Your International Healthcare Partner

International Private Health Insurance

MEDICAL QUESTIONNAIRE

The answers to this questionnaire must be handwritten by each person to be insured or his/her legal representative, who must be aware of all the questions and answer them.

Tick YES or NO. For each answer to which you tick YES, provide all relevant details on page 3, specifying the number of the question, the date of the event or result, the date of cure or consolidation, the type of treatment or hospitalization, the duration of the illness or treatment, any after-effects and any relevant justifying documents.

Information

First Name:…… Family Name:……

Gender: ☐ F ☐ M Date of Birth: ……

Questions

1	What are your height, weight, usual blood pressure?	height.....cm weight..... kg blood pressure: ...../.....
2	In the course of the 10 past years, have you been diagnosed with cardiovascular disease, digestive system, respiratory system, nervous system, genitourinary tract, endocrine or metabolic disease, psychiatric illness, bone and joint disease or tumor? Please specify on page 3: illness, date of diagnosis, treatment, evolution and consequences.	☐ Yes ☐ No
3	In the course of the 5 past years, have you followed or are you currently undergoing treatment for more than 2 weeks? Please specify what treatment on page 3.	☐ Yes ☐ No
4	In the course of the 5 past years, have you been prescribed one or more sick leaves lasting for more than three consecutive weeks or been prescribed medical treatment that lasted for at least three consecutive weeks? Please specify on page 3 the date, duration of the sick leave and the reason.	☐ Yes ☐ No
5	In the course of the 5 past years, have you been hospitalized for more than a week or should you be hospitalized soon? Please specify on page 3 the date, duration of the hospitalization and the reason.	☐ Yes ☐ No
6	Do you have any consequences as a result of an illness or accident?	☐ Yes ☐ No

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7	Have you been screened for serology, particularly for the hepatitis B and C viruses or for the human immunodeficiency virus (HIV), which has been positive? If yes, please specify on page 3.	☐ Yes ☐ No
8	Do you drink alcoholic beverages daily? Please specify on page 3 the quantity in alcohol unit (a unit corresponding to a glass of wine (10 cl), a glass of beer (25 cl) or a dose of strong alcohol.	☐ Yes ☐ No
9	Do you smoke more than 10 cigarettes a day? If yes, please specify on page 3 for how long do you smoke	☐ Yes ☐ No
10	Have you been denied or accepted under special conditions for previous healthcare private insurance ?	☐ Yes ☐ No
11	Do you, as pilot or passenger, use aircraft (off regular commercial lines)?	☐ Yes ☐ No

For all positive answers on the above section, we kindly ask you to specify below all additional data (according to the number of the question, the date of the event or result, the date of cure or consolidation, the type of treatment or hospitalization, the duration of the illness or treatment, any after-effects and any relevant justifying documents, etc)

Question 1 :
Question 2 :
Question 3 :
Question 4 :
Question 5 :
Question 6 :
Question 7 :
Question 8 :

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Question 9 :
Question 10 :
Question 11 :

Declaration and signature

The Insured, on his/her own behalf and on behalf of his/her dependants if relevant, hereby certifies that the answers are honest and true and declares that nothing has been concealed that may mislead the Insurer or distort the decision that it must make concerning the proposed insurance. Any false declaration or omission will entail the invalidity of this policy.

Signature .....

Date.....

This questionnaire is valid for three (3) months from the date of the signature of the person to be insured.

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