Stroke) or Transient Ischaemic Attack (TIA) has occurred in the past 24 months,
- A Pacemaker or AICD (Internal Defibrillator) has been inserted,
- Hospitalisation (including day surgery), or attendance to an Emergency Department has occurred within the past 24 months.

As the applicant, you are invited to submit a specialist letter certifying you are medically fit to travel and unlikely to suffer a medical episode arising from this condition.

Where this information is not supplied with the initial application **and** we initially decline your application for cover for your Pre-existing Medical Condition, the applicant may be requested to supply a specialist letter as outlined above, before any review of the assessment can be completed.

**Examples of three (3) 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.

### Warfarin Use:

Taking the medication Warfarin (also known under the brand names of Coumadin, Jantoven, Marevan, and Waran) has a complex range of serious complications and side effects. These risks are in excess of those associated with the underlying condition for which you take this medication.

If you are currently prescribed the drug, you must complete a Medical Declaration Form (even if you decide not to apply for cover for a Pre-existing Medical Condition) and we must agree in writing to provide cover.

If you do not submit a completed Medical Declaration Form, the General Exclusion in clause 17 will apply and you will not have cover.

### 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), Chronic Obstructive Pulmonary Disease (COPD) or Asthma (if you have another lung disease and are 60 years of age or over at the date of policy issue), 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 respiratory infections are also excluded.

## Privacy Policy

We (Allianz and our agent Allianz Global 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):
    - i. Medical practitioners;
    - ii. Health service providers;
    - iii. Hospitals and clinics;
    - iv. International assistance providers; and
    - v. 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 regarding Pre-existing Medical Conditions please call our dedicated Pre-existing Medical Team on 1800 227 771**

Allianz Global Assistance

Postal Address: PO Box 162, TOOWONG QLD 4066

Phone: 1800 227 771 Fax: (07) 3305 7006 Email: [medical-assessments@allianz-assistance.com.au](mailto:medical-assessments@allianz-assistance.com.au)