

**UK RELATED PARTY HEALTH DECLARATION**

You have indicated that the health of a travelling companion, relative or close business colleague or other person on whose state of health a decision by you to cancel or curtail a trip depends may give rise to claim under your travel policy. In order to confirm cover, please ensure that you/or preferably the related party completes the following questionnaire in full and return the form to:

**The Medical Screening Company Ltd**, Monitor House, 2a Belmont Road, Sutton, Surrey SM2 6DW.

(Fax to **0208 722 8711** or e-mail to [info@ehicplus.com](mailto:info@ehicplus.com))

We would recommend that the form is returned by registered post.

**PLEASE ANSWER ALL QUESTIONS**

***DETAILS OF INSURED PERSON***

Title \_\_\_\_\_ Initial(s) \_\_\_\_\_ Surname \_\_\_\_\_ Policy Reference \_\_\_\_\_  
Address \_\_\_\_\_  
Postcode \_\_\_\_\_ Telephone no: \_\_\_\_\_

***HOLIDAY DETAILS***

Departure Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Duration: \_\_\_\_\_ Destination: \_\_\_\_\_  
Have you booked your holiday? \_\_\_\_\_ Yes/No  
If yes, what is the total price of your holidays? £ \_\_\_\_\_

***DETAILS OF THE RELATED PARTY***

Title \_\_\_\_\_ Initial(s) \_\_\_\_\_ Surname \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

***MEDICAL CONDITION(S)***

Has the related party been diagnosed with any medical condition(s) and what are they?  
(1) \_\_\_\_\_ Date of Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
(2) \_\_\_\_\_ Date of Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
(3) \_\_\_\_\_ Date of Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
(4) \_\_\_\_\_ Date of Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the related party been an inpatient in hospital within the last 12 months? Yes/No

How many times has the related party been admitted into hospital over the past two years? .....

Is the related party on a waiting list for investigations or treatment (surgical or otherwise)? Yes/No

Has the related party been given a terminal prognosis? Yes/No

Has the related party had any chemotherapy or radiotherapy in the last 18 months, or been advised that you may require such treatment? Yes/No

Is the related party currently taking any prescribed medications? Please state names and dosages  
(1) \_\_\_\_\_ (2) \_\_\_\_\_  
(3) \_\_\_\_\_ (4) \_\_\_\_\_  
(5) \_\_\_\_\_ (6) \_\_\_\_\_

Has the related party ever been refused Travel Insurance before? Yes/No

Has the related party ever made a medical, cancellation or curtailment claim? Yes/No

**I declare that to the best of my knowledge and belief the above information is a full declaration of all Material Facts as stated in the Insurance Policy.**

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

