PERSONS TO BE COVERED

SURNAME				
FIRST NAME				
DATE OF BIRTH				
SEX	M ❒ F ❒	M ❒ F ❒	M ❒ F ❒	M ❒ F ❒

MEDICAL QUESTIONNAIRE – ALL QUESTIONS TO BE ANSWERED FULLY
(GOLD, SILVER, HOSPITALISATION & COMFORT AND LUXURY TOP-UP INSURANCE)

Sensitive medical information will need to be processed in order to provide cover. Please obtain the consent of any other people named before disclosing this. If you consider that information relating to your state of health or that of any other person to be covered should remain confidential, please send it in a sealed envelope for the attention of the Consulting Doctor. **Please use a separate piece of paper if there is insufficient room for your reply.**

1	Height Weight	……M ……Kg	……M ……Kg	……M ……Kg	……M ……Kg
2	**Blood pressure (COMPULSORY)** **Systolic / Diastolic**	…… / …… mmHg	…… / …… mmHg	…… / …… mmHg	…… / …… mmHg
3	Do you smoke?	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒
4	Do you suffer from any allergies? If so, please provide details	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……
5	Have you had any medical consultation/investigations/treatment in the last 6 months or is any planned? If so, please provide full details?	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
6	Have you ever been or are you currently signed off work by a doctor for medical reasons? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
7	Have you ever been hospitalised or had surgery? If so, please provide date and reason for hospitalisation	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
8	Do you need to be hospitalised or have surgery? If so, please provide date and reason for hospitalisation	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
9	Have you received or are you currently receiving medical treatment (medication, physiotherapy, psychotherapy, equipment)? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
10	Do you suffer from a chronic or long-term illness? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
11	Do you have any aftereffects from an accident, illness or disability? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
12	Do you have any dentures, dental implants or orthodontic work planned within the next 12months? **(Gold, Silver, Comfort & Luxury)**	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote..
13	Are you pregnant?	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒

WARNING: You are advised to complete this proposal form yourself. Where this is not possible, you are advised not to sign the proposal form until you have read and agreed that the answers given to the questions are accurate and complete. You should also state who completed the form on your behalf: ……

Signed in …… on the ……

SIGNATURE preceded by the text '**read and approved**'