EXPAT & CO
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Medical Questionnaire - Medical Care

Please tick the box ⊗ that is applicable. **If 'yes' is ticked always give an explanation attach medical report. No explanation/report can lead to general exclusion.** If you need more space, use the back of the paper or an annex and write your name and reference number on the annex as well. All questions must be answered.

Quote or Policy Number ....

1. Name .... First Name ....
   Date of Birth (dd/mm/yyyy) .... Gender ○ M ○ F
   Height (in cm) .... Weight (in kg) ....
   Private e-mail address* .... Private telnr* ....
   where we can reach you with any medical questions

2. Have you received treatment during the last five years from:
   - a specialist ○ NO ○ YES
   - a physiotherapist ○ NO ○ YES
   - an alternative healer ○ NO ○ YES

   If yes, what for? ....
   When? (mm/yyyy) .... *please add medical reportt*
   Do you still have complaints or is treatment still being received at the moment? ○ NO ○ YES

3. Have you undergone one of the following tests during the last five years?
   - RX ○ NO ○ YES
   - CT -scan ○ NO ○ YES
   - Arteriography ○ NO ○ YES

   If yes, what for? ....
   When? (mm/yyyy) .... *please add medical report*

4. Were you ever admitted to a hospital, rehabilitation centre, psychiatric or other nursing institution?
   ○ NO ○ YES I If yes, what for? ....
   When? (mm/yyyy) .... *please add medical report*

5. Is it expected that you will need medical treatment in the near future? ○ NO ○ YES
   If yes, what for? ....
   When? (mm/yyyy) .... *please add medical report*

6. Are you using medicines? ○ NO ○ YES, which medicine? ....
   If yes, what for? ....
   Daily dosage? ....

7. Are you suffering from or have you suffered from any of the following illnesses or disorders?
Please tick the appropriate box ⊗ and underline the illness/condition referred to. If possible add report:

- 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 the 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. 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
If yes, what for? .... When? (yyyy) ....
Please add last result ....

9. Do you wear glasses/lenses? ◯ NO ◯ YES Dioptre L ...... R ......
Do you wear a hearing aid? ◯ NO ◯ YES Loss L ...... R ......
Are you expected or advised to undergo dental treatment in the near future? ◯ NO ◯ YES
What for? ◯ orthodontics ◯ parodontics ◯ dentures, crowns, braces
How many natural teeth are you missing (excluding milk teeth and wisdom teeth)? ....
How many of the missing natural teeth are replaced by dentures, implants, braces,... ....
Please describe: ....
When was your last routine dentist visit? (mm/yyyy) ....

10. 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? ....

11. Have you consumed any form of tobacco? ◯ NO ◯ YES
Type .... Weekly consumption ....
How many units of alcohol do you drink per week? (1 unit = 1 short, 25cl beer or 1 glass of wine)
....

12. Additional questions for female applicants

Are you pregnant? .... ◯ NO ◯ YES Due Date ....

How is the pregnancy proceeding? ....

Have complications occurred in the past during pregnancy or childbirth?

◯ NO ◯ YES, which and when? ....

....

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

◯ NO ◯ YES, company .... date (dd/mm/yyyy) ....

What was the reason? ....

14. Who is your family doctor?

Address ....

....

Tel .... Email ....

DECLARATION TRUTHFULNESS

◯ **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 authorise** my general practitioner (family doctor) to transmit at the doctor of the underwriter the certificate mentioning the cause of my death.

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DECLARATION DATA PROTECTION (GDPR)

The personal data submitted to the underwriter are intended only for the following purposes: evaluation of the insured risks, management of the insurance contract and the claims covered by it, control of the portfolio and to prevent fraud or abuse. Only for these purposes can this information be transferred to a(n) (re)insurer, 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 glance into their particulars, to have them corrected if necessary, to have their personal information erased within the scope of valid legislation, to transfer their personal data and to object to the processing of their personal data. (learn more: www.expatinsurance.eu/en/privacy-cookies-and-gdpr)

◯ **I freely admit to having read the GDPR-Disclaimer** (www.expatinsurance.eu/en/privacy-cookies-and-gdpr) on the website, and hereby consent to the processing of the given personal data according to the policy conditions.

Signed, at .... on (dd/mm/yyyy) ....

City (in Europe) ....

the insured person, with signature preceded by the handwritten text 'read and approved'
(please do not forget to tick all 3 boxes: if one of the boxes is not ticked, the questionnaire will not be handled)

Signature

! Please send this completed medical questionnaire to:

- our secured and confidential mailbox medic@expatinsurance.eu.
- or per confidential postal mail at the attention of the Medical Advisor on the address you find below. (always mention your quote or policy number as a reference).