DECLARATION OF HEALTH

NAME OF INSURED PERSON: ________________________________

NAME OF PRODUCTION COMPANY:___________________________

NO PERFORMANCE DAYS: __________________________________

WILL YOU BE A CAST ☐ OR CREW ☐ MEMBER

PRODUCTION OR EVENT NAME: _____________________________

SIGNED DATE: ________________________________

DATE LAST EXAMINED BY A CERTIFIED PHYSICIAN OR DOCTOR:

____

NATIONALITY: __________________________________

AFFIDAVIT OF EXAMINED PERSON

It is mandatory that the examinee answer the following:

1) Birth Date _________/___________/__________ Age _____ Sex ______
Month Date Year

2)

		Yes	No
A.	Convulsions, paralysis or stroke, severe headaches or disease of the brain or nervous system.	☐	☐
B.	High blood pressure, heart attack, angina pectoris or any other disorder of the heart or blood vessels.	☐	☐
C.	Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system.	☐	☐
D.	Duodenal or gastric ulcer colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, or gallbladder.	☐	☐
E.	Sugar, albumin, blood, or pus in urine, kidney stones, or any other disorder of the bladder, kidney, or genito-urinary system.	☐	☐
F.	Diabetes, gout or any disease or abnormality of the thyroid or other glands.	☐	☐
G.	Any disease, disorder or injury of the bones, joints, muscles, back or spine.	☐	☐
H.	In the past five years, cold sores on lips or face?	☐	☐
I.	In the past year, any significant change in weight?	☐	☐
J.	Been treated for or had any indication of excessive use of alcohol or drugs?	☐	☐
K.	Disorder of eyes, ears, nose, or throat	☐	☐
L.	Allergies, anaemia, or other disorder of the blood	☐	☐
M.	During the past 21 days have you been exposed to any infection or contagious diseases?	☐	☐
N.	Have you consulted a doctor, been under a doctor's care, had surgical? Advice or treatment or been confined to a hospital during the past 5 years?	☐	☐
O.	Have you ever been treated for any Depression, Anxiety, Bi-Polar or? Similar conditions	☐	☐

3) FEMALES Yes No

A. Are you now pregnant? ☐ ☐

B. Have you ever had any disease of the breasts? Uterus, tubes, or ovaries? ☐ ☐

ALL PERSONS TO ANSWER QUESTIONS 4 & 5

4) When did you last receive a complete medical?

____

What were the results?

____

Name and Address of Physician?

____

5) Have you, within the past three years, been disabled because of any illness while working In any film or stage production? If you have, state full particulars, the name of the production and dates: -

____

____

____

____

For "yes" answers (2) and (3B), give diagnosis, treatment, results, dates of disability, degree of recovery, Name and Address of attending physician.

____

____

____

6) are you now or will you at any time during the period of this production be taking part in any other film or stage production or other professional engagement?
State full particulars and dates: ____

7) To the best of your knowledge and belief, are you now in good health and free from physical impairment or disease? Yes ☐ No ☐

If "No", give full details:

____

____

8) Please list all medication currently taken and reason for each: (Please submit a separate list if needed)

____

DECLARATION OF HEALTH

I declare and affirm that I am the person first named above; that the statements made hereon by me are true, correct, and complete; that I have withheld no information known to me which might alter or otherwise conflict with the statements made by me. I understand that an insurance policy may be issued based on the statements made hereon by me. If a policy is issued and a claim is paid thereunder I understand that the insurer will seek recoupment from me if it is thereafter determined that the statements I made hereon are not true, correct and otherwise complete, or that I have withheld information known to me which might alter or otherwise conflict with the statements I have made, the insurer will hold me personally liable and will seek recoupment from me for such payment. I also agree to be re-examined by the insurer's doctors in the event a claim is made.
All insured persons younger than 18 years of age must have the approval and signature from either parent or legal guardian who holds direct knowledge as to the health of the insured person.

____
Signature of Insured Person (Cast or Crew)

I authorise any physician, licensed practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, or production company having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me to provide to Centriq Insurance Company Limited, KEU Underwriting Managers or its legal representative, any and all such information.

I understand the information will be used by Centriq Insurance Company Limited, KEU Underwriting Managers, and their affiliates, agents, or brokers for underwriting and claim settlement purposes. I know that I may request a copy of this authorisation.
I agree that this authorization shall be valid for a period of two years from the date on which it was signed.

I also consent to the release of any information gathered by Centriq Insurance Company, KEU Underwriting Managers and their affiliates to any production company which may be considering me for a role.

☐ I consent to Centriq, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract. For further information please read our Privacy Notice, which can be found on www.centriq.co.za

PLEASE SIGN TO CONFIRM CONSENT

DATE: ________________________________

SIGNATURE OF INSURED PERSON:

____

NAME: ________________________________

PARENTS / GUARDIAN CONSENT IF NOMINATED PERSON IS YOUNGER THAN 18 YEARS

SIGNATURE OF LEGAL GUARDIAN OR PARENT FOR PERSON IF THEY ARE YOUNGER THAN 18 YEARS:

NAME OF LEGAL GUARDIAN / PARENT: ______________________

SIGNATURE: ______________________________________

DETAILS OF BROKER:

BROKER'S COMPANY NAME: ____

NAME OF BROKER (INDIVIDUAL): ____

E-MAIL ADDRESS: ____

TELEPHONE NUMBER: ____