

## 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 |
|---|--------------------------|--------------------------|---|
| <b>A. VISION</b>  |                          |                          |   |
| 1. Do you suffer from cataracts/glaucoma or have defective vision which is not corrected by glasses?    | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 2. Have you had eye surgery within the last five years? If Yes, when?                                   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 3. Do you require corrective glasses for driving?   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 4. Have you had your eyes examined by an Optometrist in the last 12 months?*                            | <input type="checkbox"/> | <input type="checkbox"/> |   |
| <b>B. HEART</b>   |                          |                          |   |
| 1. Do you suffer from, or have any symptoms of any heart complaints (e.g. Angina)?                      | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 2. Have you had heart surgery in the last five years? If Yes, when?                                     | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 3. Do you require Nitroglycerin Tablets?  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 4. Do you suffer from Hypertension (high blood pressure)?   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| <b>C. DIABETES &amp; OTHER AILMENTS</b>   |                          |                          |   |
| 1. Do you suffer from Diabetes?   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 2. Do you require insulin injections or other medication?   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 3. Do you suffer from any other ailments, disease or infirmity (e.g., Epilepsy, seizures, Alzheimer's)? | <input type="checkbox"/> | <input type="checkbox"/> |   |

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

\*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.)

#### Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan Coralisle Insurance Company Ltd. may process any and all of the personal data provided.
- I consent to Coralisle Insurance Company Ltd. processing my personal data, in accordance with Coralisle Insurance Company Ltd.'s Privacy Policy (<https://international.cgcoralisle.com/privacy-policy/>). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to Coralisle Insurance Company Ltd. in respect of any third party, is done with that third party's consent and knowledge of Coralisle Insurance Company Ltd. processing of their personal data.

## Road User

- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_