PANTAENIUS
Yacht Insurance

MEDICAL APPLICATION FORM FOR FOREIGN TRAVEL HEALTH INSURANCE

POLICY HOLDER

Employer: ______________________ Name of the Yacht: ______________________

Full Address: ______________________ Post Code: ______________________

Tel.: ______________ Fax: ______________ EMail: ______________________

INSURED PERSON

Family Name: ______________________ First Name: ______________________

❑ Male ❑ Female Date of Birth: __________ High: ______ Weight: ______

Nationality: ______________________ Occupation: ______________________

Last residence: ____

MEDICAL HISTORY DECLARATION

Have you consulted with a specialist, been admitted to a hospital/nursing home, or been advised to have any medical examinations/investigations, or suffered from any recurrent illness during the last five years?

❑ Yes ❑ No

Have you sought medical advice in the last 24 months?

❑ Yes ❑ No

If yes, please give full details on the attached sheet.

NOTE:
Reference is explicitly made to the limitation under §5 of the enclosed General Insurance Terms and Conditions for Foreign Travel Health Insurance

DECLARATION:

To the best of my knowledge the information provided on this application form, whether in my own hand or not, is true and complete. I understand that failure to disclose, or misrepresentation of any pertinent facts may lead to the denial of a claim or cancellation of any policy. I understand and agree that this application and the statements contained herein shall form the basis of the contract issued as a result of this application.
I authorise any doctor, who has ever attended me, to provide the Insurer with any information that may be required including prior medical history.

Begin of the Insurance: ______________________ midday 12oo am

Place and Date ______________________ Signature of Policy Holder ______________________

Place and Date ______________________ Signature of Insured Person ______________________

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Name of Doctor

Details of Condition

Details of Treatment

Dates of Treatment

Current State of Health

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I authorise any doctor, who has ever attended me, to provide the Insurer with any information that may be required including prior medical history.

Place and Date................................ Signature of Applicant...