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Rewarding experience

For Completion by the Traveller (one traveller/trip per form)

Quote / Policy number

Name | Date of birth

Postal address

Contact number | Email address

Departure date | Return date | Trip value

Countries to be visited

Q1. Have you smoked in the last 6 months? Yes ☐ No ☐

Q2. Please advise all medical conditions and medications taken. For conditions diagnosed over 12 months ago, provide approximate dates **(please attach a separate page if not enough room is available)**

Medical condition	Diagnosis Date	Medication taken	Frequency

Q3. If you are undergoing treatment for hypertension, high cholesterol or diabetes, please provide the most recent readings

Blood pressure	Date	Cholestrol level	Date	Blood sugar	Date

Q4. Have you suffered from epilepsy, provide date of last known seizure? Yes ☐ No ☐ Date

Q5. Have you ever had a CVA (cerebrovascular attack) or a TIA (transient ischaemic attack)? Yes ☐ No ☐

Q6. Have you visited a medical practitioner in the last 90 days? (including physiotherapist, naturopath etc) Yes ☐ No ☐

If so, please provide details of all appointments here:

Date	Details (including health problem and what treatment was provided)

Q7. Have you been hospitalised in the last 12 months Yes ☐ No ☐

If so, please provide details here

Date	Details (including health problem and any treatment planned)

Q8. Are you currently awaiting medical review, treatment or investigation? Yes ☐ No ☐

I hereby declare that the information details on this form and in any attachments is accurate and complete and that no information has been withheld which may influence Apia. I also give consent for you to contact any treating medical practitioner(s) for additional information as required

Customer signature | Date

Please return by fax 1300 102 566 / Email to Medex@apia.com.au / Mail to GPO Box 1619, Adelaide, SA, 5001

203543_01RR6A

For Completion by your Medical Practitioner

How long have you been this patients treating doctor

Cardiac condition(s)

Diagnosis date | Date of last specialist review

Condition(s)

Cardiac tests done and dates

Treatment / plan

Recent symptoms and when

Please provide copies of specialist reviews and relevent cardiac test results from the last 2 years as an attachment to this form

Respiratory condition(s)

Diagnosis date | Date of last specialist review

Condition(s)

Respiratory test done and dates

Treatment / plan

Recent symptoms and when

Please provide copies of specialist reviews and relevent respiratory test results from the last 2 years as an attachment to this form

Reduced immunity*

*as a result of either treatment/medication or a medical condition

Diagnosis date

Medical condition/cause

Treatment/plan

Date of last treatment

Please provide copies of all full blood counts done in the past 12 months

Metastatic (secondary) cancer

Does the patient have a terminal prognosis? Yes ☐ No ☐

Location of primary cancer | Diagnosis date

Location of secondary cancer | Diagnosis date

Treatment/plan

Date (to be) completed

Please provide a copy of most recent specialist report as an attachment to this form

Kidney condition

Diagnosed

Condition

Creatinine reading | eGFR | Date of readings

Has the patient ever had or been advised they need dialysis? Yes ☐ No ☐

If the creatinine level is > 200, please provide all blood results from the last 12 months as a separate attachment to this form

Dementia

Diagnosis date

Condition

Mini mental score (MMSE) | Date of test

Please provide a copy of the most recent specialist reports. If modified MMSE performed, please include full copy of test results

Please detail any special requirements of the patient whilst travelling on the proposed journey

Please detail any matter(s) you feel an insurer should be aware of

Declaration

I hereby declare that the information detailed on this form and in attachments is accurate and that no information has been withheld which may influence the insurer

Signature of physician

Print name

Date | Phone number

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