islands
taking care of tomorrow

TRAVEL MEDICAL CONDITION(S) DECLARATION

Name of Policyholder: _____ Policy Number: _____

Policy applied for: ◯ Annual ◯ Single Trip If Single Trip, what are the dates of travel: DD/MM/YY to DD/MM/YY

	Name of applicant: Date of Birth: DD/MM/YY	Name of applicant: Date of Birth: DD/MM/YY	Name of applicant: Date of Birth: DD/MM/YY
Medical Condition(s) To Be Considered: *(Please continue on the reverse if necessary.)*			
a) Current Medication, Dosage and Frequency:			
b) When was it first diagnosed and what treatment was given?			
c) Have you required in patient treatment in Hospital, if so give dates, reason and outcome:			
d) Have there been any periods of incapacity? If so give dates reason and duration.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
e) Is the Insured/Proposer currently under the care of a Specialist?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
f) Are you due to have any further treatment? *If 'Yes', give details*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
g) When was the last occurrence?			
h) Is the condition stable and controlled? *if 'No', give current situation*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Signed: _____ Date: _____

OFFICE USE ONLY

Agree at Normal Terms. Exclude Conditions (s).

Agree subject to following Terms (insert terms required):
(delete as appropriate) Authorised by: _____

NB: This form should be passed to the Manager in the first instance, but final authorisation may be required from a Senior Underwriter/Director.