



MARITIME LIFE (CARIBBEAN) LIMITED
ADULT DECLARATION OF HEALTH

Please print all answers.

1. NAME _____

2. ADDRESS _____

3. SEX

MALE	FEMALE

4. DATE OF BIRTH

dd	mm	yy

5. HEIGHT

	f/m
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6. WEIGHT

	lbs/kg
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7. NAME OF EMPLOYER _____

8. A. NAME AND ADDRESS OF PERSONAL PHYSICIAN _____

B. DATE LAST CONSULTED? _____

C. REASON / DISABILITY FOR LAST VISIT? _____

D. STATE TREATMENT GIVEN OR PRESCRIBED _____

9. A. Have you ever been treated for or ever had any known disturbances of heart, blood vessels, lungs, stomach, intestines, liver, gallbladder, kidneys, bladder, genital organs, nervous system, eyes, ears, nose, throat, glandular system, or any other serious disease? YES NO
- B. Have you ever had a tumor or cancer? YES NO
- C. Do you use alcohol? YES NO
 How much daily? _____
- D. Do you smoke? YES NO
 How many cigarettes daily? _____
- E. Have you ever had an Electrocardiogram, X-Ray, or any other diagnostic test? YES NO
- F. Have you ever had any illness, operation, medication, or medical examination not mentioned above in the past 5 years? YES NO
- G. Are you now under observation or taking treatment? YES NO
- H. Has any member of your family suffered from Tuberculosis, Diabetes, Cancer, or Mental illness? YES NO
- I. Have you ever had any mental or physical disorder not listed above? YES NO
- J. Have you ever had any persistent symptoms of (swollen glands, persistent cough, visual disturbances, headaches, chest pains, back pains, abdominal pains, fever of unknown origin) ill health for which a diagnosis was neither sought nor received? YES NO
- K. FEMALES ONLY 1. Are you now pregnant? YES NO
 2. How far advanced? _____ months

10. Please give details of YES answers in questions 9 A through K:
 Identify question number, circle applicable items.
 Include diagnosis, dates of treatment of illness, duration of illness, names & addresses of all attending physicians and medical facilities.

I hereby declare that the page 1 statements and answers are complete and correct to the best of my knowledge and belief.

DATE _____ SIGNATURE OF LIFE TO BE ASSURED _____

DATE _____ WITNESS _____

AUTHORIZATION FORM

I hereby AUTHORIZE any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment, or any hospital or clinic where I have been a patient for diagnosis, treatment, or ailment, or any insurance company to which I have applied, to give full particulars, including any prior medical history, to MARITIME LIFE (CARIBBEAN) LIMITED to which I am making an application for insurance. A photocopy of this authorization shall be as valid as the original.

DATE _____ SIGNATURE OF LIFE TO BE ASSURED _____

DATE _____ WITNESS _____