

POLICY NUMBER:

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Personal Declaration made in lieu of Medical Examination

PLEASE PRINT

1. (a) Name in full _____ (b) Marital Status _____
 (c) Occupation _____ (d) Height _____ (e) Weight _____
 (f) Has weight changed in the past two years? _____ (g) Loss _____ (h) Gain _____
 (i) Cause of weight change _____

 (j) Name and address of personal Physician (if none, so state) _____

 (k) Date of last consultation: _____ (l) Reason for last consultation: _____
 (m) Results of last consultation: _____

2. **Family history:**

Have any of your family members had heart or kidney disease, blood disorder, diabetes, stroke, mental illness or any other hereditary disease? YES NO

Please complete the following:

	Age	State of health	Age at onset	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					
Spouse					
Children					

3. **Avocations, driving, lifestyle:**

During the past five years have you:

- | | Answer
"Yes" or "No" | If "Yes" give dates and full particulars |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------|
| (a) flown, or do you contemplate making any flights other than as a fare paying passenger on a scheduled airline? | <input type="checkbox"/> <input type="checkbox"/> | |
| (b) participated in any hazardous activities such as motor vehicle racing, parachute jumping, scuba diving, or is any such activity contemplated? | <input type="checkbox"/> <input type="checkbox"/> | |
| (c) been convicted of two or more speeding violations or has your driver's licence been suspended? | <input type="checkbox"/> <input type="checkbox"/> | |
| (d) been convicted of a criminal offence? | <input type="checkbox"/> <input type="checkbox"/> | |

4. **Travel**

Do you intend to travel or have you travelled outside the Caribbean or North America for a period exceeding three months as indicated below?

Name of country/ies _____
 Length of stay _____ Date travelled _____ Date returned _____

5. **Smoking**

In the past 12 months have you smoked cigarettes, cigars, pipe or used any other form of tobacco or nicotine product? YES NO

If yes, please give details: type of tobacco _____
 amount smoked daily _____

6. **Medical questions:** Have you ever been treated for or had any known indication of.

		Answer "Yes" or "No"	If "Yes" give dates and full particulars
(a)	stroke, transient ischemic attack (TIA), dizziness, fainting, convulsions, headache, nervous breakdown, depression, epilepsy, multiple sclerosis or any other disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
(b)	high blood pressure, chest pain, angina, palpitations, heart attack, heart murmur, elevated cholesterol or any other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
(c)	asthma, bronchitis, tuberculosis, emphysema, blood spitting, persistent cough or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
(d)	colitis, intestinal bleeding or polyps, ulcer, recurrent indigestion, jaundice, hernia, hepatitis, or any other disease or disorder of the stomach, intestines, rectum, gallbladder, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
(e)	sugar, albumin, protein or blood in the urine, nephritis, kidney stones or cysts or any other disorder of the kidneys or bladder?	<input type="checkbox"/>	<input type="checkbox"/>
(f)	diabetes, taken insulin or gone on a restricted or special diet?	<input type="checkbox"/>	<input type="checkbox"/>
(g)	cancer, tumor or any other growth or malignancy, venereal disease, any disorder of the breast, prostate or other reproductive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(h)	thyroid disorder, enlarged lymph glands, anemia, allergies or any other disorders of the blood or glands?	<input type="checkbox"/>	<input type="checkbox"/>
(i)	any disorders of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
(j)	Rheumatoid arthritis, osteoarthritis or any chronic disorder of the joints?	<input type="checkbox"/>	<input type="checkbox"/>
(k)	Disorder of the muscles or bones including spinal curvature (scoliosis)?	<input type="checkbox"/>	<input type="checkbox"/>

7. (a) **Do you have or have you ever had:**

(i)	prolonged extreme fatigue for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>
(ii)	persistent fever or night sweats for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>
(iii)	significant weight loss unrelated to dieting of about 10% of body weight?	<input type="checkbox"/>	<input type="checkbox"/>
(iv)	hardening or swelling of the lymph glands in the neck, armpits or groin?	<input type="checkbox"/>	<input type="checkbox"/>
(v)	persistent diarrhoea?	<input type="checkbox"/>	<input type="checkbox"/>
(vi)	a heavy, persistent, often dry cough unrelated to smoking for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>
(vii)	a thick whitish coating on the tongue or in the throat?	<input type="checkbox"/>	<input type="checkbox"/>
(viii)	easy bruising or unexplained bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
(ix)	recent, slowly enlarging purplish or discoloured lumps on top or beneath skin?	<input type="checkbox"/>	<input type="checkbox"/>
(x)	any recent blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Do you belong to one of the following AIDS high-risk groups established by the health authorities:		
(i)	Homosexual	<input type="checkbox"/>	<input type="checkbox"/>
(ii)	Bisexual	<input type="checkbox"/>	<input type="checkbox"/>
(iii)	Intravenous ((I. V.) drug users	<input type="checkbox"/>	<input type="checkbox"/>
(iv)	Haemophiliacs, or other users of blood products	<input type="checkbox"/>	<input type="checkbox"/>
(v)	Sexual partners of the preceding groups.	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Do you have or have you ever had AIDS, any other disorder of the immune system or test results indicating exposure to the AIDS virus (HIV positive)?	<input type="checkbox"/>	<input type="checkbox"/>

