Claimant Medical History Declaration

Personal Details

Full Name

Date of Birth

Policy Number

Contact Number

Residential Address

Medical History

Do you have any existing or previous illnesses or medical conditions?

Yes No

If yes, please provide details (illness/condition, diagnosis date, treatment, current status)

Have you been hospitalized in the past 5 years? If yes, provide details.

Are you currently taking any medication? If yes, list them.

Family Doctor/Clinic Name

Doctor/Clinic Contact Number

Lifestyle Information

Do you smoke?

Yes No

Do you consume alcohol?

Yes No

Do you exercise regularly?

Yes No

Declaration

I hereby declare that the information provided above is true, accurate, and complete to the best of my knowledge. I understand that any false or incomplete information may affect the outcome of my insurance claim.

Signature

Date