Transamerica Life (Bermuda) Ltd.
(Incorporated in Bermuda with limited liability)

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DECLARATION OF CONTINUED GOOD HEALTH APPLICATION AMENDMENT

IMPORTANT INFORMATION

Please complete in ENGLISH and BLOCK CAPITALS.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

Capitalised terms in this form have the same meaning as defined in the Policy.

If the proposed Policy Owner wishes to amend an Application for a Policy, the proposed Insured must declare that he/she is of continued good health by completing this form.

Proposed Insured	Given Name(s)	Surname	
Date of Birth	(dd/mm/yyyy)		
Proposed Policy Owner (if different from Proposed Insured)	Given Name(s)	Surname	
Producer Name		Producer ID Number	

The Application for Policy Number _____ is amended as follows:

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I, the proposed Insured, declare that on the date of this form and at all times since the date of the Application Form:

1. there has not been any change in my health;
2. I have not received any medical attention, consultation or examination in relation to any injury, illness or medical condition;
3. I have not suffered from any injury, illness or medical condition for which I have not sought medical attention; and
4. I am not waiting for any scheduled medical consultation or examination in relation to any injury, illness or medical condition.

I understand and acknowledge that this form shall be part of the Application for the Policy.

Note: Failure to disclose all material facts may lead to cancellation of the insurance cover and/or non-acceptance of future claims. A material fact is one which is likely to influence the assessment or acceptance of this Application. If you are in any doubt whether a fact is material, it should be disclosed.

I confirm that the above declaration is true and correct.

Signatures

Signature of the **Proposed Insured**				Signature of the **Proposed Policy Owner** (if different from Proposed Insured)			
X				X			
Date	(dd/mm/yyyy)	Place	(Country)	Date	(dd/mm/yyyy)	Place	(Country)

I, the undersigned, hereby consent to the collection and use of my personal data by Transamerica Life Bermuda for the purpose of verifying and confirming the identity(ies) of the signatory(ies) of this form.

Signature of the **Witness** to the Proposed Insured				Signature of the **Witness** to Proposed Policy Owner			
X				X			
Name				Name			
Phone Number	Country Code – Area Code – Phone Number			Phone Number	Country Code – Area Code – Phone Number		
Mobile	Country Code – Area Code – Phone Number			Mobile	Country Code – Area Code – Phone Number		
Date	(dd/mm/yyyy)	Place	(City, Country)	Date	(dd/mm/yyyy)	Place	(City, Country)

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