

# STATEMENT OF GOOD HEALTH

To be completed by the policyholder  
(PLEASE USE BLOCK LETTERS)



## 1. POLICYHOLDER INFORMATION

|               |      |       |      |
|---------------|------|-------|------|
| Name          | Last | First | M.I. |
| Policy number |      |       |      |

I understand that this Statement of Good Health and any other document submitted with the application shall be the basis of any coverage provided, and that no coverage shall take effect unless and until the application is approved by Bupa.

With my signature below, I hereby certify to the best of my knowledge, that since the date of the original application, NO INSURED PROPOSED FOR COVERAGE under this policy has been diagnosed, has been recommended to receive, or received treatment, or has shown symptoms of any physical or mental disorders, except as described in the application.

If the above statement is incorrect, please indicate the name of the insured(s) whose condition has changed, the diagnosis, the clinical or surgical treatment received or recommended, and the results, as well as the name, address and telephone number of the physician(s) and hospital(s) involved in said insured(s) treatment.

|                                |                                   |                                      |      |
|--------------------------------|-----------------------------------|--------------------------------------|------|
| Insured's name                 | Last                              | First                                | M.I. |
| Condition                      |                                   |                                      |      |
| Diagnosis                      |                                   |                                      |      |
|                                |                                   |                                      |      |
| Clinical or surgical treatment | <input type="checkbox"/> Received | <input type="checkbox"/> Recommended |      |
| Results                        |                                   |                                      |      |
| Name of physician              |                                   |                                      |      |
| Address                        |                                   | Telephone                            |      |
| Name of physician              |                                   |                                      |      |
| Address                        |                                   | Telephone                            |      |

## 2. SIGNATURE

|                          |      |                |
|--------------------------|------|----------------|
| Policyholder's signature | Date | MM / DD / YYYY |
|--------------------------|------|----------------|