

**UNIVERSITY OF NEW ENGLAND
TRAVEL INSURANCE
APPLICATION FORM**

- AUTHORISED BUSINESS TRAVEL**
- AUTHORISED STUDY LEAVE**
- HOLIDAY TRAVEL**
- ACCOMPANYING FAMILY TRAVEL**

Note: This form is to be used:

- (a) for Insured Persons going on Authorised Business Travel in excess of 2 months, to determine pre-existing condition cover; and/or
- (b) to include accompanying family on Authorised Business Travel in order to determine a premium and if such travel exceeds two months, to determine cover for pre-existing conditions.

A separate form should be completed for each traveller.

NAME OF INSURED PERSON: **Date of Birth:**

CATEGORY: **EMPLOYEE/ACCOMPANYING PARTNER/ACCOMPANYING CHILD**

WHAT ARE THE DUTIES OF YOUR OCCUPATION:

1. Have you had Medical or Surgical advice or treatment, or been hospital-confined during the past 5 years? **YES/NO**
If YES, please answer the following for each condition: (if sufficient space use separate page)

Type of Condition Date Occurred.....
If an injury, how did it occur
Period unable to work.....
Name of Hospital Length of stay
Doctor's name & address.....
Do you foresee any further problems whilst away?..... If so, what?

2. Have you ever had abnormal blood pressure, ulcers, diabetes, tuberculosis, cancer, paralysis, arthritis or rheumatism, any disorders of the mental, respiratory, nervous, genito-urinary, digestive or circulatory systems, or of the back, spine, eyes or heart?
If YES, please answer the following for each condition: (if insufficient space use separate page) **YES/NO**

Type of Condition Date Occurred.....
If an injury, how did it occur
Period unable to work.....
Name of Hospital Length of stay
Doctor's name & address.....
Do you foresee any further problems whilst away?..... If so, what?

Insurance applies only for authorised travel outside the city limits where employed, with Medical Benefits cover only applying to travel outside Australia.

Please advise Period(s) of travel & Destinations:

From To Destination
From To Destination
From To Destination
From To Destination

POLICY NO:

**PREMIUM
GST**

DECLARATION: WE HEREBY DECLARE AND WARRANT that the answers given above are in every respect true and correct, and that we have not withheld any information within our knowledge likely to affect the decision of the Insurers as to our eligibility for insurance. This application and declaration shall be the basis of the contract between the Insurer and ourselves and we agree to accept the Insurer's policy subject to the terms and conditions to be contained therein.

SIGNATURE OF THE INSURED: **DATE:**

On completion, this form, together with your cheque for the Total Premium payable to the University of New England, should be forwarded to your in-house Insurance Officer.