

PRE EXISTING MEDICAL CONDITION FORM



EXPAT INSURANCE SERVICE

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Authorized Representative No: 267807

Please tick the appropriate entries.

1) Have you or any accompanying family ever had any of the following during the past 5 years?	
Name of Family member(s):	-----
A) Ever had any disorders which affected your heart, lungs, bowels, bladder, liver, kidneys, blood circulation, digestive system, genitals, back, ears or eyes?	<input type="checkbox"/> <input type="checkbox"/> Yes No
B) Ever had any of the following; nervous disorder, paralysis, rheumatism, tuberculosis, ulcer or cancer?	<input type="checkbox"/> <input type="checkbox"/> Yes No
C) Lost all or part of a limb or have any other physical defect or infirmity?	<input type="checkbox"/> <input type="checkbox"/> Yes No
D) Had any other illness, injury operation or treatment in the last 5 years which required hospitalisation?	<input type="checkbox"/> <input type="checkbox"/> Yes No
E) Do you take medication or drugs on a regular basis?	<input type="checkbox"/> <input type="checkbox"/> Yes No
If you have answered "Yes" to any of the above please provide details on the next page; including a description of the injury or illness, duration, cause nature of treatment (drugs), and current condition.	

Details:

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 insurer and MYSELF/OURSELVES.

Date: _____

Signature of Expatriate: _____

Please note we may require the details of your treating doctor or hospital. We could be required to discuss your condition before providing cover under the policy as well as at any stage during the policy period should an emergency arise