DECLARATION FORM

Expatriate Medical Expenses

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.

Your Details:

Company Name

ABN

Name of Employee

Nationality | Date of Birth

Accompanying Partner | Date of Birth

Accompanying Dependent Children | Date of Birth

Accompanying Dependent Children | Date of Birth

Accompanying Dependent Children | Date of Birth

Accompanying Dependent Children | Date of Birth

Occupation

City or Country of Posting

Address of Posting

Period of insurance From: To:

Medical Expenses Sum Insured $1,000,000 Other amount $ Excess/Deductible $500 $1,000

Evacuation Cover and Personal Safety (AHI Assist) $50,000 Other amount $

(Dependent Children who accompany parents are automatically covered by this policy under a family premium)

Claims History

Have you previously been insured for this type of risk? Yes No

If Yes, please give any claim details and attach an up to date claims experience

Date of Loss, Nature of Loss, Amount

AHI

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Expatriate Medical Expenses Insurance

		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?		
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 to the dentist in the next 12 months?			
7. Do you require any Personal Accident cover whilst Expatriated?			

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 ahiinsurance.com.au, including for the processing of this application and providing me/us with cover.

General Insurance Code of Practice
AHI proudly support the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

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. This 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.

Signature of Insured

Date