THE MARITIME FINANCIAL GROUP
STRENGTH ON YOUR SIDE
INSURANCE • INVESTMENTS • FINANCING

MARITIME LIFE (CARIBBEAN) LIMITED
ADULT DECLARATION OF HEALTH

PLEASE FILL ALL FIELDS WHERE APPLICABLE USING TO EDITABLE FORM BELOW.

1 **NAME** _____

2 **ADDRESS** _____

3 **NAME OF EMPLOYER** _____

4 SEX	5 DATE OF BIRTH	6 HEIGHT	7 WEIGHT
MALE ○ FEMALE ◉		FT/M	LBS/KG

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

ANSWER YES OR NO AND FILL ALL AVAILABLE FIELDS WHERE APPLICABLE .

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

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 five 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

I DECLARE THAT I HAVE READ THE ABOVE QUESTIONS CAREFULLY and that the answers to the said questions regarding the child are complete and true and are in continuation of and form part of an application for insurance to MARITIME LIFE (CARIBBEAN) LIMITED.

DATE _____ SIGNATURE OF LIFE TO BE ASSURED _____

DATE _____ WITNESS _____

AUTHORIZATION FORM

I hereby AUTHORIZE any physician or practitioner who had 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 _____