M&M INSURANCE BROKING SERVICES LTD.

#39 BOISSIERE VILLAGE, MARAVAL 622-1274 / 6829 / 1871 / 6277

HOSPITALISATION PLAN APPLICATION FORM

TO BE COMPLETED BY MEMBER IF REQUESTING INSURANCE ON SELF

1. Name _____
   FIRST NAME MIDDLE NAME LAST NAME

2. Address _____

_____

_____

3. Phone No. _____ 4. Gender ☐ Male ☐ Female

5. Date of Birth _____ / _____ / _____ 6. Place of Birth _____
   DD MM YYYY

7. Height _____ 8. Weight _____

9. Occupation _____

10. Have you at any time been treated for or been told you had any trouble with any of the following? (answer each item 'yes' or 'no' [tick] in space provided).

	Yes	No		Yes	No
Heart	☐	☐	Kidneys	☐	☐
Tumors	☐	☐	Back or Joints	☐	☐
High Blood Pressure	☐	☐	Urinary System	☐	☐
Cancer	☐	☐	Nervous disorders	☐	☐
Lungs	☐	☐	Stomach or intestines	☐	☐
Diabetes	☐	☐	Hernia	☐	☐

Answer each of the following questions 11 – 17 'yes' or 'no' [tick] in the space provided.	Yes	No
11. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
12. Have you been examined by, or consulted a doctor during the past three years?	☐	☐
13. Have you been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	☐	☐
14. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
15. Have you known physical impairments, deformities or ill health not covered by 9-13?	☐	☐

	YES	NO
16. Have you ever had an application for or reinstatement of Life, Accident or Health Insurance declined, postponed, rated or in any way modified?	☐	☐
17. Do you intend to seek medical advice, treatment, or have any medical tests performed?	☐	☐

If you have answered 'yes' to any of the above questions 10 – 17, give below details including name and address of attending physician(s) and dates attended. Indicate question number when answering.

_____

_____

_____

_____

_____

AIDS (Acquired Immune Deficiency Syndrome) Questions:
- Describe in detail any affirmative answers

	YES	NO
1. Have you received medical advice or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease? Have you been told you had AIDS or AIDS RELATED COMPLEX? Have you had or been told you had a positive blood test for antibodies to the AIDS virus (Human Immune Deficiency Virus)?	☐	☐
2. Do you have any of the following which are unexplained: Fatigue; Weight Loss; Diarrhea; Enlarged Lymph Nodes?	☐	☐

If you have answered 'yes' to any of the above questions 1 – 2, state details below including name and address of attending physician(s) and dates attended. Indicate question number when answering.

_____

_____

_____

_____

Declaration

I hereby declare that all statement and all answers to the above questions are complete and true and they are the basis on which insurance is requested under the Group Policy. I hereby authorize any doctor or other practitioner and any hospital or sanatorium to give **M&M Insurance Services Limited** any information it requests about me with reference to any treatments, examinations, advice or hospitalisation.

Signature of Applicant _____ Date _____ / _____ / _____

Name of Witness _____
FIRST NAME MIDDLE NAME LAST NAME

Signature of Witness _____ Date _____ / _____ / _____

FOR OFFICIAL USE ONLY

MAIL COMPLETED FORM TO TTARP #45 Tragarete Road, Port of Spain, Trinidad, W.I.