Trinidad and Tobago Insurance Limited
TATIL Building, 11A Maraval Road,
Port of Spain, Trinidad and Tobago, W.I.
Tel.: (868) 62TATIL(628-2845)
Web: www.tatil.co.tt
E-mail: info@tatil.co.tt

Tatil
... where people are people

ACCIDENT & HEALTH DEPARTMENT
INFANT QUESTIONNAIRE - HEALTH INSURANCE APPLICATION FORM

This form is to be completed for
all new dependents 0-4 years of age
by parent/legal guardian

1. a) **Name of Employer/Policyholder:** .....
   b) **Full Name of Primary Insured:** .....
   c) **Full Name of Infant:** ..... **Date** (DD/MM/YY): .....
   d) **Weight at Birth:** ..... lbs. ..... oz. **Height:** ..... cm.
   e) **Current Weight:** ..... lbs. ..... oz. **Height:** ..... cm.
   f) **Name of Pediatrician:** .....
   g) **Pediatrician Contact Number:** .....
   h) **Pediatrician Email Address:** .....

SECTION A - PREGNANCY HISTORY

Was any of the following experienced during pregnancy:

1. **Gestational Diabetes** ☐ Yes ☐ No
2. **Pre-Eclampsia** ☐ Yes ☐ No
3. **Placenta Abruption** ☐ Yes ☐ No
4. **Prescription Medication** ☐ Yes ☐ No
6. **Any other complications not previously listed** ☐ Yes ☐ No

If **"Yes"**, to any of the above, please give details: .....

.....

.....

.....

.....

SECTION B - BIRTHING HISTORY

Was any of the following experienced during delivery/birth:

1. **Complications during delivery or at birth** ☐ Yes ☐ No
2. **Mother underwent an Emergency Caesarean Section** ☐ Yes ☐ No
3. **Foetal Distress during labour** ☐ Yes ☐ No
4. **Pre-mature Birth** ☐ Yes ☐ No
5. **Abnormal Foetal Position or Breech** ☐ Yes ☐ No
6. **Child has symptoms or disease** ☐ Yes ☐ No

If **"Yes"**, to any of the above, please give details: .....

.....

.....

SECTION C - INFANT HEALTH HISTORY

Has the infant been treated or diagnosed with any of the following:

1. **Earaches/Ear Infection** ☐ Yes ☐ No
2. **Seizures/Epilepsy** ☐ Yes ☐ No
3. **Mental/Physical Abnormality** ☐ Yes ☐ No
4. **Blood Diseases i.e. Sickle Cell, Anaemia, Thalassemia etc.** ☐ Yes ☐ No
5. **Asthma/Bronchitis or any other disease of the lungs or respiratory system** ☐ Yes ☐ No
6. **Any disorders of the heart or circulatory system** ☐ Yes ☐ No
7. **Jaundice** ☐ Yes ☐ No

If **"Yes"**, to any of the above, please give details: .....

.....

.....

SECTION D - INFANT MEDICAL HISTORY

1. **Is the child being prescribed any medication?** ☐ Yes ☐ No
2. **Has the child undergone or will undergo any surgical procedures?** ☐ Yes ☐ No
3. **Has the child ever needed any Emergency Services?** ☐ Yes ☐ No
4. **Is the child affected by any known allergies?** ☐ Yes ☐ No
5. **Have all the normal milestones been met?** ☐ Yes ☐ No
6. **Had regular check-ups?** ☐ Yes ☐ No
7. **Received all vaccinations required for the child's age?** ☐ Yes ☐ No

If **"Yes"**, to any of the above, please give details: .....

.....

.....

DECLARATION AND AUTHORISATION

I hereby certify that to the best of my knowledge the foregoing answers are true and correct and that I have not withheld any material information or suppressed any material fact.

I hereby authorise any physician, dentist or other practitioner, hospital, clinic, insurance company or any organisation, institution(s) or person(s) that has any records or knowledge of me, my spouse or my children, to give to Trinidad and Tobago Insurance Limited any and all information about me, my spouse or my children regarding conditions for which we have been previously under observation or treatment, including findings, pathology, diagnosis, and advise.

I understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, whether I am aware of a diagnosis or not, are considered pre-existing conditions and are not covered by this Policy unless fully disclosed on this application. I understand that failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I understand and agree that Trinidad and Tobago Insurance Limited shall not be liable to refund any premiums submitted should the coverage be rescinded as a result of non-disclosure of information.

I understand that completion and submission of this application does not represent automatic enrolment nor guarantee eligibility for coverage under this Policy. I further agree that coverage shall not become effective until approved by Trinidad and Tobago Insurance Limited.

Signature: ..... **Date** (DD/MM/YY): .....

Name of Parent: ..... **Signature of Parent:** .....

Date (DD/MM/YY): .....