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Voluntary health insurance

Questionnaire on the health condition of the policy holder

A. Policy holder personal data

NAME OF THE POLICY HOLDER	DATE OF BIRTH	GENDER M ☐ F ☐

PERSONAL IDENTIFICATION NUMBER	LBO (HEALTH INSURANCE CARD NUMBER)	PHONE NUMBER	E-MAIL

CITY, MUNICIPALITY, STREET AND NUMBER

THE POLICY HOLDER IS:

DIRECTLY INSURED ☐ SPOUSE OF AN INSURED ☐ CHILD OF AN INSURED ☐ (for persons under the age of 18 to be filled by a parent or a guardian)

B. General health data

1. HIGHT (CM)	BODY WEIGHT (KG)	2. THE NAME OF THE HEALTHCARE FACILITY YOU ARE USING OR ARE REGISTERED AT, AND THE NAME OF YOUR PHYSICIAN

3. **IF YOU DO SPORTS, PLEASE SPECIFY WHICH AND THE FREQUENCY OF YOUR PRACTISE (OCCASIONAL OR ACTIVE)**

4. **ARE YOU TAKING ANY OF THE BELOW STATED?**

CIGARETTES ☐ CIGARS ☐ HOW MANY PER DAY? ☐ OTHER HEAVY AND LIGHT DRUGS (TYPE, DAILY AMOUNT AND FOR HOW LONG)?

ALCOHOL: OCCASIONALLY ☐ EVERY DAY ☐ If the answer is every day, please state the kind and the amount of alcohol used:

5. **HAVE YOU EVER HAD DISORDERS THAT REQUIRE REGULAR MEDICAL CONTROL AND THERAPY?** YES NO
If YES, please provide details: diagnosis, duration, type of treatment (in which dose), frequency of control and the last control? Please attach a copy of the medical documentation if available.

6. **HAVE YOU EVER SUFFERED FROM FOLLOWING DISEASES?**
If the answer to any part of the question is YES, please indicate which and in what periods. Please attach a copy of the medical records if available.

HEART, BLOOD, BLOOD VESSELS? YES NO
(elevated blood pressure, heart problems, feeling of chest pressure, lack of air, blood flow disorders, stroke, enlarged veins, thrombosis, etc.)

NERVOUS SYSTEM? YES NO
(e.g., numbness, nausea, epilepsy, multiple sclerosis, headache, migraine, dizziness, or mental disorders (depression, psychosis, neurosis, anxiety,etc))

SENSES? YES NO
(e.g., eyes – sight disturbances or retina disorders, duplicated images, ears or nose, etc.)

BONES, SPINE, JOINTS, MUSCLES? YES NO
(e.g., rheumatism, arthritis, spinal column disease, arthrosis, osteoporosis, knee joint, and the like)

SYSTEM FOR THE EXCHANGE OF MATTER (METABOLISM)? YES NO
(e.g., sugar, increased fat in the blood - for example, cholesterol, triglycerides, and the like, gout, glands - for example, thyroid gland, etc.)

RESPIRATORY ORGANS? YES NO
(e.g., chronic bronchitis, asthma, TBC, and the like)

DIGESTIVE SYSTEM? YES NO
(gastritis, stomach or intestines, hemorrhoids, bile, liver or pancreas, abscess, hemorrhoids, gallstone, fat liver, etc.)

KIDNEYS, URINARY TRACT? YES NO
(inflammation of the bladder or kidneys, stone or sand in the kidney, blood in the urine, etc.)

BLOOD OR IMMUNE SYSTEM? YES NO
(infectious diseases, anemia, allergies, HIV infection, leukemia, etc.)

SKIN OR ECTODERMAL TISSUE? YES NO
(e.g., eczema, fungal diseases, psoriasis, etc.)

MALE AND FEMALE REPRODUCTIVE ORGANS?
(e.g., myomas on the womb, cysts, cervix damage, breast disorders, etc., testicular inflammation, prostate, and the like) YES NO

TUMORS?
(benign tumors, cysts, polyps, malignant tumors, other malignant diseases, etc YES NO

OTHER HEALTH ISSUES THAT HAVE NOT BEEN REFERRED TO? YES NO

7. **ARE YOU CURRENTLY ON A SICK LEAVE AND HAVE YOU BEEN ON A SICK LEAVE WITHING THE PREVIOUS YEAR?** YES NO
If YES, please indicate for how long and due to which illness / surgery?

8. **HAVE YOU EVER BEEN UNDER THE CONSTANT DOCTOR'S CONTROL, HAVE YOU EVER HAD AN OUTPATIENT EXAMINATION OR TREATMENT, AND HAVE YOU EVER BEEN HOSPITALIZED OR TREATED IN ANY HOSPITAL OR SANATORIUM?** YES NO
If YES, please state why, when, with what result, and attach a copy of the discharge note with medical case history. If you do not have it, state where and why you were treated?

9. **HAVE YOU EVER HAD SURGICAL INTERVENTIONS OR ARE PLANNING TO HAVE ANY SURGERY IN NEAR FUTURE, AND HAVE YOU EVER BEEN RECOMMENDED FOR SOME SURGERY?** YES NO
If YES, state the type and time of surgery, and attach a copy of the discharge note with medical case history or the report from the surgery. Specify the date and description of the surgery.

10. **HAVE YOU DONE ANY OF THE DIAGNOSTIC PROCEDURES OR ANALYZES IN THE PREVIOUS TWO YEARS: TUMOR MARKERS, HORMONES, HIV TEST, X- RAY, ULTRASOUND, DOPLER, EKG, HOLTER, LOAD TEST, SCANNER, MAGNETIC RESONANCE, CORONAROGRAPHY?** If YES, please indicate why and how many times? YES NO

11. **HAVE YOU HAD AN ACCIDENT THAT CAUSED SERIOUS TRAUMA (INJURIES)?** YES NO
If YES, please describe the date, accident, injury, treatment and the treatment results.

12. **HAVE YOU EVER WORKED ON JOBS (INCLUDING HOBBIES) THAT MAY BE / HAVE BEEN HARMFUL TO YOUR HEALTH OR MAKE YOU / HAVE MADE YOU VULNERABLE TO INJURY OR ILLNESS (EG WORKING AT HEIGHTS, HARMFUL DUST OR GASES OR DANGEROUS SUBSTANCES, AVIATION, EXCLUDING BEING A PASSENGER WHO PAYS FOR A TICKET)?** YES NO
If YES, indicate where, when, what, how long have you been doing or practicing, sports or hobbies, and what kind of damage have you been exposed to?

13. **DO YOU WEAR GLASSES, LENSES, OR HAVE SOME EYE DISEASE?** YES NO
If YES, state what type of illness you have and for how long?

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14. **DO YOU HAVE ANY ORGANIC, INNATE OR ACQUIRED DEFECT / DEFORMITY THAT REQUIRES REGULAR MEDICAL CHECK-UPS?** YES NO
If YES, please specify.

15. **DO YOU HAVE A REDUCED WORKING-ABILITY (DISABILITY)?** YES NO
If YES, how many percent is the estimated disability?

16. **(for women in reproductive age) ARE YOU PREGNANT AT THE MOMENT AND HAVE YOU HAD A CAESAREAN SECTION OR A DELIVERY THAT REQUIRED THE USE OF FORCEPS OR VACUUM EXTRACTORS? HAVE YOU HAD ANY COMPLICATIONS DURING PREGNANCY OR CHILDBIRTH?** If YES, please provide details. YES NO

17. **DOES ANYONE IN YOUR FAMILY (THE CLOSEST RELATIVE) SUFFER FROM OR HAVE EVER SUFFERED OR DIED AT THE AGE BELOW FIFTY DUE TO: DIABETES, MYOCARDIAL INFARCTION, STROKE, HIGH BLOOD PRESSURE, KIDNEY DISEASE, MALIGNANT TUMORS, MULTIPLE SCLEROSIS, PSYCHIATRIC DISORDERS AND OTHER HEREDITARY DISEASES?** If YES, please provide details. YES NO

18. **HAVE YOU TAKEN SOME MEDICINES REGULARLY (FOR LONGER THAN 15 DAYS) IN THE LAST YEAR?** YES NO
If YES, state which and for how long?

In the case of YES answers to previous questions, provide detailed information about events, illnesses, hospitalization, and the like.

C. Statement of the policy holder / legal representative of the policy holder

I confirm that I have truthfully and correctly answered all the questions asked and that, if otherwise proved, I agree to bear the consequences. Hereby, I authorize the insurer to verify the truthfulness of the data given with the competent healthcare institutions or doctors. I release the insurer from the obligations of keeping business secret, except for third parties. I give consent to use my personal data necessary for the execution of this contract. By my signature, I hereby confirm that I have received an original copy of the proposal, and that I am familiar with the content of the Insurance Terms and Conditions.

DATE AND PLACE	SIGNATURE	Signature of the policy holder / the representative of the policy holder (the parent or a guardian is signing for a minor child)