Medical Questionnaire

CONFIDENTIAL

All questions must be answered. Check by "Yes" or "No" to all questions.	**Insured**	**Spouse Partner**	**Child no 1**	**Child no 2**	**Child no 3**	**Child no 4**
Name Surname	....	....	....	....	....	....
Date of birth						
Weight (kg) (if spouse is pregnant, give the weight prior to pregnancy)						
Height (cm)						
1. Are you currently on full or partial sick leave due to an illness or accident?	Yes ☐ No ☐	Yes ☐ No ☐				
Over the past three years, have you ever been on sick leave for more than 30 consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐				
2. Are you currently under medical supervision (therapy, medical care) and/or are you taking prescribed medication (other than contraceptives)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Are you entitled to military or civil disability pension of more than 15 percent?	Yes ☐ No ☐	Yes ☐ No ☐				
4. Over the past 5 years, have any of your medical or viral tests yielded abnormal results?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you undergone surgery over the past 10 years or are you scheduled to do so in the future (exclusive of caesarean sections or appendectomies, or varicose veins, tonsils, adenoids or gallbladder removals).	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you, over the past 10 years, been hospitalised in a hospital, clinic, health care facility or thermal cure institution or are you scheduled to do so in the next 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Over the past 10 years, have you ever suffered from an illness or condition that required medical supervision (therapy, medical care, medication) for more than 30 consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Are you currently receiving dental care or are you scheduled to do so over the next 24 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If you answered "yes" to any of these questions, please provide details below including dates, duration, specific medical grounds or reasons, carry-over effects, therapy and results of tests:

SIGNATURE / STATEMENT

I hereby certify that the foregoing declarations are accurate, complete and fair and have been correctly written to the best of my knowledge and belief.

I have been informed and I accept that any intentional withholding of significant information or false declaration by me or on my behalf may lead to the cancellation of the insurance cover in accordance with the Luxembourg Law.

I may examine and correct any personal information in the files of the Plan Administrator and the Insurer maintain on my behalf

For underwriting and claim purposes, I permit any physician who has examined me to give medical data to the physician of the Insurer and/or the Plan Administrator.

I accept these terms and conditions and I wish to be covered by this policy subscribed by my employer's company.

Date: / /

Insured's Signature (preceded by « Read and Approved ») :