

TOURSAFE

TRAVELLERS WITH HEALTH ENQUIRIES PHONE 02 9701 6511

EXISTING HEALTH DISORDERS

An existing health disorder means any medical or dental condition of yours or any person in the travelling party on whose state of health your trip depends, which in the 30 days before you applied for this insurance:

- Required treatment, investigation, medication or advice from a doctor, chiropractor, physiotherapist, naturopath, psychiatrist or
- Which you are aware of, or could be expected to be aware of, that may lead to a claim under this policy.

It also means a chronic or on-going medical or dental condition.

Existing Health Disorder cover is only available in respect of medical conditions for persons insured under this policy.

AUTOMATIC COVER FOR ALL TRAVELLERS

Only the conditions which follow are automatically covered under this policy provided there are no planned procedures and there have been no complications or exacerbations within the last 6 months. **You do not** need to complete an application for Existing Health Disorder.

Cataracts	Gastric Reflux	Haemorrhoids
Gout	Hiatus Hernia	Hypothyroidism
Hypercholesterolaemia (High Cholesterol)	Hypertension (High Blood Pressure)	Tinnitus
Menopause	Varicose Veins	Restless Leg Syndrome
Glaucoma	Acne	Insomnia
Essential Tremor	Hay Fever	

EXISTING HEALTH DISORDER APPLICATIONS

If you wish to apply for existing health disorder cover

1. Travellers under 70 years of age

FORM A is to be completed by the traveller, where cover is not requested for Cardiac, Vascular, or an Organ Transplant, in which case refer to FORM B. On completion return form to our Authorised Representative for assessment. We may request further detailed information from your doctor and in such event we will advise you.

FORM B is to be completed by the traveller and your usual Medical Practitioner where you are requesting cover for any **Cardiac, Vascular, or an Organ Transplant**.

2. Travellers over 70 years of age

FORM B is to be completed by the traveller and your usual Medical Practitioner if you have an Existing Health Disorder.

MATURE AGE APPLICATIONS ONLY

3. Travellers over 70 and there is NO published premium for your Age, Destination and Duration?

FORM A is to be completed by the applicant if there is no published premium for the trip duration or the applicant is aged 85 years and over.

4. Our Business Policy and Non Resident Policy is not available for travellers aged 70 years and over.

TO ENSURE SPEEDY ASSESSMENT OF YOUR APPLICATION PLEASE FULLY ANSWER ALL QUESTIONS

FORM A

REFERENCE No. _____

FAX TO (02) 9744 7855 FOR ASSESSMENT
PRIOR TO ISSUE OF THE POLICY

THIS SECTION IS TO BE COMPLETED BY THE TRAVELLER

AGENCY NAME: All Planet Travel **PHONE:** (02) 95661499

CONSULTANT/CONTACT: **FAX:** (02) 95661544

PASSENGER DETAILS: MR/MRS/MISS SURNAME **GIVEN NAME:**

BIRTH DATE: ____ / ____ / ____ **OCCUPATION** **PHONE:**

ADDRESS: **SUBURB:** **P/CODE:**

AGENCY WHERE YOU MADE YOUR TRAVEL BOOKINGS:

TRIP DETAILS: Departure Date ____ / ____ / ____ Return Date ____ / ____ / ____ **OR** Duration of Trip days/wks/mths

Policy Type Single Trip Annual Business Cancellation and Emergency Expenses

Major Destination Other countries you will visit

Mode of Transport Total Cost of Trip

Do you intend to Ski, Trek, Mountain Climb or engage in Adventure Sports?

THIS SECTION IS TO BE COMPLETED BY THE TRAVELLER

MEDICAL DETAILS

Height Weight Are you a Smoker? Yes No

Medical Conditions	Date of Diagnosis	Last Attack/Exacerbation	Last Reading (if applicable)

Please list details of all prescribed medication, by type, dosage and frequency.

- 1) 4) 7)
 2) 5) 8)
 3) 6) 9)

Have you had surgery or been hospitalised in the past 3 years? Yes No List details

Do you have any planned procedures or upcoming investigations? Yes No List details

Do you have any special travel needs? Eg. Wheelchair, Oxygen Support, CPAP, etc.

Have you been refused cover for this trip by any other insurer? Yes No

Privacy Agreement: By my signature, I give my explicit consent for Compusure Pty. Limited to direct correspondence regarding this application to the Agency named above and to use this information solely for the purpose of administering my application for Travel Insurance and any resultant Travel Insurance cover as detailed in our Travel Brochure/Application.

Signed Date ____ / ____ / ____

I hereby declare that the information provided on this form and any attachments is accurate and complete and that no information has been withheld.

Signed Date ____ / ____ / ____

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



TRAVELLERS UNDER 70 YRS CARDIAC, VASCULAR, RESP, ORGAN TRANSPLANT

TRAVELLERS OVER 70 YRS EXISTING HEALTH DISORDER

FORM B

REFERENCE No.

FAX TO (02) 9744 7855 FOR ASSESSMENT
PRIOR TO ISSUE OF THE POLICY

THIS SECTION IS TO BE COMPLETED BY THE TRAVELLER

AGENCY NAME: All Planet Travel PHONE: (02) 95661499

CONSULTANT/CONTACT: FAX: (02) 95661544

PASSENGER DETAILS: MR/MRS/MISS SURNAME GIVEN NAME:

BIRTH DATE: / / OCCUPATION PHONE:

ADDRESS: SUBURB: P/CODE:

AGENCY WHERE YOU MADE YOUR TRAVEL BOOKINGS:

TRIP DETAILS: Departure Date / / Return Date / / OR Duration of Trip days/wks/mths

Policy Type Single Trip Annual Business Cancellation and Emergency Expenses

Major Destination Other countries you will visit

Mode of Transport Total Cost of Trip

Do you intend to Ski, Trek, Mountain Climb or engage in Adventure Sports?

Have you been refused cover for this trip by any other insurer? Yes No

Privacy Agreement: By my signature, I give my explicit consent for Compusure Pty. Limited to direct correspondence regarding this application to the Agency named above and to use this information solely for the purpose of administering my application for Travel Insurance and any resultant Travel Insurance cover as detailed in our Travel Brochure/Application.

Signed Date / /

THIS SECTION IS TO BE COMPLETED BY YOUR USUAL DOCTOR

How long have you been the applicants' usual Medical Practitioner? Last examination date / /

List the nature of your patients existing health disorders

A) C)

B) D)

Please list details of all prescribed medication, by type, dosage and frequency.

1) 4) 7)

2) 5) 8)

3) 6) 9)

B/P Pulse/Rhythm U/a Chol Ht Wt BSL

Has the applicant ever suffered a Stroke / / TIA / / DVT / / PE / /

If the applicant has a cardiac condition, have they ever had;

Angina last attack / / frequency of attacks Corrective surgery? Stent / /

CABG / / / Angioplasty / / / Cardioversion/Ablation / / / Other

Does the applicant see a cardiologist Yes No Frequency Please attach copies of recent reports/tests results

Has the applicant been hospitalised in the past 3 years for any other condition? Yes No List Details

Is the applicant under specialist care for any disorder Yes No Please attach recent reports/test results

Does the applicant have any special travel needs? Eg. Wheelchair, Oxygen Support, CPAP

Do you consider the applicant fit and able to complete the trip? Yes No

Are there any other details we should know?

Dr's Signature Date / / Dr's Name

Telephone No. Facsimile No.

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

IMPORTANT NOTES FOR APPLICANTS

EXISTING HEALTH DISORDER COVER IS ONLY AVAILABLE

- When written Authority and Authority Number has been given by us.
- In respect of medical conditions for persons insured under this policy.
- By payment of Additional Premium as advised in the letter of Acceptance/Authority.

THERE ARE SOME HEALTH AND RELATED DISORDERS WHICH WE CANNOT COVER

- Where terminal or malignant prognosis has been given.
- Sexually transmitted disease or virus.
- A.I.D.S. (Acquired Immune Deficiency Syndrome) A.I.D.S. related complex (A.R.C.) or Human Immuno Deficiency Virus (H.I.V.).
- An addiction to alcohol or non prescription drugs.
- Mental or Nervous Disorder, depression, anxiety or stress.
- Replenishment of any medication presently being used.
- Maintenance of any form of treatment commenced prior to your trip.
- Your or any other person's pregnancy or related complications after 26 weeks of pregnancy, or child birth after 26 weeks of pregnancy unless the child birth was accelerated by accidental injury, irrespective of whether or not the pregnancy was known at the date of the certificate of insurance was issued.
- You travelling against medical advice or for the purpose of obtaining medical advice, treatment or hospitalisation.
- Existing health disorders of any person or relative(s) who are not travelling with you.

IMPORTANT NOTES FOR APPLICANTS

Your duty of disclosure

Before you enter into this contract of travel insurance you have a duty under the insurance contracts act 1984 to disclose to us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before you renew, extend, vary or re-instate this Contract.

Non Disclosure! If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the policy in respect to any claim or may cancel the policy. If your non disclosure is fraudulent we also have the option of avoiding the policy from its beginning.