D) MEDICAL HISTORY (To be completed for all applicants) (Pre-existing conditions may be excluded from foreign travel emergency assistance) Please read carefully and complete all the required information by placing a tick in the correct box. If the answer to any of the questions is "YES", please provide details in the space provided below in respect of the member or dependants applicable. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of your membership or benefits.

Have you, your spouse or any of your dependants experienced or are presently experiencing any of the following?	PLEASE SPECIFY YES	NO
1. Heart (Cardiac) Diseases: Heart attack, Rheumatic fever, Congenital heart abnormalities, Angina, Embolism, High Blood Pressure.	☐	☐
2. Circulatory Disorders: Varicose veins/Thrombosis, Blood disorders (e.g. anaemia, leukemia).	☐	☐
3. Diseases of the Liver: Jaundice, Gall bladder diseases, Liver cirrhosis.	☐	☐
4. Diseases of the Airway/Lungs: Asthma, Chronic bronchitis, Tuberculosis, Emphysema, Cystic Fibrosis, Interstitial Fibrosis of any cause.	☐	☐
5. Diseases of the Digestive System: Gastric/Duodenal ulcers, Hiatus hernia, severe recurring diarrhoea.	☐	☐
6. Diseases of the Bladder/Kidney: Kidney stone, Congenital kidney disorder, Nephritis, bladder infections.	☐	☐
7. Neurological Disorders: Migraine, Stroke, Epilepsy.	☐	☐
8. Diseases of the Bone, Joints & Muscles: Rheumatic Arthritis, Gout, Back, Neck, Joint problems.	☐	☐
9. Endocrine Disorders: Diabetes mellitus, Thyroid disease (e.g; goitre).	☐	☐
10. Mental Health Disorders: Psychotic disorders (e.g; schizophrenia), Mood disorders, Anxiety disorders (e.g; Panic disorders).	☐	☐
11. Are you currently taking medication for any permanent or recurring condition? If so, please detail name, dosage & frequency?	☐	☐
12. Is there any illness or factor not mentioned on this questionnaire that might affect your health in the next 12 months?	☐	☐
13. Are you pregnant? If so what is the expected date of delivery?	☐	☐
14. Any condition not mentioned above?	☐	☐

15. **IF YOU HAVE TICKED YES FOR ANY OF THE ABOVE, PLEASE COMPLETE THE SECTION BELOW. PLEASE NOTE ALL IMPORTANT INFORMATION MUST BE DISCLOSED. THE FOLLOWING SECTION IS FOR DETAILS OF 1-14 ABOVE.**

QUEST No.	NAME	DATE	PLEASE SUPPLY FULL DETAILS OF DISORDER, DATE, DURATION OF TREATMENT AND MEDICATION (IF ANY).

If there is insufficient space above, please attach a separate sheet with additional information.

NB: IF YOU OR YOUR FAMILY SUFFER FROM ANY CHRONIC ILLNESSES, (i.e, DIABETES, ASTHMA, ETC) PLEASE COMPLETE THE CHRONIC REGISTRATION FORM IN ORDER TO RECEIVE SPECIAL CHRONIC DRUGS. SECTION 15 ABOVE MUST ALSO BE COMPLETED

E) DECLARATION BY APPLICANT - ON BEHALF OF HIMSELF AND ALL HIS DEPENDANTS (Please read carefully).

I declare that any false information in the above questionnaire, or the non disclosure of any material information will render the membership entirely null and void.

1. I understand that any condition for which I or any of my dependants have received medical advice or treatment in the previous 3 months may be excluded from benefits offered under the scheme.
2. I understand that I or any of my dependants may be required to obtain a medical report or undergo a medical examination to provide further information on any of the conditions declared above.
3. I authorise MASCA to have unrestricted access to my medical records but require their confidentiality to be maintained.
4. I have completed the medical history for myself and all my dependants declared in this application.

PRINCIPAL MEMBER'S SIGNATURE _____ DATE _____

LIAISON OR SALARIES OFFICER SIGNATURE AUTHORIZING COVER AND DATE OF COMMENCEMENT _____ DATE OF COMMENCEMENT _____