

Have you, within the past three years, been unable to work as a result of any accident or illness? If you have, state full particulars and dates: _____

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 Cast Medical 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.

Signature

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.

Witness to Signature

Signature

SECTION TWO

To be completed by examining doctor:

General Appearance: _____ Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Heart: _____

EENT: _____

Lungs: _____

LUNG FUNCTION TEST (if applicable): Satisfactory / Unsatisfactory

FLEXIBILITY TEST: Satisfactory / Unsatisfactory

MUSCULO - SKELETAL FLEXIBILITY TEST: Satisfactory / Unsatisfactory

ABDOMEN EXAMINATION: Satisfactory / Unsatisfactory

Are there any hernias present? Yes No

CNS: Satisfactory / Unsatisfactory

GENERAL COMMENTS: _____

Signature of Doctor

Date