Declaration of **Pre-Existing Conditions**

Section I. **Applicant** Information

1. Policy number:
2. Last name(s):
3. First name:
4. M.I.:
5. Date of birth: M M / D D / Y Y Y Y
6. Gender: ◯ Male ◯ Female
7. Phone number (office or cell):
8. Fax:
9. Email address:
10. Address:
11. City:
12. State:
13. Zip code:
14. Country:
15. Departure date: M M / D D / Y Y Y Y
16. Return date: M M / D D / Y Y Y Y
17. Destination(s):

Section II. **Medical** Information

1. Diagnosis:
2. Date of diagnosis: M M / D D / Y Y Y Y
3. Treatment type and scope:
4. Hospitalization or other medical treatment for the pre-existing condition or its complications within six months of the departure date:
5. Ongoing medical treatment or change in medication within six months of the departure date:
6. Anticipated check-ups or additional treatment: ◯ Yes ◯ No
7. Anticipated treatment type and scope:
8. Date of anticipated treatment: M M / D D / Y Y Y Y
9. Others:

NOTE: The applicant must pay any physician's fees that may apply when obtaining this medical information.

Section III. **Certification** and Authorization

I certify that I have read and reviewed all answers and statements in this form and that, to the best of my knowledge, the information is complete and correct. I understand that any omissions, incomplete statements, or incorrect answers may result in the delay or denial of this claim.

I hereby authorize VUMI® or VUMI® Group, its subsidiaries and affiliates to request my medical records and/or those of my dependents or travel companions, as well as any prescription drug history and any other medical or pharmaceutical information to be considered in the claim process for myself, my dependents or travel companions. I authorize any physician, hospital, laboratory, pharmacy or other medical provider, health plan, insurer, the Medical Information Bureau (MIB), or any other organization or person, including any family member who has medical records or knowledge of me or my health to disclose such information, or any other information required to process this claim, to VUMI® or VUMI® Group or its designated representatives. Likewise, I hereby authorize VUMI® or VUMI® Group and its subsidiaries and affiliates to disclose to my agent/insurance agency, affiliates, successors and the Medical Information Bureau (MIB) the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that

may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage and claims payments. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A photocopy of this authorization shall be as valid as the original.

1. Insured's full name (*or parent's/legal guardian's if the insured is a minor*):

2. Insured's signature (*or parent's/legal guardian's if the insured is a minor*): X.....

3. Date: M M / D D / Y Y Y Y

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