Policy Amendment Form

Please complete all details then fax this form to us on (03) 8805 2979 for processing.
For all enquiries call Toll Free 1300 555 017 or 03 8805 2777.

Part A Agency/Customer Details

Travel Consultant/Customer Name | Agent Code

Phone ( ) | Fax ( ) | Email

Travel Agency Name | Date / /

Relationship to Insured

Part B Insured Details

Insured Name | Date of birth (must be completed) / /

Address

State | Postcode

Policy Number (must be completed) | Medical Appraisal No. (if applicable)

Please briefly describe adjustment required (other than Change of Travel Dates - refer Part C)

Part C Change of Travel Dates (Please note: This form is **not used** for Policy Extensions)

New Dates / / to / / | Total Duration (Duration cannot be longer than original policy)

Reason for Alteration (If due to Medical Reasons you must complete Part D & E below)

Are there any claims pending? If yes, please provide details: (If claiming for full cancellation fees the dates cannot be ammended on this policy)

If the alteration for Travel Dates is received after the original departure date on the Certificate of Insurance, you must also submit evidence of no travel at the time (eg. a cancellation letter from your Travel Agent).

Part D Insured Declaration/Authorisation To be signed by insured

I/We declare that the answers given above are true and correct. I acknowledge the policy amendment applied for is contingent on the correctness of the answers given to the questions above. I/We agree that I/We will not be covered for any alterations to travel dates due to medical reasons unless my usual doctor has completed Part E of this form and the Insurance company has agreed to insure those changes. I/We authorise any hospital or medical adviser who has attended to, or examined me, to disclose any information to organisations listed in the QBE Privacy Policy available from QBE Travel, where the alteration is due to medical reasons.

Name | Signature | Date / /

Part E To be completed by your Doctor/Specialist (Only required if alteration is for Medical Reasons)

1. Are you the patient's usual Medical Practitioner? ☐ Yes ☐ No If so, how long?
2. Are you well versed with the patient's medical history and state of health? ☐ Yes ☐ No
3. What illness/injury has the patient suffered to cause the change of the trip dates?
4. What medication/treatment are they receiving?
5. Please list any existing medical condition/s the patient suffers:
6. Is the illness/injury described in question 3 an existing medical condition or has it impacted on an existing medical condition? ☐ Yes ☐ No If yes, please explain:
7. When will the patient be fit for travel?
8. Will your patient require any additional treatment or do they have any special travel requirements? (eg. oxygen, wheelchair to aircraft etc.)

Name | Signature | Date / /

Address

Qualifications

11452/J–12–06