

# CHI Travel Insurance Application Form

Please do not detach. Return the entire brochure to your agent.  
If you have insufficient space to complete your answers, please attach a separate sheet.

## Traveller's details

			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH
			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH

## Children's details

			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH
			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH
			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH
			/ /
INSURED'S SURNAME	FIRST NAME	TITLE	DATE OF BIRTH

## Traveller's contact details

RESIDENTIAL ADDRESS	SUBURB	STATE	POSTCODE
EMAIL			
( )	( )		
PHONE (AFTER HOURS)	PHONE (BUSINESS)	PHONE (MOBILE)	

## Travel details

/ /	/ /
DEPARTURE DATE	RETURN DATE / EXPIRY DATE
PERIOD OF TRAVEL (DAYS / MONTHS)	MAJOR DESTINATIONS

## Declaration

- I/we acknowledge that a copy of the combined Financial Services Guide [FSG] and Product Disclosure Statement (including Policy Wording) [PDS], were provided to me/us before I/we applied for this insurance, and that I/we have made the decision to purchase the policy after carefully reading the terms and conditions contained in the PDS, and agree that this product is suitable for my/our needs.
- I/we acknowledge that I/we have read and understood the Duty of Disclosure and the consequences of non-disclosure.
- I/we authorise any doctor or clinic to provide Allianz Global Assistance with information concerning my/our current or past medical history. I/we have read the Privacy Notice and I/we consent to the collection, use and disclosure of my/our personal information by Allianz or Allianz Global Assistance to such persons and for such purposes stated in the Privacy Notice.

## Cover required

Single  Family  Duo

Cover Area 1  2  3  4  Australia

## Plan selected

Cost

PLAN A Comprehensive	<input type="checkbox"/>	\$
PLAN B Australia Only	<input type="checkbox"/>	\$
PLAN C Budget	<input type="checkbox"/>	\$
PLAN D Frequent Traveller	<input type="checkbox"/>	\$
PLAN E Non Resident	<input type="checkbox"/>	\$
PLAN F Residents Returning	<input type="checkbox"/>	\$

## Additional costs

**You are not automatically covered for Pre-existing Medical Conditions. Please refer to the definition of and guidelines for Pre-existing Medical Conditions on pages 9 to 14 of the PDS.**

Do you have a Pre-existing Medical Condition (as outlined in the PDS)?  Yes  No  
Do you want cover for your Pre-existing Medical Condition for your Journey?  Yes  No

We are unable to offer cover for those Pre-existing Medical Conditions outlined on pages 10 & 11 under the heading "Group 1 – Pre-existing Medical Conditions which are automatically excluded".

If you have any of the conditions which are excluded, travel insurance is still available to you, however, there is no provision to claim for any of the medical conditions as listed in Group 1 (pages 10 & 11).

If you do not expressly apply for cover and pay an additional premium for Pre-existing Medical Conditions, your claim may be declined.

- Do all your Pre-existing Medical Conditions fall under Group 2?  Yes  No  
(If yes, we do provide automatic cover for these Pre-existing Medical Conditions listed in Group 2 at no additional premium)
- Are you required to complete and submit a Medical Declaration Form?  Yes  No  
(If yes, please complete the Pre-existing Medical Condition application form.  
If your application for cover is approved, an additional premium will be payable.  
Only available for Plans A, B & D.)

Travellers 61-80 years additional premiums  \$

Travellers 81 years or over additional premiums  \$

Approval codes

Pre-existing Medical Conditions additional premiums  \$

Approval codes

Increased Rental Vehicle Excess Cover (not available Plan C)  \$

Additional Sum Insured \$ Additional Premium

Specified Luggage and Personal Effects Cover (not available Plan C)  \$

Specified items and value \$

Removal of Standard Excess (not available Plan F)  \$

**TOTAL COST \$**

4. I/we acknowledge that this policy does not automatically provide cover for Pre-existing Medical Conditions.

5. I/we agree to abide with the terms and conditions of this policy and confirm that the above information is correct.

Insured/Sponsor Signature \_\_\_\_\_ Date \_\_\_\_\_

Insured/Sponsor Signature \_\_\_\_\_ Date \_\_\_\_\_

If Duo has been selected, both insured's must sign.