

SureSave Application Form

If you have insufficient space to complete your answers, please attach a separate sheet.

PERSONAL DETAILS (Travelling Persons details only)

Name: (Mr/Mrs/Ms) _____

D.O.B.: (Day/Month/Year) _____

Name: (of partner/spouse) _____

D.O.B.: (Day/Month/Year) _____

Name: (accompanying child) _____

D.O.B.: (Day/Month/Year) _____

Name: (accompanying child) _____

D.O.B.: (Day/Month/Year) _____

Name: (accompanying child) _____

D.O.B.: (Day/Month/Year) _____

Address: _____

State: _____ Postcode: _____

Phone: Work: _____ Home: _____

Mobile: _____ Fax: _____

Email: _____

Mailing address: if applicable (PO Box/RMB/etc) _____

State: _____ Postcode: _____

Membership Number: _____

TRAVEL DETAILS

Total No. Persons: _____ **Destinations:** _____

Departure Date: / / **Return Date:** / /

Period of Trip: Days _____ Weeks _____ Months _____

TRAVEL PLAN SELECTED (Please tick)

Single

Family

PLAN A Holiday Travel Premium \$

PLAN D Annual Frequent Traveller Premium \$

PLAN J Australia Premium \$

PLAN KA Advance Purchase Premium \$

PLAN KB Advance Purchase Premium \$

PLAN L Budget/Inbound Travel Premium \$

PLAN NZ1 Advance Purchase Premium \$

PLAN NZ2 Advance Purchase Premium \$

All plans available to Australian residents only except Plan L.

Premiums include GST and Stamp Duty where applicable

PRE-EXISTING MEDICAL CONDITIONS

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 17 to 21 of the PDS.

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

We are unable to offer cover for those Pre-existing Medical Conditions outlined on pages 18 and 19 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 18 and 19).

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

1. Do you require cover for your Pre-existing Medical Condition? Yes No
2. 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)

3. 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. Not available for Plan L)

4. If approved, what is your assessment number? MPE: _____

EXCESS BUYOUT (\$15)

Premium \$ _____

ADDITIONAL LUGGAGE SPECIFIED ITEMS (attach valuation/receipt)

(Not available Plan L), (over \$700; maximum per item is \$4,000 and \$10,000 in total)

Sum Insured \$ _____

Sum Insured \$ _____

Sum Insured \$ _____

Total Sum Insured \$ _____ @ 4% = **Premium \$** _____

RENTAL VEHICLE EXCESS OPTIONS

(Not available Plans KA, KB, NZ1, NZ2) \$25 per \$500 cover, maximum \$4,000 additional

Sum Insured \$ _____ = **Premium \$** _____

ADDITIONAL BUSINESS BENEFITS OPTION (15% of the Plan A Premium)

Premium \$ _____

TOTAL AMOUNT PAYABLE \$

Payment Method Cash Cheque Credit Card

Credit Card Authority – Please debit my: Visa Mastercard AMEX

Card No:

Expiry Date:

Card Holder's Name: _____

Signature: _____

Date: / /

- I/we acknowledge that a copy of the combined Financial Services Guide (FSG) and Product Disclosure Statement (PDS) (including Policy Wording), which contains the Duty of Disclosure was given to me before I/we applied for this insurance and that I/we have made the decision to purchase this after carefully reading the terms of the policy and agree that this product is suitable for my/our needs.
- I/we authorise any doctor or clinic to provide Mondial Assistance with information concerning my current or past medical history. I/we have read the Privacy Notice and I/we consent to the collection, use and disclosure of my personal information by Allianz or Mondial Assistance to such persons and for such purposes stated in the Privacy Notice.
- I/we acknowledge that this policy does not automatically provide cover for Pre-existing Medical Conditions.
- I/we agree to abide with the terms and conditions of this policy and confirm that the above information is correct.

Signature _____

Signature _____

Date / /

Date / /