

## Travellers Aged 80 Years And Over

This assessment form is supplementary to the Product Disclosure Statement (PDS) for applicants who reside in New Zealand 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.

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## 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 **0800 000 333** If You Have Any Questions.

## Applicants Details

Title \_\_\_\_\_ First Name \_\_\_\_\_ Surname \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Region: \_\_\_\_\_ 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 A New Zealand Citizen?  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: \_\_\_\_\_

## 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**): \_\_\_\_\_

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.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date



