MOISTEN AND SEAL

HEALTH DECLARATION & REGISTRATION FORM

1 YOUR DETAILS (PLEASE USE BLOCK CAPITALS)

PLEASE CIRCLE: MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

UNIQUE REFERENCE NUMBER

FULL POSTAL ADDRESS

POSTCODE

CONTACT EMAIL ADDRESS

CONTACT TEL. NUMBER

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

SURNAME	FORENAME(S)	DATE OF BIRTH	RELATIONSHIP

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.

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

4 PLEASE GIVE FURTHER DETAILS OF CONDITION(S)

NAME	CONDITION/ILLNESS	DATES

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 / /

Health Shield Friendly Society Ltd., Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.
Telephone: 01270 588555 Fax: 01270 251366 Telephone hours: 8.00am to 6.00pm, Monday to Friday
Email: info@healthshield.co.uk Website: www.healthshield.co.uk

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