Uni-Care International Travel Insurance
Crombie Lockwood (NZ) Limited
P O Box 68 910, Newton, Auckland 1145
Telephone: + 64 9 623 9890
Email: insure@uni-care.org
Web: http://www.uni-care.org

Medical Declaration Form

Family Name: _____ **Given Name:** _____

Date of Birth: _____/_____/_____ **Gender:** Male / Female
(Please circle)

Education Provider Name: _____

Please circle your answer to each question

1. Have you been hospitalised in the last 12 months? YES / No
2. Do you suffer from, or have you ever suffered from a serious or life threatening medical condition? YES / NO
3. During the 6 months prior to this application, have you suffered sickness or injury for which medical treatment has been sought, given, recommended, or for which a reasonable person would have sought medical attention? YES / NO
4. Are you suffering from a medical condition, illness or injury, included sports related injury? YES / NO
5. Are you currently taking medication? YES / NO

If you have answered YES to any of the questions above please provide full details of:

Medical condition(s) & Medication: _____

_____

_____

_____

Doctor's Name: _____

Address of Practice: _____

Doctor's Phone Number: _____

Doctor's email: _____

Signed: _____ Date Completed: _____/_____/_____

Please return this form to your Education Provider