Insurance proposal

Medical questionnaire - confidential (one questionnaire per person)

1. Person to be insured

Name: | **First name:**

Sex : M ☐ **F** ☐ **Date of birth:**

Street: | **Number:** | **Box:** | **Zip code:**

City: | **Country:** | **Telephone / Mobile:**

Place of birth (city/country):

Way of communicating: ☐ **electronic** ☐ **paper**

E-mail address :

2. Policyholder (please mention the address of the domicile or of the registered office of the policyholder)

Number of current policy:

Name or denomination: | **First name:**

Street: | **Number:** | **Box:** | **Zip code:**

City : | **Country:**

3. Information

Possible medical documents allow us, if they are attached to this questionnaire, to treat your file better. If you wish, you can send this medical questionnaire by separate mail to DKV Belgium N.V./S.A., to the attention of the medical advising doctor, Bd Bischoffsheimlaan 1-8, 1000 Brussels. Similarly, each person to be insured who wishes, can obtain with his insurance intermediary, or on the website www.dkv.be, a copy of the medical questionnaire to be completed and returned.

The Law requires from you when concluding an insurance contract, to transmit all relevant and known information in order to enable the insurer to accurately assess the risk. Any omissions and/or intentional inaccuracies can lead to the cancellation of the subscribed guarantees with retaining by the insurer of the premiums paid, as provided in article 59 of the law of 4 April 2014 on insurances.

The answers to the questions below are the required minimum for the insurer and help you with the complete declaration of the medical history of the persons to be insured. The medical information that is transmitted to us, is processed by our company in compliance with the law on privacy and the law on patient rights.

4. Medical questionnaire for the person to be insured (for DKV Smile (dental plan), please fill out question 5)

4.A.: Have you been in treatment or have you consulted within the last 5 years or do you take medicines for one or more of the following disorders:

**** if yes, tick the box next to the disorder in question.***
***** if 'other disease', please fill out the disorder in question.***

A. Disorders of the heart, the veins or the blood? ☐ No ☐ Yes*

1. anaemia ☐
2. heart valve disorder (including valve prostheses) ☐
3. heart attack ☐
4. artery disease ☐
5. varices (not treated) ☐
6. hypertension (high blood pressure) ☐
7. hyperlipidaemia/hypercholesterolaemia ☐
8. other disorder**: ..... ☐

B. Disorders of the nervous system or the muscles? ☐ No ☐ Yes*

9. epilepsy ☐
10. multiple sclerosis (MS) ☐
11. cerebral haemorrhage or cerebral attack (cerebral vascular accident / CVA) ☐
12. migraine ☐
13. Parkinson's disease ☐
14. Alzheimer's disease ☐
15. chronic fatigue syndrome ☐
16. fibromyalgia ☐
17. chronic Lyme disease ☐
18. other disorder**: ..... ☐

C. Disorders of the respiratory system? ☐ No ☐ Yes*

19. asthma ☐
20. allergic rhinitis ☐
21. chronic pulmonary disease (emphysema, chronic bronchitis) ☐
22. other disorder**: ..... ☐

D. Disorders of the skin? ☐ No ☐ Yes*

23. psoriasis ☐
24. eczema ☐
25. other disorder**: ..... ☐

E. Disorders of the digestive system, the liver or the abdominal wall? ☐ No ☐ Yes*

26. reflux ☐
27. stomach ulcer ☐
28. Crohn's disease ☐
29. colitis ulcerosa ☐
30. pancreas disorders ☐
31. liver cirrhosis ☐
32. colon polyp ☐
33. inguinal hernia (non operated) ☐
34. umbilical hernia ☐
35. hiatal hernia ☐
36. other disorder**: ..... ☐

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Person to be insured Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

F. Disorders of the eye, the ear or the throat? ☐ No ☐ Yes*

37. cataract (non operated) ☐
38. glaucoma ☐
39. strabismus (squint) (non operated) ☐
40. hearing loss / hearing aid ☐
41. sleep apnea / excessive snoring ☐
42. cholesteatoma (chronic middle ear inflammation) ☐
43. tinnitus ☐
44. other disorder**: .... ☐

G. Endocrine disorders? ☐ No ☐ Yes*

45. diabetes ☐
46. thyroid disorder (goiter, hyperthyroidism, thyroid nodule) ☐
47. other disorder**: .... ☐

H. Kidney and urinary disorder or genital disorder?

☐ No ☐ Yes*

48. renal insufficiency ☐
49. kidney disease requiring dialysis ☐
50. kidney stones ☐
51. incontinence ☐
52. prostate hyperplasia ☐
53. endometriosis ☐
54. ovary disorders (cysts, inflammation, ...) ☐
55. abnormal PAP-smear results ☐
56. other disorder**: .... ☐

I. Disorders of the musculoskeletal system? ☐ No ☐ Yes*

57. cervical disc herniation (neck) ☐
58. thoracic disc herniation (upper back pain) ☐
59. lumbosacral disc herniation (low back pain) ☐
60. chronic back pain ☐
61. shoulder disorders (dislocation, frozen shoulder, ...) ☐
    ☐ left ☐ right
62. osteoarthritis of the knee ☐
63. coxarthrosis (hip arthrosis) ☐
64. fracture : specify ☐
    ☐ left shoulder ☐ right shoulder
    ☐ left hip ☐ right hip
    ☐ left knee ☐ right knee
    ☐ vertebra
65. arthritis (rheumatism, ...) ☐
66. rip / rupture of the cruciate ligaments of the knee ☐
    ☐ left ☐ right
67. rip / rupture of the meniscus ☐
    ☐ left ☐ right
68. hallux valgus (deviation of the big toe) (non operated) ☐
69. carpal tunnel syndrome (non operated) ☐
70. other disorder**: .... ☐

J. Infectious disorders? ☐ No ☐ Yes*

71. AIDS or HIV positive ☐
72. hepatitis ☐
73. tuberculosis ☐
74. other disorder**: .... ☐

K. Mental and behaviour disorders? ☐ No ☐ Yes*

75. burn-out ☐
76. depression ☐
77. psychosis (schizophrenia, manic depression, ...) ☐
78. alcohol abuse ☐
79. drugs abuse ☐
80. psychomotor development disorder (hyperactivity) ☐
81. hyperkinesis ☐
82. autism ☐
83. gender dysphoria ☐
84. other disorder**: .... ☐

L. Malignant disorders (cancer)? ☐ No ☐ Yes*

85. specify (type, organ)?
    ☐ colorectal ☐ throat
    ☐ stomach ☐ thyroid
    ☐ leukemia ☐ bladder
    ☐ melanoma ☐ prostate
    ☐ non-Hodgkin lymphoma ☐ breast
    ☐ pancreas ☐ cervix
    ☐ lung ☐ ovary
    ☐ kidney ☐ other:

Have you been treated with

86. - radiotherapy? ☐ No ☐ Yes
87. - chemotherapy? ☐ No ☐ Yes

M. Current, foreseen or recommended dental treatment? ☐ No ☐ Yes*

88. orthodontic ☐
89. parodontal ☐
90. prosthetic, crown, bridge or implant ☐

N. Current, foreseen or recommended tests? ☐ No ☐ Yes*

91. cardiovascular examination ☐
92. sleep test (polysomnography) ☐

O. Are you an organ transplant recipient or waiting list candidate?

☐ No ☐ Yes*

Which organ:

93. kidney ☐
94. liver ☐
95. heart ☐
96. other: .... ☐

P. Do you have a handicap or are you invalid? ☐ No ☐ Yes*

Specify: ....

Q. Do you have a prosthesis or an implant?

☐ No ☐ Yes*

97. breast prosthesis ☐ left ☐ right
98. knee prosthesis ☐ left ☐ right
99. hip prosthesis ☐ left ☐ right
100. neurostimulation ☐

R. Current length/weight?

101. length .... cm
102. weight .... kg
    (if you are pregnant, please give your weight just before your current pregnancy)

S. Other disorders which are not stated above?

....

....

....

Is a hospitalisation foreseen? ☐ No ☐ Yes

If yes, when and for which reason? ....

Are you pregnant? ☐ No ☐ Yes

If yes, what is the foreseen delivery date? ....

Do you smoke daily? ☐ No ☐ Yes

If yes, how many cigarettes, cigars, ... average per day? ....

Don't forget to sign on the next page

Person to be insured Name: ________________ **First name:** ________________

4.B. Additional questions for a home care insurance or a loss of income insurance.

1. Have you already been disabled to work for more than 3 weeks? ☐ No ☐ Yes

What was the cause? Percentage of disability? During which period?

....

2. Are you currently partially or completely in working disability? ☐ No ☐ Yes

What is the cause? Since when? Percentage?

....

3. Are you currently disabled? ☐ No ☐ Yes

What is the cause? Since when? Percentage?

....

4. Are you currently in diminished ability of self-care and/or dependent on the help of a third person to perform the activities of daily living? Is such a assistance foreseen or recommended? ☐ No ☐ Yes

What is (are) the reason(s)? and for what kind of activities? How many hours a day?

....

5. Medical questionnaire specific for DKV Smile (dental care).

1. Have you undergone an orthodontic treatment in the past, or is such treatment ongoing, foreseen or recommended by your dentist? ☐ No ☐ Yes

Treatments with both fixed and removable appliances. For example: braces, brackets or other treatments to optimize the position of the teeth.

....

2. Have you undergone a periodontal treatment in the past, or is such treatment ongoing, foreseen or recommended by your dentist? ☐ No ☐ Yes

Treatments for diseases of the supporting tissue of the teeth. For example: inflamed gums, degradation of the jawbone, loose teeth.

....

3. Have you undergone a prosthetic treatment in the past with an implant, a bridge or a removable prosthesis (full or partial), or is such treatment ongoing, foreseen or recommended by your dentist? ☐ No ☐ Yes

....

4. How many teeth are missing, including the missing teeth which are replaced by an implant, a bridge or a removable prosthesis (full or partial)?

(wisdom teeth and baby teeth should not be counted)

....

General statements of the person(s) to be insured

1. I know that the insurance proposal consists of an administrative and a medical questionnaire and that it aims at the conclusion of an insurance contract with DKV Belgium N.V./S.A. The insurance conditions are determined upon issuance of the policy, provided that DKV Belgium N.V./S.A has previously received the 2 questionnaires mentioned above and if applicable the signed appendices to the insurance contract, drawn up according to the Law on insurances.
2. I declare that all information is adequate, relevant an not excessive and authorize DKV Belgium N.V./S.A. to collect and to process this information in order to conclude and execute the contract. Therefore, I declare that the information is accurate and complete and that they are binding me even if a third party has provided and/or completed them.
3. I know that the signature of the insurance proposal engages neither the policyholder, nor DKV Belgium N.V./S.A. to conclude the contract. However, I know that if, within 30 days of receipt of the insurance proposal, DKV Belgium N.V./S.A. has not notified an insurance offer, has not subject the insurance to a request for an inquiry or has not refused the conclusion of the contract, DKV Belgium N.V./S.A is obliged to conclude the contract under penalty of damages and interests. The signature of the insurance proposal does not start the coverage.
4. The Medi-Card® is granted upon the conclusion of an insurance plan of DKV Belgium N.V./S.A. if contractually provided. Upon receipt of this card, I agree to respect the Tariff Insurance Conditions for using the Medi-Card®.
5. I undertake to communicate in writing with DKV Belgium N.V./S.A. any change in my health condition occurred before the policy is issued.
6. If chosen to communicate via electronic means, I accept that my e-mail address is also used for communication and management of my (pre-)contractual relationships and my client files with DKV. I agree to be informed in the future, regardless the way of communication, about the commercial activities, products and services of DKV. I have the right., to oppose the use of my personal data for marketing purposes upon simple written request to DKV Belgium N.V./S.A.
7. Any possible complaint about this contract or the related services can be addressed to the department Quality Control of DKV Belgium N.V./S.A., acting under the name of DKV Belgium N.V./S.A. located at 1000 Brussels, Bd Bischoffsheimlaan 1-8 (Tel.: 02/287 64 11 – Fax: 02/287 64 12 – qualitycontrol@dkv.be) or secondly to the Ombudsman of insurances, located at 1000 Brussels, square de Meeûs 35 (Tel. : 02/547 58 71 – Fax : 02/275 59 75 – www.ombudsman.as).

Specific statements of the person(s) to be insured

8. I declare having been explicitly informed and have given my consent that my personal data collected through this document and communicated to DKV Belgium N.V./S.A., whose registered office is located in Belgium (Bd Bischoffsheimlaan 1-8, 1000 Brussels), are processed by DKV Belgium N.V./S.A. as responsible of the processing for the purpose of providing customer service, risk evaluation, issue and management of insurance contracts, management of claims, drawing up statistics and promotion. The personal data are accessible to the departments Contracts, Claims, Accounting, Sales & Marketing, Legal, Compliance, Archiving and Scanning, Actuarial & Statistics, Planning & Controlling, Internal Audit and Quality Control. DKV Belgium N.V./S.A. attaches great importance to the protection of privacy and makes every effort to protect and treat the personal data of its customers in accordance with the law of December 8, 1992 on the protection of privacy with regard to the processing of data of personal nature (Law on privacy). I have the right to consult all data concerning myself and if necessary to change or remove it, under the conditions provided for by the above mentioned law.
9. Based on the data completed on the medical questionnaire and related to the state of health, DKV Belgium N.V./S.A can, if appropriate, apply limitations to the extent of the insurance coverage or apply an additional premium in order to grant the insurance guarantee. These are mentioned in the policy. To this end, I authorize the policyholder and the insurance intermediary to receive a copy of the policy mentioning the possible limitations and/or additional premiums mentioned above. The information provided in the medical questionnaire is, however, strictly confidential and is not transmitted neither to the policyholder nor to the insurance intermediary.
10. I have the right., to oppose the use of my personal data for marketing purposes upon simple written request to DKV Belgium N.V./S.A.
11. I explicitly give my consent to DKV Belgium N.V./S.A. to process the data regarding my health in accordance with the law of 08/12/1992 on the protection of the privacy with regard to the processing of personal data (law on privacy) and its Royal Decree of 2001 for the purpose of providing customer services , risk evaluation, issue and management of insurance contracts, management of claims.

General and specific statements read and approved.
Signature for approval of adult person to be insured or the legal representative:

Date: ___ / ___ / ______