MARITIME LIFE (CARIBBEAN) LIMITED
ADULT DECLARATION OF HEALTH

Please print all answers.

1. NAME _____

2. ADDRESS _____

_____

3. SEX		4. DATE OF BIRTH			5. HEIGHT	6. WEIGHT
MALE	FEMALE	dd	mm	yy	_____ ft/m	_____ lbs/kg

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 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

10. Please give details of YES amswers 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 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 diagnoisis, 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**_____