Travellers medical appraisal form for non travelling relative/business partner

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Please fax your completed medical appraisal form to 1300 657 127 or email **travel.emc@qbe.com**

Before completing the medical appraisal form, please ensure you have read the following information in conjunction with the policy booklet. This form is to be completed by each applicant. If you have insufficient space on the form provided, please provide additional information on a separate sheet.

Privacy

QBE's Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Duty of disclosure

Before you enter into an insurance contract, you have duty of disclosure under the Insurance Contracts Act 1984.

If we ask you questions that are relevant to our decision to insure you and on what terms, you must tell us anything that you know and that a reasonable person in the circumstances would include in answering the questions.

You have this duty until we agree to insure you.

If you do not tell us something

If you do not tell us anything you are required to tell us, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

Existing medical condition of a non travelling relative or business partner

(Not available on all travel plans, to non residents of Australia or after departure.)

Provided your non travelling relative or business partner is under 80 years of age at the time the Certificate of Insurance is to be issued you can apply to cover their existing medical condition if their state of health could disrupt your travel plans even though they are not travelling with you.

Complete your application form and this form and submit for approval, via our representative. If cover is approved you will be advised of any additional amount payable and of any special terms imposed.

If you do not select this additional benefit there will be no cover if your trip is cancelled, cut short or disrupted as a result of your non travelling relative's or business partner's existing medical condition.

An existing medical condition is:

An existing medical condition is:

(a) 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

(b) 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.

Once we have reviewed this form:

- We may offer you insurance; and
- We may provide cover for an existing medical condition. A Travellers Appraisal Number will be issued and you will be advised of the additional amount payable; or
- We will advise you that we are unable to insure for an existing medical condition

IF OFFERED, COVER FOR AN EXISTING MEDICAL CONDITION MUST BE TAKEN UP WITHIN 14 DAYS OF THE ASSESSMENT DATE OR PRIOR TO DEPARTURE,WHICHEVER OCCURS FIRST. AN ASSESSMENT NUMBER MUST APPEAR ON YOUR CERTIFICATE OF INSURANCE.

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

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Part A to be completed by you, the traveller

Travel agent's name and address | State | Postcode

Consultant's Name

Contact details | Phone | Fax

Name of persons travelling | Relationship

Phone work | Home/mobile

Email

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?

Travel dates *(dd/mm/yyyy)* | to | Trip value ($)

Travel plan selected (refer to the PDS)

Part B to be completed by non traveller

Confidentiality: I consent to the travel agent/intermediary having access to information about my medical condition/s. Yes ☐ No ☐

If you don't consent to the travel agent having access to information about your medical condition/s please provide your email address to allow QBE to transact directly with you

Full name | Postcode

Height (cm) | Weight (kg) | Date of birth *(dd/mm/yyyy)*

Have you been hospitalised or attended an Emergency Department in the past 12 months? Yes ☐ No ☐

If yes please provide details | Date *(dd/mm/yyyy)*

List details of your visit(s) to a doctor including a specialist over the past 12 months;

Reason | Date *(dd/mm/yyyy)*

Reason | Date *(dd/mm/yyyy)*

Reason | Date *(dd/mm/yyyy)*

List any treatment or medication you have had in the past 12 months?

Have you ever had cancer? Yes ☐ No ☐ If yes, please provide treatment details | Date *(dd/mm/yyyy)*

Have you ever had heart disease? Yes ☐ No ☐ If yes, please provide treatment details | Date *(dd/mm/yyyy)*

Do you smoke cigarettes? Yes ☐ No ☐ If Yes, how many per day?

Declaration

I consent to the collection, use and discolsure of my heath information for the purpose of assessment and provision of travel insurance to my relative or business partner. I authorise any hospital or medical adviser who has attended to, or examined me, to disclose any or all information regarding the treatment given for any condition related to the declaration.

Signature | Date *(dd/mm/yyyy)*

(The signatory must be 18 years of age or over and is authorised to sign on behalf of all named persons.)

Part C doctor's declaration

Are you the patient's usual Medical Practitioner? Yes ☐ No ☐ If so, how long?

List the nature and extent of Existing Medical Condition(s) (refer to front page) in the past 12 months.

Condition		First consulted *(dd/mm/yyyy)*	
Medication		Last consulted *(dd/mm/yyyy)*	
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Medication		Last consulted *(dd/mm/yyyy)*	
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Medication		Last consulted *(dd/mm/yyyy)*	
Condition		First consulted *(dd/mm/yyyy)*	
Medication		Last consulted *(dd/mm/yyyy)*	

What other medication has this patient taken in the last 12 months? (e.g. chemotherapy, Ab's etc)

Has your patient had ANY history of:

Hypertension	Yes ☐ No ☐	Date *(dd/mm/yyyy)*			
Angina	Yes ☐ No ☐	Last attack *(dd/mm/yyyy)*		Frequency of attacks	
Heart failure	☐ CCF ☐ LVF ☐ Cardiomyopathy ☐ IHD ☐ Angiography ☐ Valvular Disease ☐ Stenting ☐ C.A.G.S				
	☐ Other	Detail			
Diabetes	Yes ☐ No ☐	Type?		Complications?	
Respiratory condition(s)	☐ Asthma ☐ Bronchitis ☐ COAD ☐ COPD Please give details below				

Any other conditions or disease? Please give details

Are any of the conditions mentioned under review or unstable? Yes ☐ No ☐
If yes, please give details

Is your patient currently in hospital/nursing home? Yes ☐ No ☐

Are you aware of any recent deterioration, changes, planned surgery or reviews that may require the passenger to cancel the trip? Yes ☐ No ☐
If yes, please give details

Is your patient suffering from a terminal condition? Yes ☐ No ☐
Please give details

Is your patient suffering from a malignant condition? Yes ☐ No ☐
Please give details

Is there any planned surgery or treatment in the future? Yes ☐ No ☐
Please give details

Part C doctor's declaration

Any other comments/details you wish to add?

Doctor's signature		Phone			
Doctor's name					
Address		State		Postcode	
Qualifications		Date *(dd/mm/yyyy)*			
Email		Fax			