

Please complete in **BLOCK CAPITALS**. Kindly complete this form and submit to your Health International Agent / Regional Office, thank you. Should you have any queries or require any further information contact us on +263 (0) 86 7700 8964.

Full Name:

Date of Birth:

DD / MM / YYYY

Please indicate and answer questions where applicable:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Motocross | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Enduro / Bush or Off-Road Motorbiking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. BMX | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Karting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Farm Riding (for work or recreation) - No Loading however, helmet must be worn | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

6. Other:

Yes No

*** 25% loading is applicable to any / all of the above mentioned on a non accumulative basis.**

Confirm that all relevant safety equipment and precautions are utilised whilst you are participating in the activity indicated (helmet; heavy duty jacket & pants; body protectors, boots; gloves; eye protection etc.)

Yes No

Frequency of participation (per year): _____

Tracks, Areas and Types of Terrain: _____

Number of Years Experience: _____

Any other Health Insurance or Medical Aid Membership: _____

Applicant Signature _____

Date (DD / MM / YY) _____