HEALTH DECLARATION FORM

- * Please refer to the exclusions and conditions relating to the Medical and Cancellation sections of this insurance which apply to you, all travelling companions and anyone upon whose state of health your decision to cancel or curtail your trip would depend.
- * If you think any of these exclusions or conditions apply, you must complete both sides of this form and send it to us within 14 days of receiving the insurance at the following address

Fogg Travel Insurance Services Limited, Crow Hill Drive, Mansfield, Notts. NG19 7AE (Tel: 01623 635958) or by Fax on 01623 632861

Your Travel Arrangements

To:

Travel Dates: From:

- * It is a condition of this insurance that you advise us of all material facts, which might influence us in the issue of this insurance to you.
- * If necessary, please continue on a separate sheet.

Your Insurance (please tick as appropriate)

Name of insurance:

Date of Issue (if already	/ issued):			ountries to be visited	:			
Is this an Annual Policy		NO						
Γο include Winter Spor		NO		Number of persons to be insured?				
Have you been declined travel cover elsewhere or had special Terms imposed? YES NO				Details of any planned high risk activities, e.g. skiing, scuba diving, white water rafting etc:				
If YES, please give deta	ails							
			A	re you permanently re	esident in the UK:	YES / NO		
			Г	ate of Birth:	/	/		
Your Details								
Name :				ecupation:				
Address:								
				,				
				-mail address:				
				B. We may use the	above in order to comr			
Post Code :				you regarding co	onfidential medical infor	rmation		
state of health your de	o those <u>no</u> ecision to	cancel or curtail your tr	ip would depe	nd. If the person co	ou intend to stay and up ncerned has received a			
Part A: <i>Applies only to</i> state of health your de prognosis no cover w	o those <u>no</u> ecision to		ip would depe	nd. If the person co	ncerned has received a	terminal How often		
Part A: <i>Applies only to</i> state of health your de prognosis no cover w	o those <u>no</u> ecision to ill be prov	cancel or curtail your tr ided by the Insurer in re Specify all medical	p would dependence of Cano	end. If the person co cellation or Curtailmon Details of medication and	Any treatment or hospital admission in	How often are check-up		
Part A: <i>Applies only to</i> state of health your de prognosis no cover w	o those <u>no</u> ecision to ill be prov	cancel or curtail your tr ided by the Insurer in re Specify all medical	p would dependence of Cano	end. If the person co cellation or Curtailmon Details of medication and	Any treatment or hospital admission in	How often are check-up		
Part A: <i>Applies only to</i> state of health your de prognosis no cover w	o those <u>no</u> ecision to ill be prov	cancel or curtail your tr ided by the Insurer in re Specify all medical	p would dependence of Cano	end. If the person co cellation or Curtailmon Details of medication and	Any treatment or hospital admission in	How often are check-up		
Part A: <i>Applies only to</i> state of health your de	o those <u>no</u> ecision to ill be prov	cancel or curtail your tr ided by the Insurer in re Specify all medical	p would dependence of Cano	end. If the person co cellation or Curtailmon Details of medication and	Any treatment or hospital admission in	How often are check-up		
Part A: Applies only to state of health your de prognosis no cover w Name & Relationship	Age/ DOB	cancel or curtail your tr ided by the Insurer in re Specify all medical	Date of onset	Details of medication and dosages	Any treatment or hospital admission in the past 12 months	How often are check-up		
Part A: Applies only to state of health your de prognosis no cover w Name & Relationship	Age/ DOB	cancel or curtail your trided by the Insurer in research	Date of onset	Details of medication and dosages	Any treatment or hospital admission in the past 12 months	How often		

B - SECTI				panions had a cancerous, ca	rdio-vascular,	cerebro-vascular, renal,	
YES	NO	hiatric or ment	al condition? ed YES, please complete	e the section below:			
NAME(S)	, 110	AGE/ DOB	CONDITION (S)	DETAILS OF MEDICATION AND DOSAGES	DATE OF ONSET	ADVISE HOW OFTEN CHECK-UPS ARE REQUIRED	
B - SECTI	supe	-		oanions had any other medio or doctor or has required any			
YES	NO	If you ticked	YES, please complete	the section below.			
NAME(S)		AGE/ DOB	CONDITION (S)	DETAILS OF MEDICATION AND DOSAGES	DATE OF ONSET	ADVISE HOW OFTEN CHECK-UPS ARE REQUIRED	
B - SECTI	char		cation or increase in de	panions been taking continu osage in the last twelve mon			
YES	NO		YES, please complete	the section below.			
NAME:				NAME:			
DETAILS	:			DETAILS:			
B -SECTION	ON 4 – Do Y	OU or any of Y	OUR travelling compar	nions have any medical cond	lition for which	you are on a hospital	
YES	waiti NO	ng list or awaiti	ing the results of test of YES, please complete to	r investigations?			
NAME:				NAME :			
DETAILS:			DETAILS :	DETAILS:			
				_			
DECLARA	TION						
I declare the no information of the Neithern	nat all the in ation has been er I nor any	en withheld whic of my travelling	ch may influence the insucompanions will travel a	any attachments is truthful to the arer in his assessment of this rigagainst the advice of a medical	sk. Furthermor		
• If preg	gnant, the e		companions have receiv delivery is more than 8 v	weeks before the booked date	of return home	of myself or my travelling	
Signed				Agent Stamp :			
Print Nam Date	е			Contact Name : Fax No :			

Part B: Applies only to YOU and YOUR travelling companions