

Assessment Form

Effective February 2007

Fax: (02) 8920 2737

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

Easy Steps

1. If you have known medical conditions that are not covered as a "Self Assessment" (see your policy wording), you may be able to be covered by filling in this form.
2. Some conditions need to be disclosed to us before you buy the policy (see your Enrolment Form for details).
3. You must complete Questions 1 – 30 of this form. All questions must be answered.
4. If you have a heart condition, have your doctor fill in page 4 (if you want to be assessed for heart cover). All heart conditions (past and present) are deemed Existing Medical Conditions.
5. Fax this form to us (or ask our agent to do it on your behalf) on (02) 8920 2737 (you can mail it, but faxing is faster).
6. We will contact you or advise you in writing of the outcome of your assessment within 1 working day.

For a Faster Response

1. Answer all questions – without all the information, we can't perform an assessment and our response will be delayed.
2. The most commonly missed questions are travel dates, destinations and your signature at Point 29.
3. Failing to tell us about a medical condition or medication can have serious effects. Please double check all these details.
4. If you have a heart condition, unless page 4 is filled in by your doctor, we cannot assess for cover for your heart and it will be excluded from your policy. You cannot fill page 4 out for yourself, even if you are a doctor.
5. Unless taking an Annual Multi-Trip policy, you must apply with a new assessment form for every trip you take.

Other Important Information

1. If you require help completing this form, please ask your doctor for help with medical information, or our issuing agent for other details.
2. If your doctor fills in any question on pages 2 or 3 they must sign at Point 33.
3. If you are over 17 years of age, this form must be signed by you. If someone is signing on your behalf, we will require a copy of the legal authorisation that indicates that they may sign for you (eg Power of Attorney documents).
4. Any costs associated with the submission of this application are your responsibility
5. Existing Medical Condition Cover is not available under any circumstances for certain conditions. These conditions include:
 - Back or neck conditions
 - Food/drug allergies
 - Dental conditions
 - The conditions named in "We Will Not Pay For" No. 14 of our policy.

Premiums (please pay the issuing agent if accepted)

The premiums below apply for each person who has an Existing Medical Condition/Known Pregnancy which is not automatically covered free of charge, and who wants to be covered for the condition. These are minimum amounts payable, there are times that the payment may be higher than these amounts. If you are travelling on a policy containing two adults, when you pay for additional cover your family/travelling companion will also be covered under the "amendment or cancellation costs" section for claims arising from approved conditions.

• **Single Trip Policies**

Plan/ Area	Days						Weeks						Months									
	5	8	12	16	23	31	5	6	7	8	9	10	3	4	5	6	7	8	9	10	11	12
1	64	67	69	74	84	99	103	109	115	120	127	134	144	160	181	197	222	240	254	270	292	305
2	61	63	65	67	71	76	78	82	85	88	91	95	100	110	120	128	140	150	158	168	178	182
3	60	62	63	65	69	74	77	79	83	86	90	93	98	107	117	128	136	145	153	162	173	178
4	55	55	56	57	59	61	62	63	65	66	67	68	72	76	80	84	-	-	-	-	-	-
D, DA	50	50	50	50	50	50	50	50	50	50	50	50	-	-	-	-	-	-	-	-	-	-

• **Multi-Trip Policies:** \$100

You do not have to re-apply for cover for each journey. You must however advise us immediately of any change(s) to your medical condition(s).

IMPORTANT: Please read page 1 before proceeding. Questions 1 - 30 are to be completed by YOU.

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Please answer yes or no to the following questions:

1. This travel insurance is not automatically available to me due to my age, destination and/or duration. YES NO
2. I wish to apply for Existing Medical Condition(s) and/or some Known Pregnancies cover. YES NO
3. If approved for cover I am willing to pay the minimum extra premium shown on page 1 of this form. YES NO
4. I have one or more of the following conditions:
 - a lung condition (other than asthma satisfying the criteria under the "Self Assessment" section)
 - dementia • kidney failure • metastatic cancer • a condition with a terminal prognosis.
 - reduced immunity (e.g. as a result of medication or a medical condition) • haemophilia
 YES NO
5. I have been diagnosed with or treated for a heart condition. "Heart condition" means any condition relating to your heart, including (but not limited to) heart disease e.g. angina or myocardial infarction (heart attacks), palpitations, arrhythmias and congenital heart conditions. YES NO

If you answered "Yes" to questions 1,2, 4 or 5, you must submit this form. We will advise whether we can provide a policy, and if so, on what terms. If you wish to be assessed for heart coverage, your doctor must also complete the questions on page 4.

If you answered "No" to all of the above questions you do not need to complete this form. No cover will be provided for claims arising from any Existing Medical Condition(s) and/or Known Pregnancy which is not automatically covered.

Applicant's details PLEASE USE BLOCK LETTERS Each applicant must complete a separate form

<p>6. Surname <input style="width: 100%;" type="text"/> Given name <input style="width: 100%;" type="text"/> Title <input style="width: 100%;" type="text"/></p> <p>Address <input style="width: 100%;" type="text"/> Postcode <input style="width: 100%;" type="text"/></p> <p>Home phone <input style="width: 100%;" type="text"/> Work phone <input style="width: 100%;" type="text"/> Email <input style="width: 100%;" type="text"/> Policy number (if already issued) <input style="width: 100%;" type="text"/></p> <p>7. We advise you of the outcome of this assessment in writing. How do you wish to receive it? (Email is quickest) Mail <input type="checkbox"/> Email <input type="checkbox"/></p> <p>8. Date of birth <input style="width: 100%;" type="text"/> Sex Male <input type="checkbox"/> Female <input type="checkbox"/> Height (m) <input style="width: 100%;" type="text"/> Weight (kg) <input style="width: 100%;" type="text"/></p> <p>9. Departure date <input style="width: 100%;" type="text"/> Return date <input style="width: 100%;" type="text"/></p> <p>10. Total value of this journey per person \$ <input style="width: 100%;" type="text"/></p> <p>Number of people in your travelling party <input style="width: 100%;" type="text"/></p> <p>11. Policy type: (Options / Business / Essentials etc.) <input style="width: 100%;" type="text"/></p> <p>Single trip policy (✓) <input type="checkbox"/> OR Multi-trip policy (✓) <input type="checkbox"/></p> <p>12. Did you apply for cover for this journey from any other insurer? (If yes, with which insurer) YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input style="width: 100%;" type="text"/></p> <p>If your cover was denied, or if you had special terms and conditions placed on your policy, please include a copy of your other assessment forms with this application</p>	<p>13. Have you smoked in the last 6 months? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>14. If you are pregnant, what is your estimated date of delivery? <input style="width: 100%;" type="text"/></p> <p>15. Do you play sport or exercise regularly? (If yes, provide details below) YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input style="width: 100%;" type="text"/></p> <p>16. If you suffer from epilepsy, have you had a fit in the last 2 years? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>17. If you are currently receiving treatment (including medication) for your blood pressure, what was your last recording? On what date was this recorded?*</p> <p><input style="width: 100%;" type="text"/> / / <small>*If this field is not answered, we will be unable to assess cover for hypertension.</small></p> <p>18. If you suffer from diabetes, what was your last blood sugar level? On what date was this recorded?*</p> <p><input style="width: 100%;" type="text"/> / / <small>*If this field is not answered, we will be unable to assess cover for diabetes.</small></p> <p>19. Have you ever had a CVA (cerebrovascular accident or stroke) or TIA (transient ischaemic attack)? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
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Proposed journey for which cover is sought Please list all destinations (If insufficient space is provided, please attach a list)

20. Country <input style="width: 100%;" type="text"/>	Length of stay <input style="width: 100%;" type="text"/>	Country <input style="width: 100%;" type="text"/>	Length of stay <input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Contact people

<p>21. Issuing agency (if not completed, attach a cover page with details)</p> <p>.....</p> <p>Location Phone</p> <p>Consultant</p> <p>Fax ()</p> <p>Email</p> <p>Have you booked your travel with this agency? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>22. GP's name <input style="width: 100%;" type="text"/></p> <p>Phone () <input style="width: 100%;" type="text"/></p>	<p>23. Specialist's name <input style="width: 100%;" type="text"/></p> <p>Phone () <input style="width: 100%;" type="text"/></p> <p>24. 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 .</p> <p>Name</p> <p>Relationship</p> <p>Phone () <input style="width: 100%;" type="text"/></p>
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Details of all existing medical condition(s) (If insufficient space is provided, please attach a list)

You must provide details below of **ALL** Existing Medical Conditions (the meaning of this term is shown in the policy brochure). 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 at question 33.

25. Medical condition(s)	Date diagnosed	Medication taken	How often medication taken
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

26. Is your current medication the same medication, strength and frequency as you were taking 3 months ago? YES NO

Medical treatment (If insufficient space is provided, please attach a list)

27. In the last 2 years have you had any medical problems while overseas? (If yes, provide details below) YES NO

Date	Details
/ /	
/ /	

28. Have you been treated in hospital in the last 12 months? (If yes, provide details below) YES NO

Date	Details
/ /	
/ /	

29. Have you had medical treatment or visited a doctor in the last 90 days? (If yes, provide details below) YES NO

Date	Details
/ /	
/ /	
/ /	

30. Are you currently awaiting medical review, treatment or investigation? YES NO

Date	Details
/ /	
/ /	

31. MEDICAL AUTHORITY AND DECLARATION

I authorise any hospital or medical adviser 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 facsimile 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 policy brochure. 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
		/ /

32. I consent to you faxing the outcome of this assessment to the issuing agency. YES NO

Doctor's declaration To be completed if your doctor has completed any of the above questions

33. I hereby declare that the information detailed on pages 2 - 4 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

Important: Please complete pages 2 and 3 before proceeding
To be completed by your doctor

Fax: (02) 8920 2737

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**

34. Surname Given names Date of birth / /

35. Are you this patient's usual treating doctor YES NO How long have you known them?

36. Details of ALL Cardiac Conditions and Existing Medical Condition(s). You must also provide details of ALL medication taken and any treatment or advice given by any doctor (if insufficient space is provided please attach a list).

Cardiac and Existing Medical Conditions	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"/>

37. Blood pressure Date of reading / / Heart rate Date of reading / / Cholesterol level Date of reading / /

38. Is the current medication the same medication, strength and frequency as the medication prescribed 3 months ago? YES NO

39. 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.

40. Have you attached the relevant results? YES NO
If No, we may need to contact you to obtain further information.

41. Does the patient suffer angina? YES NO
 If Yes, when was the last attack? what is the frequency of attacks? and is the angina stable or unstable?

42. Has corrective surgery been performed? YES NO
 If Yes, what type/s, date/s and with what result?

43. Were any complications experienced after the procedure/s described above? YES NO
 If Yes, please provide details:

44. Which arteries were treated?

45. What is the patient's current INR level (if applicable)?

46. Has the patient been advised to have a valve repair or replacement? YES NO

47. If Yes to question 46, has the patient had the procedure? YES NO

If Yes, please advise month and year:

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

48. Has the patient ever been cardioverted? YES NO
 If Yes, please give indication:

49. Will the patient require follow-up for Cardiac Arrhythmia? YES NO

50. Has the patient ever been diagnosed or treated for CCF / LVF / RVF/ Pulmonary Oedema? YES NO

General

51. Please detail any special requirements of the patient whilst travelling on the proposed journey.

52. Please detail any other matters which you feel an insurer should be aware of in assessing the medical insurance risk of the patient.

53. Declaration

I hereby 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

Date / / Qualifications

Phone Fax