CG | INSURANCE

HEALTH QUESTIONNAIRE
FOR MOTOR INSURANCE

Road User

PART 1 DETAILS OF APPLICANT

Full Name _____

Date of Birth (DD/MM/YY) _____ Policy No. _____

Physician Name _____

PART 2 HEALTH QUESTIONS

You should inform Coralisle of all the facts likely to influence the acceptance and rating of your proposal. If you withhold information, any policy subsequently issued may be declared void. All questions must be answered.

	QUESTION	YES	NO	EXPLANATION INCLUDING TREATMENT OR MEDICATION
A.	VISION			
1.	Do you suffer from cataracts/glaucoma or have defective vision which is not corrected by glasses?	☐	☐	
2.	Have you had eye surgery within the last five years? If Yes, when?	☐	☐	
3.	Do you require corrective glasses for driving?	☐	☐	
4.	Have you had your eyes examined by an Optometrist in the last 12 months?*	☐	☐	
B.	HEART			
1.	Do you suffer from, or have any symptoms of any heart complaints (e.g. Angina)?	☐	☐	
2.	Have you had heart surgery in the last five years? If Yes, when?	☐	☐	
3.	Do you require Nitroglycerin Tablets?	☐	☐	
4.	Do you suffer from Hypertension (high blood pressure)?	☐	☐	
C.	DIABETES & OTHER AILMENTS			
1.	Do you suffer from Diabetes?	☐	☐	
2.	Do you require insulin injections or other medication?	☐	☐	
3.	Do you suffer from any other ailments, disease or infirmity (e.g., Epilepsy, seizures, Alzheimer's)?	☐	☐	

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	QUESTION	YES	NO	EXPLANATION INCLUDING TREATMENT OR MEDICATION
D.	HEARING			
1.	Do you suffer from any hearing impairment or disability or require the use of a hearing aid?	☐	☐	
E.	HOSPITALIZATION			
1.	Have you been an in-patient during the last 12 months?	☐	☐	
F.	MEDICATION/OTHER			
1.	Are you currently receiving any drugs, tablets or medicine other than those noted above?	☐	☐	
2.	Have you had a physical exam in the last 12 months?*	☐	☐	
3.	Were you required to undergo a physical for TCD in the last year? If Yes, please provide a copy.	☐	☐	

*If you have answered No to question A 4 or F 2, we kindly request that you have an exam.

PART 3 DECLARATION

I/We wish to effect an insurance with Coralisle Insurance Company Ltd. I/We declare that the above statements and particulars are complete and correct, and no material fact has been misrepresented, misstated or withheld. To the best of my/our knowledge, I/we do not suffer from any physical or mental disability which would increase my/our risk of having an accident while driving a motor vehicle. If this form has been completed by anyone else, that person is my/our agent for that purpose and not the agent of Coralisle. (If you have not personally completed the answers to these questions, you should check them carefully before signing this declaration.)

Print Name _____

Signature _____ Date _____

You may on occasion be contacted by a company within the Coralisle Group with offers and/or information in respect of other Coralisle Group products. We confirm that only your contact details will be available to Coralisle Group personnel for such purposes and that your private information will not otherwise be transferred between Coralisle Group companies or to any other third parties without your consent to do so.

If you DO NOT wish to be contacted in this manner by Coralisle Group personnel, please check here ☐. Note that unless you check this box, Coralisle will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.