ATLANTIC
GENERAL

HEALTH QUESTIONNAIRE
POLICY NO. ____________________

Road User

PART 1 DETAILS OF INSURED

Full Name ____ Date of Birth (DD/MMM/YY)____________

PART 2 HEALTH QUESTIONS

The Insured and all Additional Drivers must answer the following questions carefully and correctly.

Question:		YES NO	If YES, please give details:
1.	**VISION** Do you suffer from any vision impairment or disability which is not corrected by lenses?	☐ ☐	
2.	**HEARING** Do you suffer from any hearing impairment or disability which is not corrected by use of a hearing aid?	☐ ☐	
3.	**HEART** Have you ever suffered from any heart complaint or condition (e.g. Angina/ Hypertension,etc.)?	☐ ☐	
4.	**DIABETES** Do you suffer from Diabetes?	☐ ☐	If YES, how is it managed?
5.	**EPILEPSY** Do you suffer from Epilepsy or seizures?	☐ ☐	If YES, how is it managed?
6.	**HOSPITALIZATION** Have you been an in-patient during the last 12 months?	☐ ☐	If YES, for what reason and are you now fully recovered?
7.	**OTHER AILMENTS** Do you suffer from any other physical or mental ailments, disease or infirmity?	☐ ☐	
8.	**MEDICATIONS** Are you on any prescribed medications which may affect your ability to drive?	☐ ☐	
9.	**DOCTOR** What is the name of your family physician?		

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PART 3 DATA PROTECTION DECLARATION

By signing this form, I confirm/understand that:

- In order to administer the policy and plan CG Atlantic General Insurance Ltd. may process any and all of the personal data provided.
- I consent to CG Atlantic General Insurance Ltd. processing my personal data, in accordance with CG Atlantic General Insurance Ltd.'s Privacy Policy (https://international.cgcoralisle.com/privacy-policy/). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to CG Atlantic General Insurance Ltd. in respect of any third party, is done with that third party's consent and knowledge of CG Atlantic General Insurance Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/ us and the Company.

Insured/Additional Driver Signature(s): ______________________________ Date: ________________

PART 4 PHYSICIAN'S DECLARATION

To the best of my knowledge, the patient named above does not suffer from any physical or mental disability which could make it undesirable for them to drive a Motor Vehicle.

Signature: ______________________________________ Date: ________________

Physician's Stamp required here:

CG Atlantic General Insurance Ltd. Atlantic House, 2nd Terrace & Collins Avenue, Nassau, Bahamas
PO Box N-3540, Nassau, Bahamas | Tel 242 326 7100 | Fax 242 325 0948 | www.CGCoralisle.com

Personal and Business Insurance

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