TRIDENT INSURANCE

Tatil

MEDICAL FORM FOR SELF CERTIFICATION

Name of Applicant: _____

Please truthfully and completely answer all the questions below:

EYES/ EARS/ NOSE/ THROAT

1. Do you suffer with:

Condition		
Blindness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Deafness	☐ Yes	☐ No

2. Do you wear glasses: ☐ Yes ☐ No
   If yes, indicate the purpose:

3. Do you have an eye doctor: ☐ Yes ☐ No
   If yes, who is your eye doctor:

4. *Do you have difficulty in judging how fast another vehicle is travelling: ☐ Yes ☐ No

5. *Does glare affect your eyes: ☐ Yes ☐ No

6. *Do you lose temporary vision when moving from a lit to a dark environment: ☐ Yes ☐ No

7. *Do you have any problems with your eyes/ ears/ nose/ throat not mentioned above: ☐ Yes ☐ No

NEURO-/ PSYCHO-LOGICAL

8. Have you ever had/ suffered with:

Condition		
Blackouts	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Syncope	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No
Parkinson's	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Severe Anxiety	☐ Yes	☐ No
Severe Depression	☐ Yes	☐ No
Senility/Dementia	☐ Yes	☐ No
Unusual Weakness	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Sleep Disorders	☐ Yes	☐ No

9. Do you suffer with any neurological or psychological illness not mentioned above: ☐ Yes ☐ No

   Please elaborate on all yes answers above: _____

CHRONIC ILLNESS/ MUSCULOSKELETAL

10. *Do you suffer from or ever been diagnosed with:

Condition		
Type I/ II Diabetes	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Other	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Neck Pains	☐ Yes	☐ No
Lower Back Pains	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No
Fractures	☐ Yes	☐ No

GENERAL MEDICAL HISTORY

11. What medical conditions, not otherwise mentioned, have you seen a doctor for within the last 5 years:

12. Do you go for regular checkups: ☐ Yes ☐ No
    Name/ address of regular doctor(s):

13. *Have you had a fall in the last 2 years: ☐ Yes ☐ No

MEDICATION / DRUG HISTORY	LUNG / HEART	SOCIAL / PAST DRIVING HISTORY
14. List the names of all the medications used on a regular basis:	16. Do you suffer with:	17. Do you exercise regularly: ☐ Yes ☐ No
	Condition	If yes, how often:
	Angina ☐ Yes ☐ No	
	Shortness of breath ☐ Yes ☐ No	
	Heart Disease ☐ Yes ☐ No	18.Do you drink alcohol: ☐ Yes ☐ No
	Lung Disease ☐ Yes ☐ No	If yes how many units per week:
15. Do you experience any side effects from your medications: ☐ Yes ☐ No	PLEASE ELABORATE ON ALL YES ANSWERS WITH THE ACCOMPANYING (*):	19.Smoke while driving: ☐ Yes ☐ No
If yes, please specify:		20. Any previous accidents: ☐ Yes ☐ No
		If yes, state the year and who was at fault.
		Year:
		Fault:
		21.*Ever been declared disabled: ☐ Yes ☐ No
		If yes, please state when and why.

THE APPLICANT MAY USE THE SPACE BELOW TO ELABORATE ON ANY YES* ANSWER TO QUESTIONS 1 – 21

ADDITIONAL COMMENTS

DECLARATION: I do declare and warrant that the answers and particulars given above are in every respect true and correct, and I have not withheld any information likely to affect the acceptance of this proposal of insurance; and I agree that the information provided in this medical form and this declaration shall be the basis of the contract between the Company and myself and shall be held to be promissory; and I further agree to accept the Company's policy subject to the terms and conditions to be contained therein or endorsed therein.

Signature _____ Date _____