ACTIVITY TOPUP MEDICAL QUESTIONNAIRE

(to be submitted if required)

IMPORTANT

Prior to completing this questionnaire, please note that failure to disclose material information (i.e. information that would influence the acceptance of the risk and/or terms applied) could invalidate the Insurance. If you are in any doubt as to whether any information is material, it should be disclosed. **ALL QUESTIONS MUST BEANSWERED.**

Person to be Insured

Full Name:.....

Address.....

Occupation:.....

Date of Birth: ..... **Height** .... **Weight** .....

Proposer: (if not person named above)

Full Name:.....

Please tick (✓) the reason(s) for submission of this form and supply the information requested:

☐ **Existing Medical Condition**
Please describe the Condition and supply a letter from your Doctor/Specialist stating your actual condition and your suitability to Travel and take part in Sport.

☐ **Over 64 Years of age**
Please list where and how you will travel and the Sports that you will take part in. If 65 or over please supply a letter from your Doctor/Specialist stating your suitability to Travel and take part in your chosen Sport/Activity.

☐ **Medically related claim made within the past 3 years**
Please supply details of the Incident which led to the claim (Date, place, weather conditions etc) and details of the Claim itself (Medical diagnosis, time in Hospital, whether repatriated, total cost). Also supply a Doctor's note to state that you are fit to travel and partake in your chosen Sport/Activity if ongoing risk might exist.

Please tick (✓) Yes or No to the following questions. If Yes please give full details in the box provided:

1. Has the Person to be Insured:
   a) Any physical or mental defect or infirmity?..... .... Yes☐ / No☐
   b) Defective sight or hearing? Yes☐ / No☐
   c) Suffered from any recurring, intermittent, acute or chronic disease, condition or disorder?. ..... Yes☐ / No☐

2. In the past 12 months has the Person to be Insured sought medical advice for any injury or condition (other than minor ailments)? .... Yes☐ / No☐

3. Has any Insurer in connection with Accident, Sickness, Medical or Life Insurance in respect of the Person to be Insured ever:
   a) deferred or declined a proposal, refused renewal or terminated an insurance?..... .... Yes☐ / No☐
   b) required an increased premium or imposed special conditions?... .... Yes☐ / No☐

4. Are you covered under any other Personal Accident Insurance Policy. .... Yes☐ / No☐

DECLARATION

I declare to the best of my knowledge and belief that the above statements and associated explanations are true and complete. I further declare that I have not withheld any material facts likely to influence acceptance or assessment of my application for Insurance.

Signature: Date

Description of Condition (with date of first occurrence) and Further details:

(use further sheets if necessary)

Now please post the completed Application Form to:SportsCover Direct Ltd., Freepost (RLZL-ZXRT-HLBZ), 29 Great George Street, Bristol BS1 5QT (no stamp is required if posted in UK) or Fax this application form to SportsCover Direct on 0845 120 6401