

MOISTEN AND SEAL
HEALTH DECLARATION FORM

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1 YOUR DETAILS (PLEASE USE BLOCK CAPITALS)

PLEASE CIRCLE SURNAME FORENAME(S)

DATE OF BIRTH MEMBER NUMBER

FULL POSTAL ADDRESS CONTACT EMAIL ADDRESS

 POSTCODE CONTACT TEL. NUMBER

2 DETAILS OF PARTNER AND DEPENDENT CHILDREN COVERED BY YOUR MEMBERSHIP (WHERE APPLICABLE)

SURNAME	FORENAME(S)	DATE OF BIRTH	RELATIONSHIP
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
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3 MEDICAL HISTORY (NOT REQUIRED WHEN REGISTERING NEW BORN BABIES)

Have you (or your partner and/or children where applicable) ever suffered from any of the following medical conditions?
 Please tick the boxes as appropriate.

<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART PROBLEMS (e.g. ANGINA)	<input type="checkbox"/> CANCER
<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> CIRCULATORY CONDITIONS (e.g. THROMBOSIS)	<input type="checkbox"/> MENTAL DISABILITY
<input type="checkbox"/> RESPIRATORY CONDITIONS (e.g. ASTHMA)	<input type="checkbox"/> GYNAECOLOGICAL DISORDERS	<input type="checkbox"/> PHYSICAL DISABILITY
<input type="checkbox"/> SKIN DISORDERS (e.g. ECZEMA, PSORIASIS)	<input type="checkbox"/> LIVER/BOWEL/STOMACH AND DIGESTIVE DISORDERS	<input type="checkbox"/> BACK, NECK OR SHOULDER PROBLEMS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> KIDNEY DISORDERS	<input type="checkbox"/> ANY OTHER CONDITION

4 PLEASE GIVE FURTHER DETAILS OF CONDITION(S)

NAME	CONDITION/ILLNESS	DATES
<input type="text"/>	<input type="text"/>	<input type="text"/>
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5 DECLARATION

I understand that Health Shield membership does not cover any pre-existing condition which has arisen before the time of joining or increasing cover. Should Health Shield request a medical report I am prepared to be examined at Health Shield's expense. I give my consent to all processing of personal and sensitive data. I declare that all the information included is accurate, true and complete to the best of my knowledge and belief.

SIGNATURE DATE / /



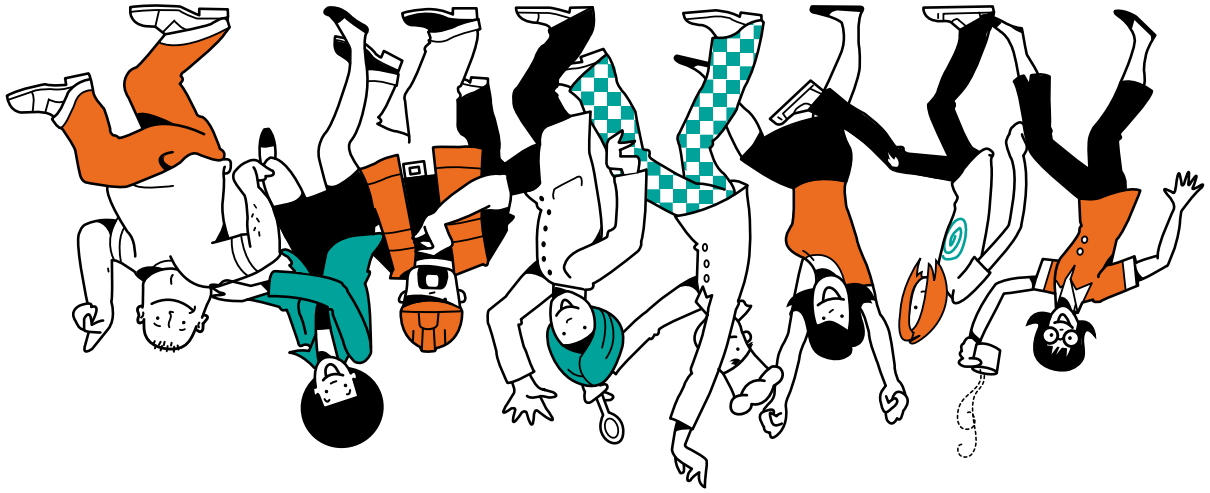
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 Email: info@healthshield.co.uk Website: www.healthshield.co.uk

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 As part of our on-going quality control programme, calls may be monitored or recorded.

The paper in this literature is made from sustainable certified forests.
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