



## BRITCAY

## SECTION I DETAILS OF APPLICANT

Full Name \_\_\_\_\_ Date of Birth (DD/MM/YY) \_\_\_\_\_

Name of Physician \_\_\_\_\_ Policy No. \_\_\_\_\_

## SECTION 2 HEALTH QUESTIONS

NB: You should inform BritCay of all the facts likely to influence the acceptance and rating of your proposal. If you withhold information, any policy subsequently issued may be declared void. All questions must be answered.

QUESTION	YES	NO	EXPLANATION INCLUDING TREATMENT OR MEDICATION
<b>A. VISION</b>			
1. Do you suffer from cataracts/glaucoma or have defective vision which is not corrected by glasses?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you had eye surgery within the last five years? If Yes, when?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you require corrective glasses for driving?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you had your eyes examined by an Optometrist in the last 12 months?*	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B. HEART</b>			
1. Do you suffer from, or have any symptoms of any heart complaints (e.g. Angina)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you had heart surgery in the last five years? If Yes, when?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you require Nitroglycerin Tablets?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you suffer from Hypertension (high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C. DIABETES &amp; OTHER AILMENTS</b>			
1. Do you suffer from Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you require insulin injections or other medication?	<input type="checkbox"/>	<input type="checkbox"/>	

QUESTION	YES	NO	EXPLANATION INCLUDING TREATMENT OR MEDICATION
3. Do you suffer from any other ailments, disease or infirmity (e.g., Epilepsy, seizures, Alzheimer's)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>D. HEARING</b>			
1. Do you suffer from any hearing impairment or disability or require the use of a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>E. HOSPITALIZATION</b>			
1. Have you been an in-patient during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>F. MEDICATION/OTHER</b>			
1. Are you currently receiving any drugs, tablets or medicine other than those noted above?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you had a physical exam in the last 12 months?*	<input type="checkbox"/>	<input type="checkbox"/>	
3. Were you required to undergo a physical for the Dept. of Vehicle & Drivers' Licensing in the last year? If Yes, please provide a copy.	<input type="checkbox"/>	<input type="checkbox"/>	

\*If you have answered No to question A 4 or F 2, we kindly request that you have an exam.

### SECTION 3 DECLARATION

I/We wish to effect an insurance with British Caymanian Insurance Company Limited. I/We declare that the above statements and particulars are complete and correct, and no material fact has been misrepresented, misstated or withheld. To the best of my/our knowledge, I/we do not suffer from any physical or mental disability which would increase my/our risk of having an accident while driving a motor vehicle. If this form has been completed by anyone else, that person is my/our agent for that purpose and not the agent of British Caymanian Insurance Company Limited. (If you have not personally completed the answers to these questions, you should check them carefully before signing this declaration.)

Signed \_\_\_\_\_ Dated \_\_\_\_\_

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