

PRIVATE & CONFIDENTIAL - DECLARATION OF HEALTH

Section 1 – Cast Insurance

INSURED PERSON :

AGE NEXT BIRTHDAY :

PRODUCTION COMPANY :

TITLE OF PRODUCTION :

I hereby certify that to the best of my knowledge, I am fit and well and capable of fulfilling the role I am contracted for in this production and have not received treatment or been advised to seek treatment for any recurring illness or disorder in the last 45 days.

In addition;

I authorise any medical practitioner, hospital, clinic, laboratory or medical facility or health care provider, insurance or reinsurance company having information regarding diagnosis, treatment and prognosis of any medical or mental condition, to permit Chubb Group of Insurance Companies or its duly authorised representative to review and copy all medical reports, X-rays, charts, records and other data which may pertain in any manner to my medical history, physical or mental condition, care and/or treatment. I understand that the medical information obtained will be used by the Chubb Group of Insurance Companies for underwriting and claim settlement purposes. I agree that this authorisation for release of medical information shall be valid until a Cast claim relating to the examinee has been settled and closed with the Insured Production Company. A copy of this form shall be considered as valid as the original and I understand that I may obtain a copy of this authorisation if I so request it.

SIGNATURE:

DATE:

Data Protection Notice

We use personal information which you supply to us or, where applicable, to your insurance broker for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: <https://www2.chubb.com/uk-en/footer/privacy-policy.aspx>. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at [dataprotectionoffice.europe@chubb.com](mailto:dataprotectionoffice.europe@chubb.com).