

Medical Risk Assessment Form



This Medical assessment form must be completed and forwarded to us as soon as possible. This will be reviewed by us prior to acceptance of cover for your condition. Our written confirmation of acceptance (in addition to any Policy certificate issued) is a pre-requisite in respect of any claim. On review of this Travel Risk Assessment Form, we will confirm whether cover for the condition is accepted.

Important Note:

If cover is provided for any pre-existing medical conditions which you suffer, an additional premium charge may be required. Where this is the case you will be advised as part of your application for insurance whether the insurance is accepted, accepted with an additional premium loading or the application is denied.

First Name		Surname		
Address		Suburb		
City		Phone No.		
Educational Body		Travel Insurance Policy No/Student ID		
Date of Birth		Date first enrolled		
Main Destination		Duration		
Height (cm)		Weight (kg)		
Policy Type:	StudentSafe <input type="checkbox"/>	VisitSafe <input type="checkbox"/>	OffShore <input type="checkbox"/>	Other (please specify) <input type="text"/>
Course Start Date:	/	/	Proposed Length of Study Anticipated:	(Months)
Course Type:	Multi year <input type="checkbox"/>	12 Month <input type="checkbox"/>	Part year/Short course	<input type="checkbox"/>

Please answer the following questions:

Q1 Please list the names of all the medications that are prescribed by a doctor that you are taking:

Drug - Dose	How long have you been taking?

Q2 Please list all medical conditions, physical defects, infirmities, existing or recurring illnesses, injuries or disabilities you are currently aware of or being treated for?

1.	Date First Diagnosed	
2.	Date First Diagnosed	
3.	Date First Diagnosed	

Q3 Has your medication or treatment changed in the last 12 months? Yes No

If Yes please describe:

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Q4 Have you been treated or seen by a specialist in a hospital or in the specialist's private rooms in the last 12 months? Yes No

If Yes please describe:

Q5 Have you been seen by your general practitioner in the last 6 months? Yes No

If so please provide the reason for this visit and the outcome?

Q6 Are you under specialist care for any conditions? Yes No

If Yes please describe:

Q7 Do you have any conditions under review where a medical diagnosis has not yet been determined? Yes No

If Yes please describe:

Q8 Are you waiting for the results of any tests? Yes No

If Yes please describe:

Q9 Are you on a waiting list for surgery or treatment, or are you waiting to see a specialist? Yes No

If Yes please describe:

Q10 Have you previously made any insurance claim for any of the medical conditions you have disclosed to us? Yes No

If Yes please describe:

Signature

Date / /

Please fax this form to 0800 800167