médis

Holder's Médis Number:

☐☐☐☐☐☐☐☐☐ ☐☐

Full name of insured Person: _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

Sex: F ☐ M ☐

Individual Medical Questionnaire

Address: _____

Postcode: _____ City: _____

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

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

Insurance Holder: _____

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

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

Document filing 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 know 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.

Biometrics 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 ever been diagnosed with any of the following diseases?

A - Cardiovascular Diseases? Yes ● No ● If Yes, which

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

B – Respiratory Diseases ? Yes ● No ● If Yes, which

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

C – Digestive Tract Diseases? Yes ● No ● If Yes, which

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

D –Diseases of Liver, Bile Ducts and Pancreas? Yes ● No ● If Yes, which

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

E –Genitourinary Diseases? Yes ● No ● If Yes, which

- ☐ Renal insufficiency(1)
- ☐ Chronic Nephritis(1)
- ☐ Prostate Disease(1)
- ☐ Hemodialysis
- ☐ Kidney Stones
- ☐ Male infertility
- ☐ Renal Transplant
- ☐ Urinary Tract Disease(1)
- ☐ 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) ☐ Spondylosis ☐ Kyphosis ☐ Sciatica

☐ Anakylosing Spondylitis(1) ☐ Disk Herniation ☐ Painful Shoulder(1) ☐ Rheumatoid Arthritis(1)

☐ Systemic Sclerosis (Dermatosclerosis)(1) ☐ Scoliosis ☐ Low Back Pain ☐ Fractures(2)

☐ Systemic Lupus Erythematosus(1) ☐ Arthritis ☐ Osteoporosis ☐ Other _____

G – Skin Diseases ?	Yes ●	No ●	If Yes, which

☐ Contact Dermatitis ☐ Seborrhoeal Eczema ☐ Acne

☐ Atopic Dermatitis ☐ Fungal Infection of the Skin ☐ Urticaria / Angioedema

☐ Stasis Dermatitis / Leg Varicose Ulcer ☐ Psoriasis ☐ Other _____

H - Nervous System diaseses?	Yes ●	No ●	If Yes, which

☐ Depression ☐ Multiple sclerosis(1) ☐ Scizophrenia(1) ☐ Other _____

☐ Parkinson Diseases(1) ☐ Epilepsy(1) ☐ Bipolar Disorder(1)

☐ Thrombosis / Cerebrovascular Accident ☐ Dementia(1) ☐ Cranial or Spinal Cord Trauma(3)

I - Blood Diseases?	Yes ●	No ●	If Yes, which

☐ Anaemia(1) ☐ Leukaemia (Acute / Cronic)(1) ☐ Multiple myeloma(1) ☐ Haemophilia(1)

☐ Lymphoma (Hodgkin's / Non-Hodgkin's)(1) ☐ Myelodysplasia(1) ☐ Pupura (1) ☐ Other _____

J - Endocrine Diseases?	Yes ●	No ●	If Yes, which

☐ Tyroide Disease(1) ☐ Hypophiseal Tumor(1) ☐ Diabetes Mellitus Type 2 ☐ Other _____

☐ Adrenal Disease(1) ☐ Diabetes Mellitus Type 1(1) ☐ Nervous Anorexia(1)

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

☐ Increase Uric Acid (Gout) ☐ Increase Triglycerides ☐ Increase Cholesterol ☐ Other _____

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

L - Eye Diseases?	Yes ●	No ●	If Yes, which	
☐ Impaired Visual Acuity / Use of Graduated Spectacles or Contact Lenses (Myopia, Astigmatism, Hyperopia)	☐ Strabismus		☐ Retinal Diseases	
	☐ Cataract		☐ Glaucoma	☐ Other _____

M - Ear, Nose and Troat Diseases ?	Yes ●	No ●	If Yes, which
☐ Repeating or Chronic Otitis Atopic	☐ Sinusitis		☐ Recurring Tonsillitis and Adenoiditis
☐ Dizziness	☐ Nasal Septum Deviation		☐ Impaired Hearing / Use of Hearing Aids
			☐ Others _____

N – Gynaecological Disorders?	Yes ●	No ●	If Yes, which	
☐ Benign Breast Nodes	☐ Uterine Tumour (Benign)(1)		☐ Endometriosis	
☐ Adnexal Tumour (Benign)(1)	☐ Uterine Prolapse		☐ Female Infertility	☐ Others _____

O – Infectious Diseases?	Yes ●	No ●	If Yes, which
☐ HIV or AIDS Carrier(1)			☐ Syphilis
☐ Tuberculosis of the Lymphatic Glands, Kidney or Another Organ(1)			☐ Others _____

P – Neoplasias?	Yes ●	No ●	If Yes, which	
☐ Lung (1)	☐ Stomach (1)		☐ Kidney (1)	
☐ Uterus (1)	☐ Colon (1)		☐ Breast (1)	
☐ Thyroid	☐ Prostate (1)		☐ Skin (1)	☐ Other _____

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

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

☐ Cardiac ☐ Renal ☐ Pulmonary ☐ Digestive

☐ Neurological ☐ Other _____

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 the option "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 authorize 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 centers and forensic medicine institutes, including after my death, with a view to confirming or to complement the information provided on after subscription contract, for the purpose 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.

Autorisation 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 receive from them any information related to the services provided and covered by the professional secrecy, as well as its processing.

I authorise the recording of telephone conversations undertaken within the scope of the insurance contract, for the purpose 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 the Policy Holder.

/ /	
Location and date	The Insured Person

The present document is a translation of the Portuguese version. In case of discrepancy between the versions, the Portuguese version shall prevail. Does not exempt consultation of the legally required pre-contractual and contractual information.

Médis – Companhia Portuguesa de Seguros de Saúde, S.A Public Limited Company with its head office in Praça Príncipe Perfeito 2, 1990-278 Lisboa, tax nr. 503 496 944 and registered with this same number in the Lisbon Trade Registry, with a share capital of € 12.000.000. ASF Register 1131, www.asf.com.pt