## GEHI HEALTH STATEMENT (DEPENDENT FORM)*

INSURED NAME : ______________________________ DEPARTMENT: ___________

CURRENT POST: ______________________________ POLICY NO.: _____________

| **TO BE COMPLETED IF REQUESTING INSURANCE FOR DEPENDENTS** | | | | | |
|---|---|---|---|---|---|
| 1. Name of eligible dependents: (if more space needed, complete additional forms) | | | | | |
| Full name | Relationship to you | Date of Birth | Height | Weight | Occupation |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Local Physician | Date of last visit | Reason for visit | | | |
| | | | | | |
| | | | | | |
| | | | | | |

2. Are you currently insured? YES/NO – If ‘YES’, please give details below. If ‘NO’, who was your last insurer; give details below: (circle one)

| Name of Insured: | Policy Date (d/m/y) | Policy Number: | Type of insurance | | Name of Insurance Company |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

3. Are you currently employed? YES/NO (circle one) If ‘YES’ provide name of employer. If ‘NO’ provide name and address of last employer:

4. How many months per year do you reside in Bermuda?

5. Are you a student? YES/NO (circle one). If ‘YES’ provide school name, address, telephone number and dates of attendance.

6. Are you entitled to age subsidy? (i.e. have you resided in Bermuda continuously for 10 years between ages 45-65)

7. Have any of the persons named above:
(i) at any time been treated for or been told they had trouble with any of the following: (answer yes or no)

| | Yes | No | Explain **YES** answers: inc. dates, treatment, results, names & addresses of doctors, hospitals, etc. |
|---|---|---|---|
| a) Disease or disorder of the eyes, ears, nose or throat? | | | |
| b) Asthma, bronchitis or any other respiratory disorder? | | | |
| c) Chest pain or discomfort, breathlessness, palpitations, heart murmur or any problems with the heart, veins or blood circulation? | | | |
| d) Stomach or intestinal bleeding, chronic diarrhea or other disorder of the stomach or bowel? | | | |
| e) Any kidney or urinary problems? | | | |
| f) Amputation or other deformity, any sprain, strain, pain or disease of the back or neck, muscles, bones, joints or spine? | | | |

| | | | |
|---|---|---|---|
| g) Dizziness, fainting, recurrent headaches, convulsions, paralysis, stroke or other disorder of the nervous system? | | | |
| h) Nervous anxiety, stress, fatigue, depression or any other mental disorder? | | | |
| i) Diseases or disorders of the blood or lymph glands, inc. skin allergies, lupus, gout, anemia, hemophilia? | | | |
| j) Diabetes, a disorder of the thyroid or other endocrine glands? | | | |
| k) Unusual or persistent skin lesions | | | |
| l) Aids Related Complex (ARC) or any immune deficiency disorders? | | | |
| m) Cysts, polyps, tumours or cancer? | | | |
| (ii) been a patient in a hospital or similar institution during the past three years? | | | |
| (iii) been examined by or consulted a doctor during the past three years? | | | |
| (iv) been advised to have any a surgical operation or procedure but did not do so? | | | |
| (v) been advised to have any hospital/medical treatment in the future? | | | |
| (vi) any known physical impairments, deformities, or ill health not covered by questions 2. part (i)-(ix)? | | | |

I hereby declare that all statements and all answers to the above questions are complete and true and that they are the basis on which insurance is requested under the policy. I hereby authorize any doctor or other practitioner and any hospital or sanitarium to give the **Government Employees' Health Insurance** any information it requests about any member of my family with reference to any treatments, examinations, advice or hospitalization.

____________________ ____________________________ ______________________________

Date Witness Signature

*** This form to be completed by the INSURED on behalf of any dependent person(s) applying to join the GEHI Scheme under the policy of the insured.**