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 ☐ Received ☐ Recommended			
Results			
Name of physician			
Address		Telephone	
Name of physician			
Address		Telephone	

2. SIGNATURE

Policyholder's signature		Date	MM / DD / YY

17901 Old Cutler Road, Suite 400 • Palmetto Bay, Florida 33157
Tel. +1 (305) 398 7400 • Fax +1 (305) 275 8484 • www.bupasalud.com/MyBupa