

COMPLETION INSTRUCTIONS FOR THE TRAVELLER

Medical Appraisal Form A is required for all HBF Travel policies, when:

1. You or any applicant to be Covered by this insurance suffer from any Pre-existing Medical Conditions and have received medical or dental treatment or advice, or taken prescribed medication in the last 90 days, and You wish to take Cover for the condition(s).

AND/OR

2. You or any applicant to be Covered under a Gold, Super, or Budget Policy suffer from any of the automatically Covered Pre-existing Medical Conditions listed in the Travel Policy Wording and Product Disclosure Statement, where You don't meet the qualifying criteria, and You wish to take Cover for the condition(s).

Medical Appraisal Form A & B are required when:

1. You or any applicant to be Covered by this insurance have any Physical Conditional, for which a specialist review is planned other than the automatically Covered Pre-existing Medical Conditions listed in the Travel Policy Wording and Product Disclosure Statement, irrespective of whether You wish to take Cover for the condition(s) or not.

AND/OR

2. You or any applicant to be Covered by this insurance has submitted Medical Appraisal Form A and HBF require further information before acceptance of risk can occur.

Medical Appraisal Form A – Is completed by the Traveller

Medical Appraisal Form B – Is completed by a Medical Practitioner

COMPLETION INSTRUCTIONS FOR THE DOCTOR

If Your medical practice has computerised patient records and the Health Summary sheet is sufficiently detailed as to adequately answer any question on the part of this form to be completed by the Doctor, then You may indicate this on the form and attach a copy of the Health Summary sheet. If You choose to attach the Health Summary sheet, We reserve the right to contact You should clarification or additional information be required.

YOUR DUTY OF DISCLOSURE

What You must tell Us

When answering Our questions, You must be honest and You have a duty under law to tell Us anything known to You, and which a reasonable person in the circumstances, would include in answer to the question. We will use the answers in deciding whether to insure You and anyone else to be insured under the Policy, and on what terms.

Who needs to tell Us

It is important that You understand You are answering Our questions in this way for Yourself and anyone else whom You want to be Covered by the Policy.

If You do not tell Us

If You do not answer Our questions in this way, We may reduce or refuse to pay a claim, or cancel the Policy. If You answer Our questions fraudulently, We may refuse to pay a claim and treat the Policy as never having worked.

If You do not understand Your duty please contact Us.

IMPORTANT INFORMATION

Your records

The Policy and Your current Certificate of Insurance, Variation or Endorsement are a record of Your Cover. They are important documents containing the terms and conditions which apply to our agreement. You may need them from time to time and particularly when You need to make a claim. Please retain these documents and keep them in a safe place.

PRIVACY STATEMENT

HBF Insurance Pty Ltd (ABN 11 009 268 277) (HBF Insurance) will use the personal information on this form when it is returned to HBF Insurance either by the medical practitioner or the patient, upon completion of the form. HBF Insurance uses this information to decide whether to issue a travel insurance policy, and if so, on what terms, and to assist HBF Insurance in managing any claims made by the patient. HBF Insurance may disclose the personal information on this form to an external consultant providing a recommendation on whether to issue a travel insurance policy or dealing with the assessment or investigation of claims made by the patient or the Financial Ombudsman's Service or any other external adviser used by HBF Insurance to assist in the resolution of a dispute with the patient. There are requirements under the Insurance Contracts Act 1984 that the patient discloses to HBF Insurance all material information in relation to their travel insurance policies, and this may include the information provided by the medical practitioner on this form. If the personal information requested in this form is not provided, HBF Insurance may not be able to provide a travel insurance policy to the patient. Both medical practitioner and patient have a right to access their personal information held by HBF Insurance.

Further details on the way We handle personal information are in Our Privacy Policy, which is available at www.hbf.com.au or on request by calling a Member Service Advisor on 133 423.

If there is insufficient space on this Medical Appraisal form please attach a separate sheet or use the reverse side of Form B.

Medical Appraisal Form A



THIS FORM IS TO BE COMPLETED BY THE TRAVELLER

1

Title Surname Given Names HBF Member Number
 Address Postcode
 Home Phone Business Mobile
 Email Address Fax Number Date of Birth
 Destinations (List All) Departure Date Return Date
 HBF Service Centre

2

PLEASE PROVIDE DETAILS OF ALL EXISTING MEDICAL CONDITIONS (Attach a separate sheet of paper if more than 2 conditions)

Name of Condition/Diagnosis	CONDITION 1	CONDITION 2
1. Date of diagnosis/onset	<input type="text"/>	<input type="text"/>
2. Date of operation	<input type="text"/>	<input type="text"/>
3. Operation details	<input type="text"/>	<input type="text"/>
4. Medication type and dosage	<input type="text"/>	<input type="text"/>
5. Current symptoms	<input type="text"/>	<input type="text"/>
6. Do You have any special needs	<input type="text"/>	<input type="text"/>
7. Have there been any flare ups within the last 18 months?	<input type="text"/>	<input type="text"/>
a) complications	<input type="text"/>	<input type="text"/>
b) causes	<input type="text"/>	<input type="text"/>
c) treatment during flare ups	<input type="text"/>	<input type="text"/>
8. When was the last "event" eg seizure, asthma attack etc	<input type="text"/>	<input type="text"/>
9. Are You on a waiting list for surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) type of surgery	<input type="text"/>	<input type="text"/>
b) proposed date	<input type="text"/>	<input type="text"/>
10. Have You had any investigations or referrals in the past 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) type of investigations or referrals	<input type="text"/>	<input type="text"/>
b) date of investigations or referrals	<input type="text"/>	<input type="text"/>
c) when is Your next review due?	<input type="text"/>	<input type="text"/>
11. Are You having any other treatment in regard to the condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has the treatment or medication changed in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. If yes, how?	<input type="text"/>	<input type="text"/>

3

REASONS AND DATES OF HOSPITALISATION DURING LAST 3 YEARS AND REASONS AND DATES OF MEDICAL CONSULTATIONS (IN DOCTORS ROOMS) DURING THE LAST 6 MONTHS (FOR ANY CONDITION).

Details Date
 Date

4

AUTHORITY TO RELEASE MEDICAL INFORMATION

I authorise HBF Insurance Pty Ltd to release the information declared in this Medical Appraisal Form to its medical assessors and the agent authorised to arrange this insurance. I also authorise any hospitals, clinic, doctor or any other person to release to HBF Insurance Pty Ltd or its assessors any and all information concerning my past and present medical history. A photocopy or facsimile copy of this authority shall be as valid as the original.

DECLARATION AND ACKNOWLEDGMENT

I declare that I have not withheld any information whatsoever regarding my health, and that all my information on this form is true, correct and complete. I acknowledge that it is a condition of my agreement with HBF Insurance Pty Ltd to insure me that I must comply with my Duty of Disclosure which is highlighted in the Travel Policy Wording and Product Disclosure Statements. If I fail to comply with my Duty of Disclosure, I acknowledge that HBF Insurance Pty Ltd may be entitled to reduce their liability in respect of a claim or may cancel the contract. If my nondisclosure is fraudulent, HBF Insurance Pty Ltd may also have the option of avoiding the contract from its beginning. I hereby declare that I have read and understood the Duty of Disclosure. I authorise HBF Insurance to collect or disclose any personal information relating to this insurance to/from any other insurers or insurance reference service.

Signature of Applicant Date

Medical Appraisal Form B



THIS FORM IS TO BE COMPLETED BY YOUR DOCTOR

1

TRAVELLER'S DETAILS

Title Surname Given Names Date of Birth

Address Postcode

Itinerary: Please list the countries to be visited

Date of Departure Return Date HBF Membership Number

2

DOCTOR'S DETAILS

Name Business

Address Postcode

3

PLEASE PROVIDE DETAILS IF YOUR PATIENT HAS A HISTORY OF ANY OF THE FOLLOWING

CHRONIC AIRWAYS CONDITION(S) Yes No

CANCER/TERMINAL/MALIGNANT Yes No

FITS/FAINTS/FUNNY TURNS Yes No

HEART CONDITION(S) OF ANY KIND Yes No

THROMBOEMBOLIC CONDITION(S) Yes No

CEREBROVASCULAR CONDITION(S) Yes No

JOINT OR OTHER REPLACEMENTS Yes No

CONDITIONS CURRENTLY BEING TREATED OR UNDER REVIEW

	CONDITION 1	CONDITION 2	CONDITION 3
Name of Condition/Diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of onset	<input type="text"/>	<input type="text"/>	<input type="text"/>
Current medication	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other treatment	<input type="text"/>	<input type="text"/>	<input type="text"/>
Current symptoms	<input type="text"/>	<input type="text"/>	<input type="text"/>
Special needs	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pending specialist reviews/treatments	<input type="text"/>	<input type="text"/>	<input type="text"/>

For further listing of conditions or diagnosis please use the 'Additional Notes' space on the back page.
Please include copies of relevant reports eg. Stress tests/Angiogram/Cardiology reviews etc

4

Dates and reasons of hospitalisation in last 3 years

5

Dates and reasons of Medical/Dental Consultations in last 6 months

Do you consider the applicant fit and able to travel the planned itinerary without needing additional medical treatment, assistance or consultation in relation to the above conditions. Yes No

If No, please provide details

Doctors Signature Date Doctors Official Stamp

