Senior Medical Declaration Form

1Cover Travel Insurance

Travellers Aged 80 Years And Over

This assessment form is supplementary to the Product Disclosure Statement (PDS) for applicants who reside in Australia and are over 80 years of age or older. **All medical conditions must be declared on this application form**, even if you do not think they will be covered or do not wish to be covered for them.

Please be aware that our offer of cover may include limitations to the benefits of your policy. These include (but are not limited to):

- Capping your maximum claimable benefit
- Increasing your excess, and
- Excluding specific medical conditions.

We retain the absolute right to decline cover.

Instructions - How To Fill Out The Form

Step 1: Fill Out The Form Below.

- Please answer all questions on the form and sign the declaration.
- Please also have your doctor review the questions and answers, and have them sign the doctor's declaration.
- In some cases we may need your treating doctor to provide further declaration - we will tell you if this is required.

Step 2: Decision And Additional Medical Premium

- 1Cover will assess your application as quickly as possible and let you know the outcome.
- If approved, you will need to pay the required additional premium in order to take out the cover. You are not covered for approved conditions unless the required additional premium has been paid.
- We will note payment on your Certificate of Insurance, the reference number and any special information you might need to know.

More Than One Applicant?

Please Note: Each applicant must complete a separate form.

Call The Travel Insurance Specialists At 1Cover On **1300 126 837** If You Have Any Questions.

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Applicants Details

Title ________ First Name ______________________________ Surname ____________________________________

Address: ____

____ State: _____________ Postcode: __________

Contact No. (   ) __________________________________ Email ____

Date Of Birth DD / MM / YY Height ____ cm Weight ____ kg Are You Travelling By Cruise? ☐ Yes ☐ No

Departure Date DD / MM / YY Return Date DD / MM / YY Total Trip Value $ _______._____

Have You Smoked In The Last 6 Months? ☐ Yes ☐ No

Are You An Australian Citizen Or Permanent Resident? ☐ Yes ☐ No

Destination: ____

General Health

Do you require assistance with showering, toileting or taking medications? ☐ Yes ☐ No

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

Can you walk 100 metres unaided? ☐ Yes ☐ No If No, what aid do you use? __________________________

____

Do you play sport or exercise regularly? ☐ Yes ☐ No If yes, please provide details: ___________________

____

Contact Persons

If English is not your preferred language or you wish to nominate a person to speak on your behalf, please provide the name and number of a person who can discuss your medical status with our qualified clinical staff.

Name: ____ Relationship: _______________________________

Daytime Phone No: _________________________________

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Medical Information

You must provide all details below of ALL pre-existing medical conditions. **If you are unsure what pre-existing medical condition you have, please have your doctor complete this section and sign the doctor's declaration.** If there is insufficient space please attached a separate piece of paper.

Applicants Name: ______________________________

Medical Condition (list all)	Date Diagnosed	Medications Taken (list all)
	DD / MM / YY	
	DD / MM / YY	
	DD / MM / YY	

If you are treated for your **blood pressure**, what was your last reading? ______________ date ______________

If you are being treated for diabetes, what was your last reading? ______________ date ______________

Have your medications changed in the last 90 days? ☐ Yes ☐ No

If yes, please provide details: ______________________________

If you have been diagnosed with a heart condition, have you ever had: ☐ Angioplasty ☐ Stent ☐ Bypass ☐ Cardioversion ☐ N/A ☐ Other cardiac surgery (please provide details): ______________________________

____

Have you seen a doctor or had medical treatment by a health practitioner (including nursing or allied health, such as physiotherapy, podiatry, chiropractors) in the last 90 days? ☐ Yes ☐ No

If yes, please provide details (include **date** and **reason**): ______________________________

____

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Have you been treated* in hospital in the past 2 years? ☐ Yes ☐ No

If yes, please provide details (include **date** and **reason**): ______________________________

____

____

*treated includes same day procedures or emergency department visits, even if you were not admitted overnight

Are you currently awaiting medical review, treatment or investigation? ☐ Yes ☐ No

If yes, please provide details (include **date** and **reason**): ______________________________

____

Have you had any medical problems whilst travelling in the past 3 years? ☐ Yes ☐ No

☐ N/A – I have not travelled in the past 3 years

If yes, please provide details (include **date** and **reason**):______________________________

____

Applicants 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 confirm that all my answers are correct and complete. I have not withheld any information likely to affect my application for cover. I understand that should cover be given for any Pre-Existing Medical Condition, it will be for UNEXPECTED TREATMENT ONLY.

I have read and retained a copy of the Product Disclosure Statement (PDS). I acknowledge my Duty of Disclosure as detailed in the PDS. I have read the privacy information in the PDS and consent to the collection, use and disclosure of my health information for the purposes outlined within it.

______________________	______________________	DD / MM / YY
Signature of Applicant	Print Name	Date

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Doctors Declaration

The questions and answers on this form must be reviewed by your usual doctor, and this must be signed by them before we can process your application.

PATIENT NAME:____

Please advise: Blood pressure reading ____/____ Date __DD__/__MM__/__YY__ Heart Rate _____ Date __DD__/__MM__/__YY__

Cholesterol Level _______ Date __DD__/__MM__/__YY__ HbA1C (if applicable) ___________ Date __DD__/__MM__/__YY__

Travel overseas, particularly by commercial aircraft, places significant stress on individuals with a medical condition which may result in decompensation. This fact must be taken into account when completing this declaration.

In your opinion, is your patient medically fit to undertake the proposed journey without suffering a medical episode?

☐ Yes ☐ No ____

Please detail any special requirements of the patient while travelling on the proposed journey: ________________

____

Please detail other matters you feel an insurer should be aware of: ______________________________________

____

Doctors Declaration

I declare that I am familiar with the patient's medical condition and have been their doctor since (date/year) ____DD____/____YY____. I hereby declare that the information detailed on this form is accurate and complete and that no information has been withheld that may influence the insurer.

______________________	______________________	DD / MM / YY
Signature of Doctor	Print Name	Date

Qualifications __________________

Phone ________________________

Fax __________________________

Doctors Stamp and initial:

What Happens Next

Once all questions have been completed, please return to:

Mail:
1Cover Pre-Existing Team
Level 11, 307 Pitt Street
Sydney, NSW 2000

Email:
info@1Cover.com.au

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 by the next business day. In certain circumstances we may ask you to have our Doctor's Declaration completed by your usual Medical Practitioner before cover can be assessed.

Depending on the condition(s), 1Cover may decline or limit cover, or agree to provide cover for an additional premium. 1Cover will provide an endorsement to your policy which specifies each condition that we agree to cover.

Cover for the condition(s) is only for claims arising from unexpected treatment and will only apply after you pay any additional premium that we require.

IF OFFERED, COVER FOR A PRE-EXISTING MEDICAL CONDITION MUST BE TAKEN UP WITHIN 30 DAYS OF THE ASSESSMENT DATE AND AN ASSESSMENT NUMBER MUST APPEAR ON YOUR CERTIFICATE OF INSURANCE.

Additional Notes