

Expatriate medical and emergency travel insurance application

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545



Please return the completed form to your financial services provider, or email underwriting@qbe.com

Policy No. Claim No. Intermediary No.

The applicant(s)

Name(s) in full											
Tax status	Registered business	Yes	No	ABN						Taxable	%
Address								State		Postcode	
Contact number	Phone (private)	()			Phone (business)	()					
	Fax	()									
E-mail											
Period of insurance	From (dd/mm/yyyy)					to (dd/mm/yyyy)					at 4 p.m.

Personal details of insured person - expatriate worker

Name of insured person											
Postal address in Australia								State		Postcode	
Contact number in Australia	Phone (private)	()			Phone (business)	()					
Are you a resident of Australia?	Yes	No	What is your nationality?								
Which overseas country(ies) will you be temporarily resident in?											
Postal address overseas (if known)								State		Postcode	
Contact No. overseas (if known)	Phone (private)	()			Phone (business)	()					
Date of birth (dd/mm/yyyy)				Height			cm	Weight			Kg
Your occupation											
Describe your duties											
Are you currently employed outside of Australia?	Yes	No	If "Yes", when did you commence that employment? (dd/mm/yyyy)								
Duration of overseas employment											

If you are not currently employed outside of Australia, do you intend to commence employment outside of Australia in the near future? Yes No
 If "Yes", please provide full particulars of that employment including a letter from your prospective employer confirming the details of your overseas employment.

Do you intend to return to Australia and resume working in Australia? Yes No If "Yes", when? (dd/mm/yyyy)

Do you regard your employment overseas as temporary? Yes No Your average weekly earnings \$ pwk

Are you a member of a registered health fund or your employer's health care plan? Yes No

If "Yes", what is the amount you claimed in previous 12 months (if it exceeds \$1,000) \$

Type of cover Single Couple Family

Details of dependants to be included as insured persons

Category	Name	Relationship	Date of birth (dd/mm/yyyy)	Pre-existing conditions
Category 2 accompanying spouse				
Category 3 Accompanying children				

Note: Children between 18 and 25 who are engaged in full-time study can only be included as "student dependents". Please provide details of the study program and other evidence of attendance. Please attach details.

Insurance and medical details - applicable to ALL insured persons

1. Has any application for accident or illness insurance on your life ever been declined, modified, accepted at an increased premium, cancelled or refused renewal?	Yes	No
2. Have you ever claimed for benefits under any accident or illness policy?	Yes	No
3. Will you be entitled to claim under any other existing or intended insurance from any other source providing for weekly benefits, workers compensation or sick leave?	Yes	No
4. Have you ever received medical advice, consulted a doctor, undergone any medical treatment or investigations for high blood pressure or cholesterol; any heart complaint or problem; HIV, AIDS or AIDS related conditions; stroke, kidney, bowel bladder or liver disease; cancer or tumour of any type; diabetes; asthma or any lung complaint; mental, nervous or depressive disorder; epilepsy; alcohol or drug abuse; nervous system disorder?	Yes	No
5. During the last 5 years, have you suffered from any other health problem or physical impairment not mentioned above or have you taken prescribed medication of any kind? (It is not necessary to answer "Yes" if only for colds and flu).	Yes	No
6. Do you currently have any symptoms of ill health or injury or are you taking prescribed medication of any kind?	Yes	No
7. Is there any likelihood of recurrence of any illness or injury previously suffered or the possibility of you undergoing surgery or other treatment?	Yes	No

If you have answered "Yes" to any of the above questions, please give details including description of injury or illness, duration (dates), the cause, nature of treatment and results, current condition, names and addresses of doctors and hospitals consulted. If there is insufficient space, please attach details.

Activity details

Do you currently, or do you intend to engage in any hazardous pursuit or pastime, including but not limited to motor sports in any form, rock climbing, water skiing, snow skiing or horse riding? If "Yes", please give details. Yes No

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at www.qbe.com.au/privacy, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Declaration and signature by insured / insured person

I/we declare that the particulars are true and correct, that I/we have not withheld information likely to affect the acceptance of this application.

Signature of applicant	Date (dd/mm/yyyy)	Signature of insured person	Date (dd/mm/yyyy)
X <input type="text"/>	<input type="text"/>	X <input type="text"/>	<input type="text"/>

Office use only

Premium \$ + Government stamp duty \$ = TOTAL amount payable \$