Foreign Travel and Residency Questionnaire for Critical Illness

Personal Information

Full Name

Date of Birth

Passport Number

Nationality

Foreign Travel History (Past 5 Years)

Country Visited	City/Region	From (Date)	To (Date)	Purpose of Visit

Other countries or significant travel (if any)

Residency Information

Current Residential Address

Length of Residency at Current Address (years)

Other addresses of residency in the past 5 years

Health Declaration

Have you ever been diagnosed or treated for a critical illness?

Select

If yes, please provide details:

Additional Information

Do you have any future travel or relocation plans? If yes, please specify.

Date

Signature