

# 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"/>

## 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:


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:


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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:

## Duty of Disclosure

Subject to any rights you have under the Criminal Records (Clean Slate) Act 2004, you have a duty to give us information which is in every respect correct and complete and you have disclosed all material information, whether the information has been asked for or not. Material information is information that might influence our decision to insure you and if so on what terms and/or premium. If you have any doubt as to whether a fact is material then it must be disclosed. The duty to disclose all material information occurs prior to the commencement of cover, if your cover is varied and prior to each renewal. Failure to disclose all material information may result in us avoiding your insurance cover. This means your cover is deemed never to have existed and any claims would not be payable.

I hereby declare:

1. To the best of my/our knowledge all the statements in this form are correct.
2. I have not withheld any information material to this application.
3. I understand that:
  - the personal information provided in this form is being collected by Vero Insurance New Zealand Ltd and Comprehensive Travel Insurance 2004 Limited to enable it to evaluate my/our application;
  - I have certain rights of access to and correction of the personal information provided by me/us on this form or in support of any claim, but if I do provide any incorrect information, Vero Insurance New Zealand Ltd and Comprehensive Travel Insurance 2004 Limited may be entitled to decline any claim.
5. I authorise Vero Insurance New Zealand Ltd and Comprehensive Travel Insurance 2004 Limited or its agents to:
  - obtain personal information about me from any other party and to release that information to other parties if requested;
  - obtain information from the Insurance Claims Register (ICR Ltd), which holds details of claims made by me/us under policies with other insurers that is in their view relevant to this application;
  - place details of any claim made on the database of ICR Ltd where it will be retained and be available to other insurance companies to inspect.

Signature

Date        /        /

**Please fax this form to 0800 800167**