



Medical Reference No. _____

This certificate collects personal information about you so we can consider your request for insurance. State, a business division of IAG New Zealand Limited is collecting this information. It will be held at PO Box 298 Shortland Street Auckland. You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993. Please return by fax to **09 985 0355** or mail to State Travel Insurance, PO Box 298, Shortland Street, Auckland. For more information please call **0800 155 777**.

Contact Email: _____ Contact Fax No: _____

Part A: To be completed by the applicant

Name: _____ Weight: _____ Height: _____ Age: _____

Address: _____

Telephone Contact: _____

Countries to be visited: _____

Main destination: _____ Departure Date: _____ Return Date: _____

Have you made any Medical Travel Insurance claims within the last three years? **YES / NO** (Delete non-applicable)

I consent to the information supplied on this Medical Certificate being released to the insurer or its agent and for them to contact my doctor for further medical information for the purpose of this insurance or for any subsequent claim that may occur.

Applicant to Sign: _____ Date: _____

Part B: To be completed by the applicant's doctor

Doctor's Phone Number: _____ Doctor's Name: _____ Date: _____

DECLARATION: I confirm that this medical certificate has been completed by myself and that I am the Medical Doctor as detailed above. (NOTE: The applicant is responsible for any fee charged by you to complete this certificate. We may contact you by telephone if we require more medical information or further clarification.)

Doctor's Signature: _____

Is the patient fit to undertake the proposed journey without adverse effects? **YES / NO** (Delete non-applicable)

Do you anticipate the patient requiring medical attention? **YES / NO** (Delete non-applicable)

1. **HEART CONDITION** Date diagnosed: _____ Type: _____

Medication/surgery: _____

Has the patient seen a specialist/been hospitalised in last 6 months YES/NO (Delete non-applicable)
(If yes, please attach any specialist letters, discharge summary and test results you may have on file).

Angina on exertion? **YES/NO** (Delete non-applicable) Angina on rest? **YES/NO** (Delete non-applicable) Hypertension? **YES/NO** (Delete non-applicable)

Last three blood pressure readings: (Reading and date) 1) _____ 2) _____ 3) _____

2. **RENAL** Date diagnosed: _____ Type: _____ Condition is controlled: **YES/NO** (Delete non-applicable)

Medication/surgery: _____ Other related condition? Details: _____

Date of last hospitalisation: _____ Date of last specialist/outpatients appointment: _____

3. **CIRCULATORY** Date diagnosed: _____ Type: _____ Condition is controlled: **YES/NO** (Delete non-applicable)

Medication/surgery: _____ Other related condition? Details: _____

Date of last hospitalisation: _____ Date of last specialist/outpatients appointment: _____

4. **RESPIRATORY CONDITION** Date diagnosed: _____ Type: _____ Condition is controlled: **YES/NO** (Delete non-applicable)

Medication/surgery: _____

Last three peak flow readings: (Reading and date) 1) _____ 2) _____ 3) _____

5. **CANCER** Date diagnosed: _____ Type: _____ Condition is controlled: **YES/NO** (Delete non-applicable)

Condition is Metastatic? **YES/NO** (Delete non-applicable) Medication/surgery: _____

Date of chemo/radiotherapy: _____ Date of last check up: _____ Date of next check up: _____

6. **HOSPITALISATION / SPECIALIST** **Has the patient seen a specialist/been hospitalised in last 6 months YES/NO** (Delete non-applicable)

If yes, please attach copies of all discharge summaries/specialist letters and test results

7. **TERMINAL CONDITION** **YES/NO** (Delete non-applicable)

Details: _____

8. **MEDICAL CONDITIONS CURRENTLY UNDERGOING REFERRAL/INVESTIGATION** **YES/NO** (Delete non-applicable)

Details: _____

9. **OTHER CONDITIONS AND/OR MEDICATIONS TAKEN** **YES/NO** (Delete non-applicable)

Details: _____