



Return to: Media Insurance Brokers  
 Fourth Floor, Palladium House,  
 1-4 Argyll Street,  
 London W1F 7TA.

Tel: 020 7287 5054  
 Fax: 020 7287 0679

## STATEMENT OF HEALTH

**Please Print**

Production Company \_\_\_\_\_ Programme Title \_\_\_\_\_

Your Full Name \_\_\_\_\_ Nationality \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
Day Month Year

Number of days filming: \_\_\_\_\_ In front of / behind camera (please delete as applicable)

**MEDICAL HISTORY**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you, to the best of your knowledge and belief, ever had or have reasons to know you had:  |                          |                          |
| A. Fits, paralysis or a stroke, severe headaches or disease of the brain or nervous system?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. High blood pressure, heart attack, angina pectoris, raised blood cholesterol or any other disorder of the heart or blood vessels?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system?  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Duodenal or gastric ulcer, colitis, rectal bleeding, jaundice or any other disease of the stomach, intestines, rectum, liver, pancreas or gallbladder?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Sugar, albumin, blood, or pus in urine, kidney stones or any other disorder of the bladder, kidneys, genito-urinary system or any other sexually transmitted diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Diabetes, gout or any disease or abnormality of the thyroid or other glands?   | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Any disease, disorder or injury of the bones, joints, muscles, back or spine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| H. In the past five years, cold sores on lips or face?  | <input type="checkbox"/> | <input type="checkbox"/> |
| I. In the past year, any significant change of weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Been treated for or had any indication of excessive use of alcohol or drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Disorder of skin, lymph glands, glandular fever, cyst, tumour or cancer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Disorder of eyes, ears, nose or throat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Allergies, hayfever, anaemia or other disorder of the blood.   | <input type="checkbox"/> | <input type="checkbox"/> |

2. WOMEN
- |  |                          |                          |
|--|--------------------------|--------------------------|
| A. Are you now pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Have you ever had any disease of the uterus, cervix or ovaries or have you had pelvic inflammatory disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Have you been unable to work as a result of severe pre-menstrual syndrome or problem periods?               | <input type="checkbox"/> | <input type="checkbox"/> |

3. MEN
- |  |                          |                          |
|--|--------------------------|--------------------------|
| A. Have you ever had any infection or enlargement of the prostate gland? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

4. GENERAL
- |   |                          |                          |
|---|--------------------------|--------------------------|
| A. During the last 21 days have you been exposed to any infection or contagious disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Have you consulted a doctor, been under doctor's care, had surgical advice or treatment or been confined to a hospital during the past five years other than for minor complaints? | <input type="checkbox"/> | <input type="checkbox"/> |

5. For "Yes" answers to above give diagnosis, treatment results, dates of illness and degree of recovery and name and address of attending doctor: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Name and address of general practitioner: \_\_\_\_\_

\_\_\_\_\_

7. Have you, within the past three years, been unable to work as a result of any accident or illness? Yes  No

If 'Yes', state full particulars and dates: \_\_\_\_\_

\_\_\_\_\_

8. To the best of your knowledge and belief, are you now in good health and free from physical impairment or disease?

Yes  No  If 'No', give full details: \_\_\_\_\_

\_\_\_\_\_

---

By signing this Statement of Health Form you consent to Hiscox using the information we hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

**I DECLARE** that I am the person named above; that the statements made by me are true and correct; that I have withheld no information known to me which might alter or otherwise conflict with the statements made by me. I understand that an insurance policy may be issued based on these statements made by me. If a policy is issued and a claim is paid I understand that the insurer may seek recoupment from me if it is determined that the statements I have made are not true and correct, or that I have withheld information known to me which might alter or otherwise conflict with these statements I have made. I also agree to be examined by the insurer's doctors in the event a claim is made.

**I AUTHORISE** Hiscox to have access to my medical records for underwriting and claims purposes. I acknowledge that I may request a copy of this authorisation. I agree that this authorisation shall be valid for a period of six months, or until any claim is resolved in which I am involved.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PLEASE PRINT NAME IN CAPITALS  
\_\_\_\_\_