GALLOWAYS
TRAVEL INSURANCE PROPOSAL FORM
IMPORTANT: PLEASE ANSWER ALL QUESTIONS IN BLOCK LETTERS OR TICK AS APPROPRIATE

PARTICULARS OF PROPOSER
Address: _____
Trip Type (Business/Holiday etc): _____
Phone: _____
Next of Kin: _____
E-mail Address: _____
Tel (For Next of Kin): _____

DETAILS OF INSURED PERSON(S)

Full Names	Passport Number	Date of Birth	Relationship with the Proposer

MEDICAL & INSURANCE HISTORY

1. Does any proposed insured suffer from physical defects or infirmities? **YES / NO**
   If Yes, please give particulars: _____
2. Is any of the proposed insured travelling for the purpose of receiving medical treatment? **YES / NO**
   If Yes, please give particulars: _____
3. Has any proposed insured been treated for or told they had diabetes, abnormal blood pressure, any disorder or disease of the heart, lung, back or spine, a mental, nervous or weight condition, cancer, kidney or liver disease, alcoholism or drug addiction, or any other disease? **YES / NO**
   If Yes, please give particulars: _____
4. Has any proposed insured had any personal accident, sickness, baggage, or travel insurance cancelled, declined, or renewal refused? **YES / NO**
   If Yes, please give particulars: _____
5. Is any proposed insured already a member of any medical/rescue insurance scheme? **YES / NO**
   If Yes, please give particulars: _____
6. Has any proposed insured ever made a claim while travelling? **YES / NO**
   If Yes, please give particulars: _____

TRAVEL INSURANCE DETAILS
REQUESTED BY: Galloways
Details of Persons Travelling

- **Full Name of Traveller (As per passport):** .....
- **Passport No.:** .....
- **Contact Address:** .....
- **Email Address:** .....
- **Telephone Number:** .....
- **Date of Birth:** .....
- **Dates of Travel (From - To):** .....
- **Destination:** .....
- **Next of Kin:** .....
- **Contact of Next of Kin:** .....

DECLARATION
I warrant that the above statements are true, and that I have not withheld or concealed anything affecting the proposed insurance. I agree that this proposal and declaration shall be the basis of the contract between me and Galloways.
I hereby consent to **Galloways** contacting my doctor or medical institution to obtain medical information about me and authorize such doctor or institution to make full disclosure of such information to **Galloways** or its advisers, and to provide access to my complete medical and hospital records in order to proceed with assessment of a claim and/or render medical assistance.
I agree also to accept the underwriter's policy applicable to the insurance.
DATE: _____
SIGNATURE: _____
Note: The liability of Galloways does not attach until the proposal has been accepted and the premium paid.

CONSENT
I ALLOW YOU TO USE THE DATA I HAVE SUPPLIED LIMITED FOR THE PURPOSE OF PROCESSING INSURANCE

☐ YES
☐ NO