travelsure TRAVEL INSURANCE

Medical Assessment Form – HEART CONDITIONS

Fax (02) 9202 8002

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)

Given name | Surname | Date of Birth

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).

Cardiac, Current Medical Conditions and Ongoing Medical Conditions	Date diagnosed	Medication taken	How often medication taken

Blood pressure | Date of reading | Heart rate | Date of reading | Cholesterol level | Date of reading

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 Arrhythmia? 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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Medical Assessment Form

Effective: April 2009 CM Form

Want a faster response?
Apply securely online at **www.covermore.com.au/assessments**

IMPORTANT: Use this form for the Travelsure policy

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

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/Alzheimers disease
- Diabetes*
- Heart conditions
- Hypertension*
- Kidney conditions
- Liver conditions
- Organ transplant
- Peripheral vascular disease
- Reduced immunity (e.g. as a result of a condition or medication)
- 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 or reduced immunity (e.g. as a result of a condition or medication). 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 Travelsure PDS.

International travellers 70 years or over:

- Where a quote for a Travelsure policy is not available from your travel agent for your age, area and duration of your trip.

Pregnant travellers if:

- Policy has not been issued and;
- There have been complications with this or any previous pregnancy.
- The conception was medically assisted.

If none of the above are relevant to you and you still think you may need to apply, please ask your travel agent for more information.

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

How Much Will The Extra Cover Cost?

The premiums below apply for 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 requires approval, the premium may be higher than these amounts.

International Single Trip Policies

	DAYS											WEEKS						MONTHS									
Area	2	5	8	11	14	17	20	23	26	29	32	5	6	7	8	9	10	3	4	5	6	7	8	9	10	11	12
1	70	73	76	78	83	87	93	101	103	108	113	118	123	130	136	144	152	163	181	205	223	252	272	288	306	331	346
2	67	69	71	74	76	78	80	83	85	87	88	91	93	96	100	103	108	113	125	136	145	159	170	179	190	202	206
3	66	68	70	71	74	76	78	80	83	84	86	87	90	94	97	102	105	111	121	133	145	154	164	173	184	196	202
4	60	62	62	63	66	67	68	69	70	70	71	73	73	74	75	76	77	82	86	91	95						

Domestic Single Trip Policies: $57

Annual Multi-Trip Policies: $113

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).

Prices are indicative only and may change with fluctuations in currencies and claims experience. Charges may vary depending on your age, destination, duration or excess chosen. Please ask the agent for a quote.

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Effective: April 2009

Medical Assessment Form

CM Form

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IMPORTANT: Use this form for the Travelsure policy

I am completing this form because:

- I wish to apply for an Existing Medical Condition listed on page 1 of this form 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 (eg as a result of medication or a medical condition). — Yes ☐ No ☐
- A quote for a Travesure policy is not available from my travel agent for my age, area and duration of my trip. — Yes ☐ No ☐

If you answered 'No' to all of the above questions, it is not imperative to complete this form, although you will not be covered for your pre-existing conditions.

Your Details

Gender Male ☐ Female ☐

Title | Given name

Surname

Date of Birth | Height (m) | Weight (kg)

Home Address

Post Code | Email Address

Business Hours Phone ( ) | Mobile

Your Travel And Policy Details

Departure date | Return date

Number of people in your travelling party | Total value of this journey per person $

Single Trip ☐ Annual Multi-Trip ☐

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.

Where are you going? (Please list all destinations. If insufficient space is provided, please attach a list)

Country	Length of stay	Tick if going on a cruise

Policy number (if already issued)

Your Travel Agent's Details

Travel agency | Phone ( ) | Fax ( )

Location | Email

Consultant

Have you booked your travel with this agency? Yes ☐ No ☐

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?*

*If this field is not answered, we will be unable to assess cover for hypertension

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 (eg creatinine/urea levels in last 6 months)*

*If this field is not answered, we will be unable to assess cover for renal conditions

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

*If this field is not answered, we will be unable to assess cover for diabetes

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

You must provide details below of **all** Existing Medical Conditions (the meaning of this term is shown in the PDS). **If you do not have any Existing Medical Conditions you must write 'nil' below.** If you are unsure which Existing Medical Conditions you have, please have your doctor complete this section and sign the doctor's declaration below. If insufficient space is provided, please attach a list).

Medical condition	Date diagnosed	Medication taken	How often medication taken

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 provide details below. Yes ☐ No ☐

Date	Details

Have you had medical treatment or visited a doctor in the last 90 days? If yes, please provide details below. Yes ☐ No ☐

Date	Details

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

Date	Details

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 ☐

We will also notify your travel agent of the outcome (including medical conditions), please tick this box if you **do not** want this to happen. ☐

I authorise any hospital or medical advisor who has attended to or examined me to furnish 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) 9202 8002

By mail
Cover-More Travel Insurance
Medical Assessments
Private Bag 913
North Sydney NSW 2059

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Any Questions?
Contact your travel agent, call us on 1300 72 88 22 or email us enquiries@covermore.com.au