Newborn Additions

Policyholder:	Policy Number:

Lastname:			
Firstname:	Middle Name:		
Date of Birth (dd/mm/yyyy):	Gender (M/F):	Height (cm):	Weight (kg):
Date of Discharge from Hospital (dd/mm/yyyy):			

Newborn Details

1. Was your new born discharged from hospital in a healthy state and does not suffer from any birth defects or congenital condition(s)?
   ☐ Yes ☐ No (please explain)

   _____

2. Is your new born under treatment for any illness, injury, or medical condition?
   ☐ No ☐ Yes (please explain)

   _____

3. Have you been advised to have your new born undergo any test, treatment, procedure, or hospitalisation?
   ☐ No ☐ Yes (please explain)

   _____

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true.

_____ _____

Signature of the Insured / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date

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