MEDICAL QUESTIONNAIRE

*A Medical Questionnaire must be completed for each applicant who has answered **Yes** to any pre-qualification questions on the Travel Medical Insurance Application.*

Applicant Details:

Name:

Date of Birth: (DD/MM/YYYY): Sex: ☐ M ☐ F

Height: Weight:

Mailing Address:

City: Prov / Terr: Postal Code:

Telephone:

Email:

Medical History:

Please indicate if you have either received medical advice **or** treatment **or** are currently taking prescribed medication for any of the following conditions & diseases **or** if you have had any other medical condition or symptom **during the past 5 years**:

✓ Tick **Yes** to all medical conditions/diseases that apply and enter name of medical condition or write in under other if not listed; ✓ Tick **No** if condition does not apply:				Hospital Inpatient Date (Mth/Yr)	**Stable (Note Below)	
					NO	YES *(Indicate Length of time stable)*
Yes	**No**	**#**	**HEART, BRAIN, & BLOOD VESSEL CONDITIONS & DISEASES**			
		1	Cardiac: (i.e. Heart Attack, Bypass, Valve Repl., Pacemaker, etc.) **Condition:**			
		2	Cardiovascular: (Excluding HBP, High Cholesterol) **Condition:**			
		3	Cerebrovascular: (i.e. Stroke, TIA/Mini Stroke, etc.) **Condition:**			
		4	Vascular: (i.e Deep Vein Thrombosis, Phlebitis, etc.) **Condition:**			
		5	High Blood Pressure/HBP			

		6	High Cholesterol			
Yes	**No**	**#**	**RESPIRATORY/LUNG CONDITIONS & DISEASES**			
		7	Asthma			
		8	COPD			
		9	Pneumonia			
Yes	**No**	**#**	**OTHER CONDITIONS & DISEASES**			
		10	Cancer: (i.e. Breast, Prostate, Ovarian, Skin, etc) **Condition:**			
		11	Diabetes: (i.e. Juvenile, Type 1 or 2) **Condition:**			
		12	Gastrointestinal (i.e. Diverticulitis, GERD, Crohn's, etc) **Condition:**			
		13	Kidney (i.e. Infection, Stones, Failure, etc.) **Condition:**			
		14	Other Malignant Condition:			

Note: *** Stable means - no change in the medical condition including treatment, advice or counselling which has been sought or received for the condition and/or no change in medication taken for the condition including changes in type or dosage for at least 90 days prior to trip departure date. If a medical condition is NOT STABLE as aforementioned it is not covered by the policy. The actual policy wording shall govern in all situations.*

List all medications taken or ✓ Tick ☐ if None				
Drug Name	Quantity	Dosage (MG.)	How Often (frequency)	Condition # from above

Have you ever used home-oxygen, or have you been on renal dialysis in the past 12 months? ☐ Yes ☐ No

Have you been hospitalized for heart failure or "water on the lungs" in the past 12 months? ☐ Yes ☐ No

Have you had a travel medical claim in the <u>past 3 years</u>? ☐ Yes ☐ No
If yes, please provide date/diagnosis/location/$amount.

Declarations and Warranty

I declare that during the last five years no insurer has cancelled, declined or refused to issue me/us any form of **Emergency Travel Medical** insurance and that this application discloses the hazards known to exist at the date of this application. I declare that the statements made herein are in every respect true and correct and hereby apply for a contract of insurance to be based upon the truth of the said statements.

I, the applicant, acknowledge that any omission or misrepresentation of information provided may render null and void any policy of insurance coverage issued.

Signed by:

Name (Print):

Date:

Contact Us

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