

Pre-existing Condition Exclusion Review Form

You can submit this form to request a review of a pre-existing condition excluded from your policy. Please arrange for your vet(s) to complete all applicable sections. Both you and your vet(s) are required to certify and provide veterinary records to verify that your pet has been free of noticeable signs, symptoms or an abnormality of the pre-existing condition (or any condition(s) arising directly from this condition) for 18 months up to the completion date of this form. **Your request for a review cannot be completed without all the necessary supporting documentation.** Please allow 30 days for us to complete the review. You will be notified of the outcome of your request in writing.

Note:

- As at the submission date of this form, your pet must have been free of noticeable signs, symptoms or an abnormality of the condition deemed **pre-existing, and any related condition(s)** for a minimum continuous period of **18 months**.
- Conditions that cannot be cured are not eligible for pre-existing condition exclusion review. These conditions include chronic conditions, cruciate ligament conditions, intervertebral disc disease, hip dysplasia, elbow dysplasia, patella luxation and endocrine diseases.
- This review will be completed in accordance with the current policy terms & conditions.

1. Your details

Policy number: Title: First name: Surname: Address: Suburb: State: Postcode: Email:

2. Pet's details (one form to be completed per insured pet)

Pet's name: Species:

Dog

Cat

Breed: Pet's age/date of birth:

DD / MM / YYYY

3. Pre-existing condition exclusion(s) that you would like reviewed and waived

Provide details of the condition (or organ/body part) to which this exclusion request relates;

1.	<input type="text"/>
2.	<input type="text"/>
3.	<input type="text"/>

4. Policy owner declaration

Has your pet shown any noticeable signs, symptoms, abnormalities or received any treatment relating to the condition and/or organ/body part identified in section 3 above over the past 18 months? Yes No

If you answered Yes to the question above, please indicate the date(s) and describe the treatment and/or symptoms noted.

DD / MM / YYYY

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Please mail this completed form to:

RSPCA Pet Insurance
Locked Bag 9021
Castle Hill NSW 1765

or fax both sides of this form to 1300 367 229.

For any questions, please call 1300 855 150 between 8am - 8pm Monday to Friday (AEST).

Your vet to complete the sections below

5. To be completed by vet

Vet's instructions:

Please examine the pet and provide supporting documentation such as test results, clinical notes and/or vet history records (where applicable) to support this review.

Policy owner's surname:

Pet's name: Date of examination:

Condition(s) being reviewed:

When was this pet first registered/treated at your practice?

If this pet was referred to your practice, please provide details of the referring practice

Referring practice name:

Referring vet:

Address:

Phone number: Email:

The earliest date that this condition was first noted or diagnosed (as stated by the client or noted in your records)?

Date on which this condition, or any related condition/body part or organ, was last treated

Date you last saw this pet, and for what reason?

In your opinion, what is the probability of this condition (or any related condition) requiring treatment within the next 12 months?

Please provide any additional notes or comments to support this application:

6. Declaration

I/We certify that the information given in this form and any supporting documentation is truthful, accurate and complete. No information likely to affect this review has been withheld. I/We understand that deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the review and/or cancellation of the policy. I/We understand that the Administrators will assess information provided in accordance with the policy terms and conditions. I/We authorise any vet Surgeon who has treated my/our pet to provide to the insurer any details they may require. Please note that issuance or completion of this form does not acknowledge liability or guarantee a removal of a pre-existing exclusion.

SIGN HERE	<input type="text" value="X"/>	<input type="text" value="DD / MM / YYYY"/>	Name of attending vet and practice: (please print or stamp)
	Signature of vet	Date	
<input type="text"/>	<input type="text"/>		
Your vet Registration Number	Registration State		
SIGN HERE	<input type="text" value="X"/>	<input type="text" value="DD / MM / YYYY"/>	
Signature of policy owner	Date		

Please note the completion of this form does not mean an automatic waiver of any pre-existing condition exclusion.

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