# Health Declaration

Please answer all of the following questions in respect of yourself and all other persons to be covered by this policy. Please ensure that you only provide us with sensitive personal information, such as health information, about other people with their agreement. When you give us this information we will take this as confirmation that you have their consent to do so.

Name of Policyholder

Address

Postcode

| Details of all persons to be covered by this policy: | Date of Birth | Height (cm/ft) | Weight (kg/lbs) | Gender |
|---|---|---|---|---|
| Policyholder | | | | |
| 1st family member | | | | |
| 2nd family member | | | | |
| 3rd family member | | | | |
| 4th family member | | | | |

**1) In the last 5 years have you been diagnosed with, had treatment, medication or symptoms related to:**
**a) Cancer (whether active or in remission) b) Heart c) Stroke d) Diabetes, hyperglycemia or hypoglycemia e) Asthma or Allergies f) Anxiety / depression / psychiatric conditions**

| | Policyholder | 1st family member | 2nd family member | 3rd family member | 4th family member |
|---|---|---|---|---|---|
| a) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

**2) During the last 5 years, have you had any treatment in hospital or stayed in a nursing home, consulted a doctor, medical practitioner or specialist, or suffered from an illness which keeps returning?**

☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

**3) Do you have any treatment, consultations, investigations, diagnostic tests or check-ups, planned, pending or awaiting results?**

☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

**4) Have you had any medical condition, or health problem, whether or not a doctor has been consulted during the last 5 years?**
For example, gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, joint disorders, joint replacements, foot problems (eg bunions), indigestion or bowel problems, abdominal pain, skin problems, infertility, obesity, trouble with limbs, ears, eyes, urination etc.

☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

**5) Are you currently on any medications (whether prescribed or not)?**

☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

**6) Have you at any time in your life had any condition which may have an affect on your future health?**
Please declare any medical investigation, consultation, advice, counselling, operation, medication or treatment that you have had or have been advised to have or are currently having, but have not previously mentioned.

☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

By treatment we mean surgical or medical intervention including drugs (both organic and synthetic) prescribed by a medical practitioner/ specialist, that are needed to diagnose, relieve or cure a disease, illness or injury. A specialist is any doctor, including psychiatrist who is not your usual practitioner.

**If the answer to any of the above questions is YES, please give full details on the reverse of this form. Please note declaring a medical condition on this form is not an acceptance from us that the condition is covered. All cover is subject to the terms and conditions of the policy.**

In addition, we reserve the right to review and consider any other relevant information we have such as previous declarations or claims submitted. I hereby declare to the best of my knowledge that the information provided is complete, true and accurate. I agree that this declaration will constitute part of my application and failure to disclose any material facts may result in the contract being void.

If you are in any doubt whether certain facts are material, these should be disclosed.

Have you or any family member applying for coverage ever purchased insurance through IMG, IMG Europe, or ALC Health? ☐ Yes ☐ No

Certificate Number:

I have read the General Data Protection Regulation (GDPR) notice as contained in this Application Form and the Privacy Policy which is available at **https://www.imglobal.com/intl/legal/privacy-policy**

Signed:

Date:

Name:

(This form must be completed and signed by the Policyholder)

**TERMS CANNOT BE CONFIRMED UNTIL THIS COMPLETED DECLARATION HAS BEEN RECEIVED AND ACCEPTED BY IMG**

## Declaring illnesses

If you've answered **yes** to any of the questions above, you must give full details here. Please continue on a separate sheet if necessary.

Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/ types and dosages, and details of any future consultations/ treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

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Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/ types and dosages, and details of any future consultations/ treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

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Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/ types and dosages, and details of any future consultations/ treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.
If there is insufficient space on this form please provide details on a separate sheet and attach it to this declaration.

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