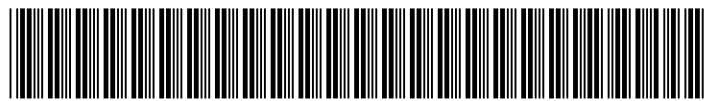

delta lloyd

Health Questionnaire

To determine the state of health of the insurees we require you to provide us with medical information. Please complete all the questions below in block letters.
If you should require more space, please add a separate attachment. Thank you for your co-operation.

client number:

Insurant: (this questionnaire is kept separately from your application due to privacy. Therefore some details need to be filled in twice).

Surname:	**ZIP code:**	**House number**

1. Length and weight:

	(date of birth)	weight (kg)	length (cm)		(date of birth)	weight (kg)	length (cm)
1	- -	kg	cm	4	- -	kg	cm
2	- -	kg	cm	5	- -	kg	cm
3	- -	kg	cm	6	- -	kg	cm

2. Are there any insurees with long term (longer than 3 months) physical or mental disorders, diseases or disabilities (also tick if this occurred longer than five years ago)?
For example: diabetes, neurological disorders, affection of the lungs, epilepsy, blood-disease, kidney failure, psychic of psychiatric disorders, incontinence, cardiovascular and/or heart diseases, chronic skin-affection, neck/back and/or limb conditions, oesophagic- abdominal and/or intestal disorders, dental problems after an accident, congenital disorders, hearing difficulties, malignant conditions, high cholesterol, hepatitis, AIDS or HIV antibodies in the blood (seropositivity).

☐ no ☐ yes, who?	- - (date of birth)	- - (date of birth)
which condition?		
which diagnosis?		

3. Are there any insurees who require an aid (like hearing aids, protheses, wheel chair, hypodermic needles or incontinence aids)?

☐ no ☐ yes, who?	- - (date of birth)	- - (date of birth)
which aid?		

4. Are there any insurees who are currently receiving treatment by, or are under the supervision of a GP, specialist, dental surgeon or midwife?

☐ no ☐ yes, who?	- - (date of birth)	- - (date of birth)
since when?		
what type of specialist care?		
what for?		
which diagnosis?		
is/was the person concerned admitted to a hospital or an institution?	☐ no ☐ yes	☐ no ☐ yes

Please continue on the next page

when?

what for?

for how long (no. of days)?

has an operation taken place or is this to be expected? ☐ no ☐ yes ☐ no ☐ yes

when?

what kind of operation?

further treatment or check-ups required? ☐ no ☐ yes ☐ no ☐ yes

how many a year?

5. Are there any insurees who use drugs, special diets or diet preparations on a regular bases?

☐ no ☐ yes, who? ☐☐-☐☐-☐☐ (date of birth) ☐☐-☐☐-☐☐ (date of birth)

what for?

which drugs?

which doses?

how many times?

which diet/preparations?

6. Are there any insurees (besides question 4) that have received treatment by, or have been under the supervision of a specialist in the past 5 years?

☐ no ☐ yes, who? ☐☐-☐☐-☐☐ (date of birth) ☐☐-☐☐-☐☐ (date of birth)

since when?

what type of specialist care?

what for?

which diagnosis?

is/was the person concerned admitted to a hospital or an institution? ☐ no ☐ yes ☐ no ☐ yes

when?

what for?

for how long (no. of days)?

has an operation taken place? ☐ no ☐ yes ☐ no ☐ yes

when?

what kind of operation?

Please continue on the next page

client number:

Surname: **ZIP code:** **House number**

7. Has treatment or an examination with regards to alleviation of childlessness taken place?

☐ no ☐ yes ☐ examination, treatment completed ☐ examination, treatment to be expected

8. Are there any insurees who are currently undergoing treatment by a speech therapist, physiotherapist or any other therapist or have been for a period of 6 weeks or longer in the past 5 years?

☐ no ☐ yes, who? __-__-__ (date of birth) __-__-__ (date of birth)

what kind of therapy?

what for?

which period? from __-__-__ __-__-__

till __-__-__ __-__-__

number of treatments?

9. Are there any insurees who are receiving alternative treatment or have received it in the past 5 years?

☐ no ☐ yes, who? __-__-__ (date of birth) __-__-__ (date of birth)

which period? from __-__-__ __-__-__

till __-__-__ __-__-__

which type of treatment?

10. Is the state of health of one or more of the persons who wish to be insured such that considerable medical expenses will be incurred or can be anticipated in the near future?

☐ no ☐ yes, who? __-__-__ (date of birth) __-__-__ (date of birth)

11. Is the state of health of any of the insurees as such that substantial medical costs are being made or are to be expected in the near future?

☐ no ☐ yes, who? __-__-__ (date of birth) __-__-__ (date of birth)

Comments:

If your current insurer has issued an approval certificate for one of the sections listed above, please enclose a copy.

This health questionnaire and the application form serve as the basis for the insurance contract, which will be concluded in accordance with the conditions that apply. The undersigned declares that he or she has answered all of the questions in this health questionnaire correctly, completely and truthfully. Owm Centrale Zorgverzekeraars groep aanvullende verzekering Zorgverzekeraar u.a. cannot be held liable for claims relating to conditions or handicaps that are not noted (in full) on this form. The undersigned declares that he or she agrees to these conditions.

City **Date** **Signature**

Please now complete the application form

Delta Lloyd uses the information provided by a person who applies for insurance primarily for the purpose of assessing the risk that needs to be insured. If the medical advisor advises Delta Lloyd to reject the application for insurance, we will notify you to this effect. You can then withdraw the application if you wish, by notifying us in writing to this effect. Once the insurance policy has been approved and issued, Delta Lloyd uses the information provided by the insured to implement the insurance and to provide the corresponding services, to carry out the activities required for sound operational management, to assure the continuity of the insurance company, to prevent and detect fraud and to meet statutory obligations.

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