EXPAT & Co

International mobility insurances

€uropat Local Plus

Lange Haagstraat 72
1700 Dilbeek
Belgium
+ 32 (0)2 463 04 04

Medical Questionnaire Medical Care (fill in all the fields)

Please tick box ☒ that is applicable. If 'yes' is ticked always give an explanation. If you need more space use the back side or an annex and write your name and ref. N° on the annex as well. All questions must be answered.

Reference ____________________ Addition to Policy number ____________________

1. Name and first name ____________________

   Date of birth (dd/mm/yyyy) ____________________ Gender ☐ M ☐ F

   Length (in cm) ____________________ Weight (in kg) ____________________

2. Have you received treatment during the last five years from:
   - a specialist ☐ No ☐ Yes
   - a physiotherapist ☐ No ☐ Yes
   - an alternative healer ☐ No ☐ Yes

   What for ? ____________________

   When? (mm-yyyy) ____________________

   Are there still complaints or is treatment still being received at the moment? ☐ No ☐ Yes

3. Have you undergone one of following tests during the last five years:
   - RX ☐ No ☐ Yes - Echo ☐ No ☐ Yes
   - CT-scan ☐ No ☐ Yes - MR scan ☐ No ☐ Yes
   - Arteriography ☐ No ☐ Yes - Doppler test ☐ No ☐ Yes

   What for ? ____________________

   When? (mm-yyyy) ____________________

4. Were you ever admitted to a hospital, rehabilitation centre, psychiatric or other nursing institution? ☐ No ☐ Yes

   What for ? ____________________

   When? (yyyy) ____________________ Period: ____________________

5. Is it expected that you will undergo medical treatment in the near future? ☐ No ☐ Yes

   What for ? ____________________

   When? (yyyy) ____________________

6. Are medicines being used? ☐ No ☐ Yes, which medicine? ____________________

   What for ? ____________________

   Daily dosage? ____________________

Ref. ______________________

7. Are you suffering or have you suffered from any of the following illnesses or disorders?
   Please tick the appropriate box ☒ and <u>underline the illness/condition</u> referred to:

- disease of the heart ☐ No ☐ Yes ____________________
- constrictions of the chest or palpitations ☐ No ☐ Yes ____________________
- shortness of breath or raised blood pressure ☐ No ☐ Yes ____________________
- asthma, bronchitis, tuberculosis, prolonged coughing or other lung affection ☐ No ☐ Yes ____________________
- diseases of stomach, liver or gall-bladder ☐ No ☐ Yes ____________________
- diseases of kidneys, urinary passages or genitals ☐ No ☐ Yes ____________________
- rheumatism, hernia, muscle, joint or bone diseases ☐ No ☐ Yes ____________________
- strain, psychological disorder, problems of nervous system, stress condition, fainting or vertigo ☐ No ☐ Yes ____________________
- diabetes, thyroid gland, varicose veins or open leg ☐ No ☐ Yes ____________________
- diseases of ears, eyes or skin ☐ No ☐ Yes ____________________
- back problems ☐ No ☐ Yes ____________________
- any other illness, disease or defect not mentioned above ☐ No ☐ Yes ____________________

8. Have either of your parents or any of your brothers or sisters, living or deceased, suffered (before the age of 65) from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholesterol, nervous or brain disorders such as Alzheimer's,Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder? ____________________

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9. Has your blood been examined for blood or kidney diseases, diabetes, fat content (cholesterol), hepatitis, sexually transmittable diseases such as syphilis or AIDS? ☐ No ☐ Yes

   What for ? ____________________

   When? (yyyy) ____________________

   Result? ____________________

10. Do you wear glasses/lenses? ☐ No ☐ Yes Dioptre L __________ R __________

    Do you wear a hearing aid ☐ No ☐ Yes Loss (dB) L __________ R __________

    Do you have dentures, crowns, braces, ... ☐ No ☐ Yes Describe ____________________

    When was your last dentist visit? ____________________

11. Did you practise sports in the past? ☐ No ☐ Yes Which sport, on what level? ____________________

    Do you still practise sports? ☐ No ☐ Yes Which sport, on what level? ____________________

12. Have you consumed any form of tobacco? ☐ No ☐ Yes Type: __________ Weekly consumption: __________

    How many units of alcohol you drink per week? (1 unit= 1 short, 25cl beer, or 1 glass of wine) ____________________

Ref. ______________________

Additional questions for female applicants:

Are you pregnant? ☐ No ☐ Yes

Presumable date of childbirth (dd-mm-yy) ______________________

How is the pregnancy proceeding? ______________________

Have complications ever occurred in the past during pregnancy or childbirth? ☐ No ☐ Yes, which and when? ______________________

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13. Has a company ever refused to give you insurance cover, terminated or imposed special conditions on it?

☐ No ☐ Yes, company ______________________

at (dd-mm-yy) ______________________

What was the reason? ______________________

14. Who is your family doctor? ______________________

Address: ______________________

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Tel ______________________

Email ______________________

I declare that I have answered all the questions truthfully and to the best of my knowledge. If this form has been completed on my behalf, I agree that I have satisfied myself as to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the underwriter shall be entitled to retain all premiums paid prior to the insurance year by virtue of a breach of this declaration.

I am also aware that I have a legal obligation to notify the insurer of any fact material to this insurance, which appears between the date of this declaration and the beginning of the policy.

As of now, I authorize my general practitioner (family doctor) to transmit at the doctor of the underwriter the certificate mentioned the cause of my death.

Signed, at ______________________, on ______________________

The insured person, with signature preceded by "**read and approved**"

Data protection:
The personal data submitted to the underwriter are intended only for the following purposes: evaluation of the insured risks, management of the commercial relationship, of the insurance contract and the claims covered by it, control of the portfolio and to prevent fraud or abuse.

Only for these purposes this information can be transferred to a reinsurer, expert or counsel. This information is only accessible to the underwriting and claims management services as part of their duties. All information will be handled with the greatest discretion.

All involved persons have the right to look into their own particulars and have them corrected, if necessary.