

Medical History Declaration form

About this form

- We shall be pleased to consider a transfer without further medical underwriting for yourself and any eligible dependant(s) upon receipt of the following information which should be supplied to the best of your knowledge and belief. Please note that the provision of this information will assist us with an underwriting decision but will not guarantee an offer of a transfer without further medical underwriting.
- Please write in blue or black ink and use BLOCK CAPITALS.
- If you need any assistance please call our helpline on 0800 197 6997. We are here to help. Your calls may be recorded and monitored for training and quality assurance purposes.
- When complete please return this form to: Simplyhealth, James Tudor House, 90 Victoria Street, Bristol BS1 6DF

1. About you

Your name			Company name	
Telephone no.			Fax no.	
Broker name (if applicable)				

2. Information

a) Have you or any dependants received treatment as a day-patient or in-patient within the last six months, or have any treatment planned? If yes, please provide details, including dates, in the box below.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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b) Have you or any dependant received treatment of any kind in respect of cancer, heart, orthopaedic or psychiatric related conditions? If yes, please provide details, including dates, in the box below.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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c) Is there any other information that you consider may be material or that you feel you ought to declare in the interest of good faith? If yes, please provide details, including dates, below.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Date of treatment	Nature of medical condition

3. Signature

Signature			
Name (Please print)		Today's date	