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TOURSAFE TRAVEL INSURANCE

Travellers Medical Assessment Form

Enquiries: Compusure Insurance Services on 1800 252 689 or (02) 9701 6511

Please Ensure You Read This Information Before Completing This Form

You have indicated that you would like to apply for cover for your existing health disorder. You do not have to take cover for your existing health disorder however there is no cover under our policy for any claims arising as a result of or exacerbated by, or consequential upon an existing health disorder. To apply please ensure that the Application Form on the PDS and appropriate sections of the Travellers Medical Appraisal Form are **CLEARLY COMPLETED IN BLOCK LETTERS**. Return completed forms to our Distributor.

Please contact Compusure Insurance Services on 1800 252 689 or (02) 9701 6511 if you have any questions.

An Existing Health Disorder is:

An existing health disorder 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, and which is medically documented or under investigation 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, and for which treatment, medication, preventative medication, advice, preventative advice or investigation has 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 Frequent Traveller Travel Plan also within 30 days prior to booking a particular trip.

Note:

- Where any condition is the subject of an investigation, that condition falls within this definition, regardless of whether or not a diagnosis of the condition has been made.
- 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 your travel plans.

Provided the following existing health disorders are stable and you or anyone else to be covered are not waiting for treatment, on a hospital waiting list or awaiting results of medical tests or investigation in relation to any of these conditions cover is provided without medical application.

- Acne
- Allergies - such as allergic rhinitis, chronic rhinitis, hayfever, sinusitis, anaphylaxis, dermatitis, eczema, psoriasis, urticaria, food intolerance, latex allergy
- Anaemia - including iron deficiency anaemia, B12 deficiency, folate deficiency, pernicious anaemia
- Asthma - not requiring cortisone medication and no hospitalisation for the past 12 months including as an outpatient
- Bell's palsy
- Benign breast or renal cysts
- Bunions
- Carpal Tunnel syndrome
- Cataracts, dry eye syndrome, glaucoma, macular degeneration
- Coeliac disease
- Colonic polyps
- Congenital blindness/deafness
- Diabetes Mellitus Types 1 and 2 - where you have no known cardiovascular, hypertensive, vascular disease and no related kidney, eye or neuropathy complications
- Epilepsy - you have been seizure free for the past 12 months and do not require more than 1 anti-seizure medication
- Goitre, hypothyroidism, Hashimotos disease, Graves disease
- Gout
- Hiatus hernia/Gastro-oesophageal reflux disease, Peptic ulcer disease
- High Cholesterol (Hypercholesterolaemia)
- High Lipids (Hyperlipidaemia)
- Insulin resistance, impaired glucose tolerance
- Incontinence
- Meniere's disease, Tinnitus
- Menopause
- Migraines except where you have been hospitalised in the past 12 months
- Nocturnal cramps
- Osteoporosis - whereby there have been no fractures and you do not require more than 1 medication
- Plantar fascitis
- Raynaud's Disease
- Sleep apnoea
- Stable High Blood Pressure (Hypertension)
- Trigeminal neuralgia
- Trigger finger
- Routine screening tests where no underlying disease has been detected

WHAT FORM DO I NEED TO COMPLETE?	APPLICATION FORM ON PDS	MEDICAL APPRAISAL	
		PART A	PART B
INTERNATIONAL TRAVEL PLAN			
0 - 59 years and requiring cover for an Existing Health Disorder	✓	✓ In some cases we may also ask you to complete PART B	✗
60 - 79 years requiring cover for an Existing Health Disorder	✓	✓	✓
80+ years regardless of state of health	✓	✓	✓
DOMESTIC TRAVEL PLANS			
All age groups and requiring cover for an Existing Health Disorder	✓	✓ In some cases we may also ask you to complete PART B	✗
FREQUENT TRAVELLER TRAVEL PLAN			
0 - 59 years and requiring cover for an Existing Health Disorder	✓	✓ In some cases we may also ask you to complete PART B	✗
FREQUENT TRAVELLER TRAVEL PLAN 60 YEARS & OVER	NOT AVAILABLE		

Additional Amount Payable

INTERNATIONAL TRAVEL PLAN	PER PERSON
0 - 59 YEARS	$75
60+ YEARS This amount is the minimum additional amount payable. Some applications may incur higher amounts payable than the amounts shown.	$100
DOMESTIC TRAVEL PLANS	**PER PERSON**
REGARDLESS OF AGE	$50

FREQUENT TRAVELLER TRAVEL PLAN	PER PERSON
0 - 59 YEARS	$100

Once we have reviewed this form:

- We may offer you insurance; and
- We may provide cover for an existing health disorder on either a full or restricted basis. A Travellers Assessment 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 health disorder;
- We may offer altered terms and conditions to the policy.

IF OFFERED, COVER FOR AN EXISTING HEALTH DISORDER MUST BE TAKEN UP WITHIN 14 DAYS OF THE APPROVAL DATE.

Privacy

If you would prefer for your application and Travellers Assessment Form to be processed directly, mark the form "Confidential" and fax to our Medical Assessment Department on (02) 9744 7855.

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

This policy is underwritten by QBE Insurance (Australia) Limited ABN 78 003 191 035 of 82 Pitt Street Sydney

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Distributors Name & Address

Travel Masters
Cnr Cotton & Ferry Streets
Nerang West QLD 4211

Part A - To Be Completed By Traveller

When complete fax Medical Assessment Form to (02) 9744 7855

Title Full Name

I am applying for cover for an existing health disorder. ☐ Yes ☐ No

Date of Birth / / Postcode

☐ Male ☐ Female Height Weight

Phone Home/Mobile ( )

Phone Work ( )

Email

Country/ies to be visited

☐ Flights ☐ Cruises ☐ Snow Sports ☐ Trekking Trip Value $

Travel Dates / / to / /

Distributors Office: Travel Masters

Consultant Name

Office Phone ( ) 07 5596 0511

Office Fax ( ) 07 5596 5663

Have you booked your travel arrangements through this Office? ☐ Yes ☐ No

Policy Selected ☐ Single ☐ Family

Travel Plan Selected (Refer to the PDS)

In most cases if you answer the questions fully and accurately we will be able to process your application for Travel Insurance on the information supplied. In certain circumstances we may ask you to have our Doctor's Declaration completed by your usual Medical Practitioner before cover can be assessed.

GENERAL HEALTH QUESTIONS

Can you walk 50 metres unaided? ☐ Yes ☐ No

Do you require a wheelchair for the trip? ☐ Yes ☐ No

Are you currently a smoker? ☐ Yes ☐ No

If you have quit smoking, how many years since you last smoked?

Do you need oxygen, CPAP or have any other special travel requirements? ☐ Yes ☐ No

If yes to any of the above please give details:

Have you been hospitalised in the past 3 years for any reason? ☐ Yes ☐ No

Date and details including treatment

Have you;

Suffered from any form of heart condition? ☐ Yes ☐ No

Suffered from any vascular condition, stroke or TIA? ☐ Yes ☐ No

Suffered from any form of cancer or malignancy? ☐ Yes ☐ No

Suffered from any respiratory conditions (including asthma)? ☐ Yes ☐ No

Suffered from any psychiatric conditions including stress, anxiety, depression or any other medical condition? ☐ Yes ☐ No

Are you;

Travelling to obtain medical treatment? ☐ Yes ☐ No

Suffering from a terminal condition or registered with palliative care? ☐ Yes ☐ No

Suffering from metastatic cancer or secondaries? ☐ Yes ☐ No

Awaiting any medical tests/investigations or treatment? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

A. HEART CONDITIONS

What is the heart condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

Please give details, including dates of any of the following: Bypass surgery, angioplasty or stenting, valve replacements or any other corrective heart surgery.

Please give details, including dates of any of the following: Heart attack, heart failure, cardiomyopathy, ventricular failure or valve disease.

Please give details of any proposed surgery, tests or treatment.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

B. VASCULAR CONDITIONS

What is the vascular condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology, angiograms or pathology for this condition in the past 2 years please give details and results if known.

Please give details, including dates of carotid artery surgery, angioplasty, stenting or any other corrective surgery.

Please give details, including dates including the dates of stroke, TIA (transient ischemic attack), peripheral vascular disease or aneurysm, pulmonary embolus, deep vein thrombosis (clot).

Please give details of any claudication (pains in the legs due to vascular disease) or lower limb ulcers.

Please give details of any proposed surgery, tests or treatment.

Dates and details of hospitalisation for vascular condition.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

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Travel Masters
Cnr Cotton & Ferry Streets
Nerang West QLD 4211

TRAVELLERS DETAILS

Title | Full Name

C. RESPIRATORY CONDITIONS

What is the respiratory condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

Please give details of bronchitis or chest infections that occur with asthma.

How often and when did you last require antibiotics?

Please give details of how often and when did you last require cortisone (prednisolone).

Please give details of any proposed surgery, tests or treatment.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

D. PREGNANCY

Are you currently pregnant? ☐ Yes ☐ No Due Date / /

How many weeks will you be when you travel?

Was the pregnancy assisted by artificial reproductive techniques, eg IVF? ☐ Yes ☐ No

If yes please give details

Please give details if you have had previous miscarriages.

Please give details if you have suffered any pregnancy related complications either in this or in previous pregnancies.

Please give details of any special recommendations made by your doctor in regard to this trip.

E. CANCER

What is the condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

Please give details of any proposed surgery, tests or treatment.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

F. MEDICAL CONDITION

What is the condition?

If you have been referred to a specialist for this condition please give specialists name, contact number and how often you are seen.

If you have had any tests, eg radiology or pathology for this condition in the past 2 years please give details and results if known.

Please give details of any proposed surgery, tests or treatment.

Please give a brief history of the condition and how it affects you.

What is your treatment? Please include all medications you are currently taking.

G. UNDIAGNOSED OR SUSPECT CONDITION

Please give details of any tests, investigations, doctors visits or referrals to specialists you would like to disclose.

Please give details if any of these tests, investigations, doctors visits or referrals have been completed.

Please give details if you know the results.

Please give details if you have been told the purpose of the tests, investigations, doctors visits or referrals to specialists.

What possible diagnosis has the doctor told you could be the outcome of the above investigations etc?

Declaration: I have read and retained a copy of the PDS. I consent to the collection, use and disclosure of my health information for the purposes outlined in the Privacy Policy section of the PDS. I agree that I will not be covered for any existing health disorder unless the insurance company has agreed to insure those conditions. I agree that cover will not include replacement medication or maintaining a course of treatment commenced before the trip. I understand that should cover be given for any existing health disorder, it will be for UNEXPECTED TREATMENT ONLY.

Signature | Date / /

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

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TRAVEL INSURANCE

Doctors Declaration Part B - To Be Completed By Traveller's Doctor

When complete fax the Application Form and this Medical Assessment Form to: (02) 9744 7855

Distributors Name & Address
Travel Masters
Cnr Cotton & Ferry Streets
Nerang West QLD 4211

TRAVELLERS DETAILS

Title Full Name

Date of Birth / / Postcode

☐ Male ☐ Female Height Weight

Phone Home ( ) Phone Work ( )

Country/ies to be visited

☐ Flights ☐ Cruises ☐ Snow Sports ☐ Trekking

Travel Dates / / to / /

Your patient has asked you to complete this form as part of their travel insurance application. Please disclose all medical conditions as failure to disclose a condition means that your patient has no cover for the undisclosed condition.

Existing health disorder means:

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, and which is medically documented or under investigation 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, and for which treatment, medication, preventative medication, advice, preventative advice or investigation has 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 Frequent Traveller Travel Plan also within 30 days prior to booking a particular trip.

Note:

- Where any condition is the subject of an investigation, that condition falls within this definition, regardless of whether or not a diagnosis of the condition has been made.
- This definition applies to the traveller, their travelling party, and their relatives, business partner or any other person whose state of health could impact their travel plans.

What are the patients active medical conditions?

Details of treatment and medications

Details of past medical history

Details of any hospitalisations you know the patient to have had

Has your patient had ANY history of:

- Hypertension? ☐ / .
- Portal Hypertension? ☐ / .
- Angina? ☐ Frequency of attacks
- Heart Failure? ☐ CCF ☐ LVF ☐ Cardiomyopathy ☐ IHD ☐ Angiography ☐ Valvular Disease ☐ Stenting ☐ C.A.G.S ☐ Other
- Diabetes? ☐ Type

Diabetes Complications?

- Respiratory condition(s)? ☐ Asthma ☐ Bronchitis ☐ COAD ☐ COPD

Has your patient ever required oxygen? ☐ Yes ☐ No

Any other conditions or disease?

Is there any planned surgery test or treatment? ☐ Yes ☐ No

Please give details

Does your patient have any undiagnosed or suspected condition(s)? ☐ Yes ☐ No

Please give details of any tests/investigations/referrals that have been completed

Have you told your patient the purpose of the tests/investigation or referrals? ☐ Yes ☐ No

Please give details

What possible diagnosis have you told your patient/the family could be the outcome of the above investigations etc?

In your opinion is the patient fit to undertake the trip without requiring any additional medical attention in connection with any condition currently under treatment? ☐ Yes ☐ No

Have you provided a medical referral to any overseas medical practitioner or hospital?

☐ Yes ☐ No Why?

Is you patient suffering from a terminal condition? ☐ Yes ☐ No

Is your patient suffering from a metastatic condition? ☐ Yes ☐ No

Has your patient been referred to palliative care, district nursing or other home assistance?

Does you patient need other special requirements for the trip? ☐ Yes ☐ No

Details

Is your patient travelling to seek medical advice? ☐ Yes ☐ No

Is your patient attending any specialists e.g. cardiologists etc? ☐ Yes ☐ No

If so, provide copies of recent review

Any other comments/details you wish to add?

Doctor's Signature Phone ( )

Doctor's Name

Address

Postcode

Qualifications Date / /

Email

Fax ( )

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