MARITIME LIFE (CARIBBEAN) LIMITED

CHILD DECLARATION OF HEALTH

(FOR PERSONS UNDER AGE 16)

TO BE COMPLETED AND SIGNED BY THE APPLICANT.
PLEASE PRINT ALL ANSWERS.

NAME OF CHILD _____

ADDRESS _____

SCHOOL _____

SEX		DATE OF BIRTH			HEIGHT	WEIGHT
MALE	FEMALE	dd	mm	yy	____ft/m	____lbs/kg

HAS THE CHILD:

A. Suffered from any illness, operations, injuries or disabilities? ☐ YES ☐ NO

B. Any impairment of sight, hearing, speech, or other deformity ☐ YES ☐ NO

C. Any relative who has ever suffered from mental illness, epilepsy, tuberculois or diabetes? ☐ YES ☐ NO

D. Been seen by a physician or been hospitalized within the past five years? ☐ YES ☐ NO

Please give DETAILS of all YES answers. Include diagnosis, dates of treatment of illness, duration of illness, names & addresses of all attending physicians and medical facilities.

_____

_____

_____

_____

_____

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 APPLICANT _____

DATE _____ WITNESS _____

AUTHORIZATION

MARITIME LIFE (CARIBBEAN) LIMITED is considering an application for insurance for my child and Ihereby authorize any physician, surgeon or other person in your employ or connected or associated with you in any way, to give the Medical Director of such Company, or his authorized representative any information including any prior medical history which he may desire and which you may have acquired attending to me or my child in a professional capacity. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF APPLICANT _____

ATE _____ WITNESS _____