

# Medical Assessment Form



**IMPORTANT:** Use this form for Options, Essentials and Business policies only

## Who Needs To Complete This Form?

### People travelling to Australia or within New Zealand who want cover for:

- Terminal conditions

### People travelling to Europe, the Middle East, Asia, UK, South Pacific or Norfolk Island who want cover for:

- 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 Options PDS.

### International travellers 70 years or over:

- Where a quote for an Options 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; or
- 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 conditions.

## 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.

### Single Trip Policies

Area		Days											Weeks			Months											
		3	5	7	10	12	15	18	21	25	28	31	5	6	7	2	3	4	5	6	7	8	9	10	11	12	
1	\$	41	44	46	52	59	63	67	68	74	78	80	98	102	108	118	135	156	178	200	200	200	200	200	200	200	
2	\$	38	42	45	48	51	54	58	60	64	68	72	79	93	100	111	120	131	139	153	165	173	198	200	200	200	
3	\$	37	40	43	46	50	53	56	59	62	66	70	77	88	92	100	114	127	134	148	159	167	191	200	200	200	
4 & 5	\$	34	36	38	42	45	47	50	54	58	58	60	65	70	76	87	104	117	130	143	153	161	184	198	200	200	
6, 7 & 8	\$	28	30	31	32	35	36	37	38	39	41	42	44	46	48	52	61	68	76	86	94	102	111	119	128	137	

### Annual Multi-Trip Policies: \$65

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. We adhere to the Privacy Act 1993 when we collect your personal information.



# Medical Assessment Form



**IMPORTANT:** Use this form for Options, Essentials and Business policies only

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 an Options 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

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
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

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.

Policy number (if already issued)

Travel Insurance Policy Selected Options  Essentials  Business  Corporate

## Your Travel Agent's Details

Travel agency

Location

Consultant

Phone ( )  Fax ( )

Email

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). This list must be in the same format as below to be accepted.

Medical condition	Date diagnosed	Medication taken	How often medication taken
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Date	Details
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

Date	Details
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

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 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>	( )

## 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

Qualifications	Phone
<input type="text"/>	( )

## How To Submit This Form



**By fax**  
(09) 300 7371



**By mail**  
Travelsure Travel Insurance  
Medical Assessments  
PO Box 105-203  
Auckland City 1143



### Any Questions?

Contact your travel agent, call us on  
0800 500 225 or email us  
enquiries@travelsure.co.nz

# 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)

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). This list must be in the same format as below to be accepted.

Cardiac, Current Medical Conditions and Ongoing Medical Conditions	Date diagnosed	Medication taken	How often medication taken
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

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