

Declaration of Health Questionnaire

Name of Applicant / Insured
 Application / Policy No. Date of Birth
 Present Occupation Duties.
 Height Weight Gain or Loss past year (+) (-) Cause of change
 Personal Physician (Name and Address)
 Please answer "Yes" or "No" if you answer "Yes" please give details below including dates, duration, treatment, names and addresses of physicians.

1. Have you ever suffered or do you now suffer from:
 - a) Diseases of the circulatory system (e.g. heart trouble, rheumatic fever, high blood pressure, diseases of and veins)? Yes No
 - b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia)? Yes No
 - c) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stone, venereal disease)? Yes No
 - d) Diseases of the gastro-intestinal system (e.g. digestive disorders, gastric or duodenal ulcer, Hepatitis B or other disorders of the liver, disorders of the gall bladder)? Yes No
 - e) Diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches, frequent headaches, nervous breakdown)? Yes No
 - f) Diabetes, cancer, or any diseases of the blood, glands, spleen, ears, eyes or skin? Yes No
 - g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhoea, unexplained infection or swollen glands? Yes No
 - h) Any other diseases or ailments not mentioned above? Yes No
2. Have you ever had been advised to have hospital treatment or surgery? Yes No
3. Have you ever had been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused as a blood donor? Yes No
4. Are you now in good health and entirely free from any mental or physical impairments or deformities? Yes No
5. Have you consulted a physician for any reason, including routine examinations and blood tests, or have you received any blood transfusions within the past 5 years? Yes No
6. Have you ever received or do you now receive any disability benefit? Yes No
7. Has any proposal for life assurance ever been declined or postponed or been accepted with an extra premium? Yes No

Question No.	Details	Date	Name & Address of physician/medical centre

*I declare that to the best of my knowledge and belief, the above declarations are true and complete and I agree that they will be the basis of the issuance of insurance for me and form an integral part thereof, The National General Insurance Company Shall not be liable for any death, illness or disability due to a health condition existing before the date of these declarations unless I declared it herein and the National General Insurance Company gave a written consent to cover it.

*I authorize any physician, nurse, hospital official or employee to disclose to the National General Insurance Company any and all information regarding my medical history.

_____ **Place** _____ **Date** _____ **Signature of Insured**