GOLDEN CARE®

Your Health
Partner
Around
The World

MEDICAL DECLARATION

This document is complementary to the medical questionnaire of your application form.
Its contents shall be treated confidentially by our Medical Advisor.

Proposal N° :		**Name :**		**First Name :**		**Birth Date :**	

Question n°	Date of the Event	Diagnosis	Nature of treatment followed	Current Condition	Future Treatments

Signature: _____ Place: _____ Date :_____/_____/_____