OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

DECLARATION OF CONTINUED GOOD HEALTH

Please submit this Declaration within seven days of issue.

Full Name of Proposer/Insured: _____

Policy No. (if applicable): _____

A. Declaration by Proposer/Insured and, if applicable, Spouse/Partner and/or Dependant(s)

1. There has been no change in my / our* health or occupation status; and **2.** I / We* have not had or have any intention to undergo any medical procedure or surgery, any medical test or **3.** I / We* have not sought any medical advice or treatment and are not intending to seek medical advice or treatment in the foreseeable future for any medical condition, disability/deformity/defect, symptom or injury. If you or your Spouse/Partner and/or Dependant(s) (if applicable) are unable to answer all or any of the above declaration, please state your reason(s) below, noting the declaration **number**.
*Delete where applicable

B. Declaration

I/We* declare that the answers I/we have given are, to the best of my/our knowledge, true and that I/we* have not withheld any material information that may influence the assessment or acceptance of my/our* application for medical I/We* agree that this declaration will constitute part of my/our* application and that failure to disclose any material known fact(s) by me/us may invalidate the contract.

Declared by the Proposer (and Spouse/Partner and/or Dependant(s), if applicable) on _____ (dd/mm/yyyy)

Signature of Proposer/Insured	Spouse/Partner or Dependant (age____)	Dependant (age____)	Dependant (age____)
Signature of all Dependants who are 16 years old and above required			