Accident & Health International
Underwriting Pty Limited

Accident and Health

APPLICATION FORM

EXPATRIATE MEDICAL EXPENSES INSURANCE

HOW TO FILL OUT THIS FORM

Please fill out every question neatly and clearly. This will assist us in evaluating your application and if we are unable to read the information you have given us, we may not be able to provide your insurance.

Organisation or Company _____

Name of Employee _____

Nationality _____ **Date of Birth** _____

Occupation _____

Accompanying Spouse or Partner _____ _____

Accompanying Dependant Children _____ **Date of Birth** _____

_____ **Date of Birth** _____

_____ **Date of Birth** _____

_____ **Date of Birth** _____

City or Country of Posting _____

Address of Posting _____

_____

Period of Cover: **From** _____ **To** _____

Medical Expenses Sum Insured _____ **Excess/Deductible** _____

Evacuation Cover and Personal Safety (Dynamiq Assist) _____

(Dependant Children who accompany parents are automatically covered by this policy under the family premium)

		YES	NO
1.	**Have you or any Family Member accompanying you:**		
a.	**ever had any disorders which affected your heart, lungs, bowels, bladder, liver, kidneys, blood circulation, digestive system, genitals, back, ears or eyes?**	☐	☐
b.	**ever had any nervous disorder, paralysis, rheumatism, tuberculosis, ulcer or cancer?**	☐	☐
c.	**lost all or part of a limb or have any other physical defect or infirmity?**	☐	☐
d.	**had any other illness, injury, operation or treatment in the last 5 years which required hospitalisation?**	☐	☐

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EXPATRIATE MEDICAL EXPENSES INSURANCE

2.	**Is there any foreseen recurrence of any illness or injury previously suffered or the possibility of You or an Accompanying Family Member undergoing surgery or other treatment?**	☐	☐
3.	**Are you or any of your Family members:**		
	a. Pregnant?	☐	☐
	b. Required to have a medical examination prior to leaving for overseas assignment?	☐	☐
	c. On a waiting list for medical treatment?	☐	☐
4.	**Do you or any Family Member take medication or drugs on a regular basis?**	☐	☐
5.	**Do you or any Family Member wear glasses or have vision impairments?**	☐	☐
6.	**Do you or any Family Member intend to go the dentist in the next 12 months?**	☐	☐

NOTE **If any of the above were answered "Yes", please provide details including description of injury or illness, duration (dates), the cause, nature of treatment and results, current condition, name and addresses of doctors and hospitals consulted.**

IMPORTANT INFORMATION

PRIVACY

I/we agree that, by submitting this form, the personal information I/we provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in the [AHI] Privacy Policy found at www.acchealth.com.au, including for the processing of this application and providing me/us with cover.

EXPATRIATE MEDICAL EXPENSES INSURANCE

INSURER

The Insurer for your policy is CGU Insurance Limited. Accident & Health International Underwriting Pty Limited are an agent acting on behalf of the Insurer under an authority (binding agreement) agreed by the Insurer.

YOUR DUTY OF DISCLOSURE

Before you enter into an insurance contract with us, the Insurance Contracts Act 1984 requires you to provide us with the information we need to enable us to decide whether and on what terms your proposal for insurance is acceptable and to calculate how much premium is required for your insurance.

The Act imposes a different duty the first time you enter into the policy with us to that which applies when you vary, renew, extend, reinstate or replace your policy. We set these two duties out below.

Your Duty of Disclosure when you enter into this policy with us for the first time:

You will be asked various questions when you first apply for this policy. When you answer these questions, you must:

- give us honest and complete answers,
- tell us everything you know, and
- tell us everything that a reasonable person in the circumstances could be expected to tell us.

Your Duty of Disclosure when you renew, vary, extend, reinstate or replace your policy:

When you renew, vary, extend, reinstate or replace the policy your duty is to tell us before the renewal, variation, extension, reinstatement or replacement is made, every matter known to you which:

- you know, or
- a reasonable person in the circumstances could be expected to know, is relevant to our decision whether to insure you and whether any special conditions need to apply to your policy.

What you do not need to tell us for either duty:

You do not need to tell us about any matter:
- that diminishes our risk,
- that is of common knowledge,
- that we know or should know as an insurer, or
- that we tell you we do not need to know.

Who do the above two duties apply to? Everyone who is insured under the policy must comply with the relevant duty. What happens if you or they do not comply with either duty? If you or they do not comply with the relevant duty, we may cancel the policy or reduce the amount we pay if you make a claim. If fraud is involved, we may treat the policy as if it never existed and pay nothing.

Renewal Procedure

Before this policy expires we will normally offer renewal by sending a renewal invitation advising the amount payable to renew this policy. It is important that you check the information shown before renewing each year to satisfy yourself that the details are correct.

DECLARATION: I/WE HEREBY DECLARE AND WARRANT that the answers given above are in every respect true and correct, and that I/We have not withheld any information within My/Our knowledge likely to affect the decision of the company as to My/Our eligibility for Insurance. The application and declaration shall be the basis of the contract between the Company and Myself/Ourselves, and I/We agree to accept the Company's Policy subject to the terms and conditions to be contained therein.

I further authorise the Company to consult my doctor regarding any condition declared on this application and authorise my doctor to release any information relevant to same.

Date _____ Signature of Insured Person _____