

**Application Form for International Health Insurance
Long Term Sailor**



Policyholder

First name _____

Last name _____

Date of birth _____

Gender male female

Address _____

_____ Post Code _____

Telephone _____

Home country _____

Nationality _____

Height _____ Weight _____

Name of yacht _____

E-mail _____

(Please state your e-mail address, so that we can provide you with all information regarding this insurance.)

DATE INSURANCE COVER IS TO START: _____

Person Insured (if not the policyholder)

First name _____

Last name _____

Date of birth _____

Gender male female

Address _____

_____ Post Code _____

Telephone _____

Home country _____

Nationality _____

Height _____ Weight _____

Policy Holder

Name _____

DECLARATION ON THE FOLLOWING DISEASES

I hereby declare, that I do not suffer or have not suffered from any of these diseases:

- Any form of cancer
- Organ failure
- Any form of organ / tissue transplant
- HIV or other syndromes related to the immune system
- Syndromes in relation to the hematopoietic (blood forming) system
- Coagulation (bleeding) disorders
- Multiple sclerosis
- Cystic fibrosis
- Insulin dependent diabetes
- Chronic hepatitis
- Growth hormone deficiency
- Infertility
- Any other material condition. A material condition is one which requires a period of hospitalisation, recurrent or continuous medical attention. If you have any doubt whether a condition is material you should disclose it.

IF YOU SUFFER OR HAVE SUFFERED FROM ONE OF THESE DISEASES, PLEASE GIVE FULL DETAILS ON THE FOLLOWING PAGE.

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.

The Insured agrees that Pantaenius will save the personal data under the conditions of the Data Protection Act 1998 and will give the data to the participating underwriters and re-insurer(s), and that Pantaenius is entitled to change underwriters.

Place/Date

Signature Policy Holder

Please send with original signature to Pantaenius.

Place/Date

Signature Person Insured

Please send with original signature to Pantaenius.



Policy Holder

Name _____

NAME OF DOCTOR

DETAILS OF CONDITION

DATE OF TREATMENT

DETAILS OF TREATMENT

CURRENT STATE OF HEALTH

DECLARATION:

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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/Date

Signature Person Insured