

## MEDICAL APPLICATION FORM FOR YACHT CREWS

### POLICY HOLDER

Employer:..... Name of the Yacht:.....

Full Address:..... Telephone Number:.....

### INSURED PERSON:

Family Name:..... First Name:.....

Male  Female  Date of Birth:..... Height:..... Weight:.....

Nationality:..... Occupation:.....

Cover Required:

Yacht Premier  Plan Yacht Basis Plan  Yacht Short Term Plan (max. 3 months)

Area Required:

Europe  Europe, Caribbean, USA, Canada  Worldwide

Currency:  GBP  USD  EUR  CHF

APPLICANTS FOR THE YACHT SHORT TERM PLAN DO NOT HAVE TO ANSWER THE FOLLOWING HEALTH QUESTIONNAIRE.

### MEDICAL HISTORY DECLARATION

1. Have you sought medical advice in the last 24 months?

Yes  No If yes, please give full details on the attached sheet.

2. Have you consulted with a specialist, been admitted to a hospital/nursing home, or been advised to have any medical examinations/investigations, or suffered from any recurrent illness during the last five years?  Yes  No If yes, please give full details on the attached sheet.

3. Have you ever suffered from, or had symptoms of the following, whether or not a doctor was consulted, and other than disclosed above: If yes, please give full details on the attached sheet.

	Yes	No
a. Nervous or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure, heart or circulatory disorders	<input type="checkbox"/>	<input type="checkbox"/>
c. Any rheumatic, arthritic, muscular or bone disease	<input type="checkbox"/>	<input type="checkbox"/>
d. Disorders of the back	<input type="checkbox"/>	<input type="checkbox"/>
e. Respiratory or allergic conditions	<input type="checkbox"/>	<input type="checkbox"/>
f. Urinary, stomach, liver or bowels disorders	<input type="checkbox"/>	<input type="checkbox"/>
g. Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>
h. Cysts, tumours or cancer	<input type="checkbox"/>	<input type="checkbox"/>
i. Gynaecological or menstrual problems/complications of pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
j. Congenital illnesses or deformities	<input type="checkbox"/>	<input type="checkbox"/>
k. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>

### DECLARATION:

To the best of my knowledge the information provided on this application form, whether in my own hand or not, is true and complete. I understand that failure to disclose, or misrepresentation of any pertinent facts may lead to the denial of a claim or cancellation of any policy. I understand and agree that this application and the statements contained herein shall form the basis of the contract issued as a result of this application.

I authorise any doctor, who has ever attended me, to provide the Insurer with any information that may be required including prior medical history.

**BEGIN OF THE INSURANCE:**.....

Place and Date..... Signature of Policy Holder.....

Place and Date..... Signature of Insured Person.....

**NAME OF DOCTOR**

**DETAILS OF CONDITION**

**DETAILS OF TREATMENT**

**DATES OF TREATMENT**

**CURRENT STATE OF HEALTH**

**DECLARATION:**

To the best of my knowledge the information provided on this application form, whether in my own hand or not, is true and complete. I understand that failure to disclose, or misrepresentation of any pertinent facts may lead to the denial of a claim or cancellation of any policy. I understand and agree that this application and the statements contained herein shall form the basis of the contract issued as a result of this application.

I authorise any doctor, who has ever attended me, to provide the Insurer with any information that may be required including prior medical history.

Place and Date..... Signature of Applicant.....