



**PART A**

Please consider the following questions as they apply to each of the person named. Answer each question by clearly ticking one of the corresponding YES / NO boxes.	<b>Applicant</b>	<b>1ST Dependant</b>	<b>2ND Dependant</b>	<b>3RD Dependant</b>	<b>4TH Dependant</b>	<b>5TH Dependant</b>
	NAME:	NAME:	NAME:	NAME:	NAME:	NAME:
	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1. Have you ever been treated as an in-patient in a clinic/ hospital?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. Has any medical practitioner been consulted and/or provided prescriptions for any drugs or medication within the last five years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
3. Does any chronic/ long-term medical condition exist or is there any other known disability, abnormality or recurrent illness or injury?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4. Is there any known or foreseeable need to consult a medical practitioner, dentist, optometrist or are you pregnant?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. Are you a smoker and/ or do you consume alcohol?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

**PART B** (please use *block capitals* throughout)

This part applies if you have indicated any 'Yes' replies in PART A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply.

1	2	3	4	5
Name	Medical Condition	Treatment and consultations received (with dates)	Needs for any further treatment or consultation	Present state of health

6. Are you presently insured under any medical insurance and have you ever been declined or quoted special terms for same?	YES	NO	If YES give details:
	<input type="checkbox"/>	<input type="checkbox"/>	

**4. Declaration**

*I hereby declare that the statements and answers given above are true and correct and that I have not withheld or concealed any information that might influence the acceptance of this proposal.*

*I authorise any Medical Source, insurance office, organisation or person to release to the Company any relevant information concerning any of the persons who are proposed for the cover under this insurance. A photographic copy of this authorisation shall be valid as original.*

*I agree that this proposal and declaration shall be the basis of the contract between SACOS Insurance Company Limited and myself and I agree to accept a Policy in the company's usual form for this class of Insurance.*

Date: .....

Signature: .....