

Medical Report

Requested	Received



Court No 8143
Membership No

Esplanade House, 29 Glatigny Esplanade, St Peter Port Guernsey. GY1 1WR
 Tel: 01481 728864 Fax: 01481 728705 Email: info@forestershealthcare.com
 Licensed by the Guernsey Financial Services Commission

The questions in this proposal must be answered fully to the best of your knowledge. You **MUST** disclose to the Society in writing any facts which we would regard as material (i.e. facts likely to influence the assessment and acceptance of the proposal). Failure to do so may cause the Insurance to be declared void.

Name in Full:	<input style="width: 100%;" type="text" value="Mr./Mrs./Miss./Master"/>		
Address:	<input style="width: 100%;" type="text"/>		
	Post Code	<input style="width: 100%;" type="text"/>	
Tel Numbers:	Home: Mobile:	Email Address	<input style="width: 100%;" type="text"/>
Date Of Birth :	<input style="width: 100%;" type="text" value=" / /"/>	Occupation:	<input style="width: 100%;" type="text"/>
Name and Practice of your Doctor:	<input style="width: 100%;" type="text"/>		How long have you been resident in the Channel Islands: <input style="width: 100%;" type="text"/>
Current Health Insurer:	<input style="width: 100%;" type="text"/>	Introduced by:-	<input style="width: 100%;" type="text"/>
			If a personal recommendation
<p>I consent to the Society seeking medical information from any Doctor who at any time has attended me concerning anything which affects my physical or mental health and I authorise the giving of such information.</p> <p>The Society reserves the right to charge non standard premium rates where applicants have pre-existing conditions or represent a non-standard risk.</p> <p>To be signed by the applicant (where the applicant is under the age of 16, the signature must be that of a Parent or Legal Guardian)</p> <p>If parent or legal guardian please print name clearly under signature</p>			
Signature		Date.....	
PRINT name of Parent or legal guardian			
<u>Please complete the back of this form.</u>			

	YES	NO
Have you suffered any serious or ongoing illness in the last 5 years.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes state nature and dates.....		

Are you expecting to undergo treatment in the near future.....	<input type="checkbox"/>	<input type="checkbox"/>
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Are you receiving treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes declare the condition.....		

Are you taking medication.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes how many prescriptions per month.....		

Have you any prospect of undergoing an operation.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes declare the condition requiring surgery.....		

Healthcare cover requested :	Scheme A	<input type="checkbox"/>	<input type="checkbox"/>
	Scheme B	<input type="checkbox"/>	<input type="checkbox"/>
If yes to Scheme B how many units required:		<input type="text"/>	

On average, how often do you visit your Surgery:	<input type="text"/>
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Preferred frequency of payment :	Monthly	Quarterly	Half Annual	Annual
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred method of payment:	States Wage Deduction	Monthly Office	Account (not monthly)	Direct Debit	Debit/Credit Card
weekly	<input type="checkbox"/>	monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

From where did you hear about Foresters Healthcare:	Radio	TV	Gsy Press	Other (please specify)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

An applicant should keep a record of any information supplied to or received by the Society, including letters and this application form. If a copy is required, please tick the box and we will send one to you.