médis

Holder's Médis Number: ☐☐☐☐☐☐☐☐☐ ☐☐ **Date of Birth:** ☐☐ ☐☐ ☐☐☐☐ **Sex:** F ☐ M ☐

Full name of Insured Person: _____

Individual Medical Questionnaire

Address: _____

Postcode: _____ City: _____

IBAN: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ Taxpayer No: ☐☐☐☐☐☐☐☐☐

Insurance Policy Holder (For Company/Group, fill in the respective name):: _____

Insurance Holder: _____

Policy No: _____ Employee No: _____ Date of Inclusion: ☐☐☐☐☐☐☐☐

Degree of Kinship: Holder ☐ Spouse ☐ Descendant ☐ Ascendant ☐ Other ☐

Document filling is mandatory

VERY IMPORTANT: Make sure all questions are answered with YES or NO, by putting a cross in the corresponding box. Whenever YES is answered, describe the situation in as much detail as possible. Incompletely filled forms will not be accepted; this will lead to a request for further information, which may considerably delay analysis and final decision by the Médis Medical Board. The present questionnaire is an integral part of the Insurance Proposal. Under the terms of article 429 of the Commercial Code, "any inexact declarations, as well as withholding of facts or circumstances known to the Insured or person taking out the insurance policy, which might have influenced the contract or its conditions, will render the insurance contract null and void. If the party making the declarations in question has done so in bad faith, the Insurer will be entitled to the premium". Inexact declarations, withheld information or omission of facts will render the subscription request null and void; during the contract period, such situations will release the Insurer from any obligation to pay compensation.

Biometric indicators and habits

Height (m, cm) ☐☐☐ Weight (Kg) Blood Pressure ☐☐☐ max ☐☐ min

Do you drink alcohol? Yes ☐ No ☐ If yes, indicate daily consumption? _____ What do you drink? _____

Do you smoke? Yes ☐ No ☐ If yes, indicate the number of cigarettes per day? _____ How long have you smoked (years)? ___

Personal Background – Do you have or have you ever been diagnosed with any of the following diseases?

A - Cardiovascular Diseases? Yes ○ No ○ **If Yes, which:**

- ☐ Cardiac Insufficiency (1)
- ☐ Infarction or Angina Pectoris (1)
- ☐ Arrhythmias or Blocks / Pacemaker
- ☐ Pericarditis (1)
- ☐ Valve Diseases (1)
- ☐ Myocardiopathy (1)
- ☐ Thrombophllebitis (1)
- ☐ Endocarditis (1)
- ☐ Varicose Veins
- ☐ Hypertension
- ☐ Other _____

B - Respiratory Diseases? Yes ○ No ○ **If Yes, which:**

- ☐ Respiratory Insufficiency (1)
- ☐ Respiratory Allergic Diseases
- ☐ Asthma (1)
- ☐ Chronic Bronchitis (1)
- ☐ Emphysema (1)
- ☐ Pulmonary Tuberculosis (1)
- ☐ Bronchiectasis (1)
- ☐ Pulmonary Fibrosis (1)
- ☐ Pleurisy (1)
- ☐ Pneumothorax (1)
- ☐ Other _____

C - Digestive Tract Diseases? Yes ○ No ○ **If Yes, which:**

- ☐ Oesophageal Diseases (1)
- ☐ Hiatus Hernia
- ☐ Chronic Gastritis
- ☐ Gastro Duodenal Ulcer
- ☐ Diverticulosis
- ☐ Intestinal Polyps (1)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Haemorrhoids (1)
- ☐ Inguinal Hernia
- ☐ Digestive Haemorrhage (1)
- ☐ Other _____

D - Diseases of Liver, Bile Ducts and Pancreas Yes ○ No ○ **Se sim, indique qual:**

- ☐ Chronic Liver Disease or Cirhosis (1)
- ☐ Hepatitis B, C, D or E (1)
- ☐ Pancreatitis (1)
- ☐ Gallstones
- ☐ Other _____

E -Genitourinary Diseases? Yes ○ No ○ **If Yes, which:**

- ☐ Renal Insufficiency (1)
- ☐ Haemodialysis
- ☐ Renal Transplantl
- ☐ Chronic Nephritis (1)
- ☐ Kidney Stones
- ☐ Urinary Tract Diseases (1)
- ☐ Prostate Disease (1)
- ☐ Male Infertility
- ☐ Other _____

Personal Background – Do you have or have you ever been diagnosed with any of the following diseases? (cont)

F - Bone, Musculoskeletal and Connective Tissue Diseases? Yes ○ No ○ If Yes, which:

- ☐ Polymyositis (Dermatomyositis) (1)
- ☐ Ankylosing Spondylitis (1)
- ☐ Systemic Sclerosis (Dermatosclerosis)(1)
- ☐ Systemic Lupus Erythematosus (1)
- ☐ Spondylosis
- ☐ Disk Herniation
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Kyphosis
- ☐ Painful Shoulder (1)
- ☐ Low Back Pain
- ☐ Osteoporosis
- ☐ Sciatica
- ☐ Rheumatoid Arthritis(1)
- ☐ Fractures (2)
- ☐ Other _____

G - Skin Diseases? Yes ○ No ○ If Yes, which:

- ☐ Contact Dermatitis
- ☐ Atopic Dermatitis
- ☐ Stasis Dermatitis / leg Varicose Ulcer
- ☐ Seborrhoeal Eczema
- ☐ Fungal Infection of the Skin
- ☐ Psoriasis
- ☐ Acne
- ☐ Urticaria / Angioedema
- ☐ Others _____

H - Nervous System Diseases? Yes ○ No ○ If Yes, which:

- ☐ Depression
- ☐ Parkinson's Disease (1)
- ☐ Thrombosis / Cerebrovascular Accident
- ☐ Multiple Sclerosis (1)
- ☐ Epilepsy (1)
- ☐ Dementia (1)
- ☐ Schizophrenia (1)
- ☐ Bipolar Disorder (1)
- ☐ Cranial or Spinal Cord Trauma (3)
- ☐ Other _____

I - Blood Diseases? Yes ○ No ○

- ☐ Anaemia(1)
- ☐ Lymphoma (Hodgkin's / Non-Hodgkin's)(1)
- ☐ Leukaemia (Acute / Chronic)(1)
- ☐ Myelodysplasia (1)
- ☐ Multiple Myeloma (1)
- ☐ Purpura (1)
- ☐ Haemophilia (1)
- ☐ Other _____

J - Endocrine Diseases? Yes ○ No ○ If Yes, which:

- ☐ Thyroid Disease (1)
- ☐ Adrenal Disease (1)
- ☐ Hypophyseal Tumour (1)
- ☐ Diabetes Mellitus Type 1 (1)
- ☐ Diabetes Mellitus Type 2
- ☐ ANervous Anorexia (1)
- ☐ Other _____

K - Metabolic Disorders? Yes ○ No ○ If Yes, which

- ☐ Increased Uric Acid (Gout)
- ☐ Increased Triglycerides
- ☐ Increased Cholesterol
- ☐ Other _____

L - Eye Diseases? Yes ○ No ○ If Yes, which:

- ☐ Impaired Visual Acuity / Use of Graduated Spectacles or Contact Lenses (Myopia, Astigmatism, Hyperopia) (1)
- ☐ Strabismus
- ☐ Cataract
- ☐ Retinal Diseases
- ☐ Glaucoma
- ☐ Other _____

M - Ear, Nose and Throat Diseases? Yes ○ No ○ If Yes, which:

- ☐ Recurring Tonsillitis and Adenoiditis
- ☐ Dizziness
- ☐ Sinusitis
- ☐ Nasal Septum Deviation
- ☐ Recurring Tonsillitis and Adenoiditis
- ☐ Impaired Hearing / Use of Hearing Aids
- ☐ Others _____

N - Gynaecological Disorders? Yes ○ No ○ If Yes, which:

- ☐ Benign Breast Nodes
- ☐ Adnexal Tumour (Benign) (1)
- ☐ Uterine Tumour (Benign) (1)
- ☐ Uterine Prolapse
- ☐ Endometriosis
- ☐ Female Infertility
- ☐ Others _____

O - Infectious Diseases? Yes ○ No ○ If Yes, which:

- ☐ HIV or AIDS Carrier (1)
- ☐ TTuberculosis of the Lymphatic Glands, Kidney or another Organ (1)
- ☐ Syphilis
- ☐ Others _____

P - Neoplasias? Yes ○ No ○ If Yes, which

- ☐ Lung (1)
- ☐ Uterus (1)
- ☐ Thyroid
- ☐ Stomach (1)
- ☐ Colon (1)
- ☐ Prostate(1)
- ☐ Kidney (1)
- ☐ Breast (1)
- ☐ Skin (1)
- ☐ Other _____

Q - Congenital Diseases? Yes ○ No ○ If Yes, which

- ☐ Cardiac
- ☐ Neurological
- ☐ Renal
- ☐ Other _____
- ☐ Pulmonary
- ☐ Digestive

If you have marked any disease up to this point, please indicate _____

Clarifications / Further information

1. In points "A, B, C, D, E, F, H, I, J, N, O and P", for diseases marked with (1), please indicate:

Year of appearance: _____ Duration: _____ Examinations performed and treatment: _____

Describe the situation: _____

2. If you have marked the option "Fractures", in point "F", please indicate :

Location of the fracture _____ Treatment: _____

Sequels: _____

3. If you have marked the option "Cranial or Spinal Cord Trauma", in point "H", please indicate:

If you have neurological sequels: _____

If you have marked "Other", please indicate: Which: _____ Year of appearance: _____ Duration: _____

Examinations performed and treatment: _____

Describe the situation: _____

Family Background

Have any of your Parents or Siblings already died? ☐ Yes ☐ No

If Yes, which: ☐ Father ☐ Mother ☐ Sibling Age(s) _____

Specify the cause(s): _____

Does anyone in your Family suffer from a Serious and/or Chronic Disease? ☐ Yes ☐ No

If Yes, which: _____

DECLARATIONS, DATE AND SIGNATURES

Authorisation to collect personal data :

I authorise the Insurance Company to collect personal data relative to my state of health from medical doctors or other health professionals and from public or private entities such as hospitals, clinics, health centres and forensic medicine institutes, including after my death, with a view to confirming or to complement the information provided on or after subscription of the insurance contract, for the purposes of assessing the insurance subscription risk or management of the subsequent contractual relationship, namely for the purpose of determining the origin, cause and evolution of any disease and I understand that this authorisation is essential for the conclusion and operation of this insurance contract.

Authorisation to process personal data:

I authorise the Insurance Company to process the personal data provided, as well as the information collected from other entities, with a view to managing the contractual relationship, without prejudice to the right to consult, amend or delete said data by written communication addressed to the Insurance Company responsible for their processing.

I authorise the medical doctors and other health care providers I may use, within the scope of the insurance contract, to provide to the clinical services of the Insurance Company and to receive from them any information related to the services provided and covered by professional secrecy, as well as its processing.

I authorise the recording of telephone conversations undertaken within the scope of the insurance contract, for the purposes of management of the contractual relationship.

I also authorise the information relative to the benefit statement, containing information relative to the health care provider, date on which the medical act was performed and the value of the expenses incurred, to be provided to the Policy Holder.

_____, ___/___/___ _____

Location and Date — The Insured Person