



EXPATRIATE APPLICATION FORM

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.

Organisation or Company _____

Name of Employee _____

Nationality _____ **Date of Birth** |___/___/___|

Occupation _____

Accompanying Spouse or Partner _____ **Date of Birth** |___/___/___|

Accompanying Dependent Children _____ **Date of Birth** |___/___/___|

_____ **Date of Birth** |___/___/___|

_____ **Date of Birth** |___/___/___|

City or Country of Posting _____

Address of Posting _____

Period of Cover: **From:** |___/___/___| **To:** |___/___/___|

Medical Expenses Sum Insured _____ **Excess/Deductible** _____

Evacuation Cover and Personal Safety _____

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

1. Have you or any Family Member accompanying you: **Please tick YES/NO**

a) Ever had any disorders which affected your heart, lungs, bowels, bladder, liver, kidneys, blood circulation, digestive system, genitals, back, ears or eyes? YES NO

b) Ever had any nervous disorder, paralysis, rheumatism, tuberculosis, ulcer or cancer? YES NO

c) Lost all or part of a limb or have any other physical defect or infirmity? YES NO

d) Had any other illness, injury, operation or treatment in the last 5 years which required hospitalisation? YES NO

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? YES NO

3. Are you or any of your Family Members:

a) Pregnant? YES NO

b) Required to have a medical examination prior to leaving for overseas assignment? YES NO

c) On a waiting list for medical treatment? YES NO

4. Do you or any Family Member take medication or drugs on a regular basis? YES NO

5. Do you or any Family Member wear glasses or have vision impairments? YES NO

6. Do you or any Family Member intend to go to the dentist in the next 12 months? YES NO

NOTE – If any of the above were answered “Yes”, please provide details including description of injury or illness, duration (date), the cause, nature of treatment and results, current condition, name and addresses of doctors and hospitals consulted.



IMPORTANT INFORMATION

INSURER

The Insurer of Your policy are Certain Underwriters at Lloyd's of London, who are authorised under the Insurance Act 1973 to write Australian Insurance business.

PRIVACY

Woodina Underwriting is committed to protecting the privacy of the personal information You provide Us. Woodina Underwriting collects, uses and retains Your personal information in accordance with the National Privacy Principles.

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 agree that this Declaration shall be the basis of the contract between me/us and Insurers.

Date _____ Signature of Insured Person _____