



Avenue Louise 166 Box 1  
1050 Brussels  
Belgium  
+ 32 (0)78 150 135

Ref \_\_\_\_\_

2006/MQ

# Masterkey<sup>2</sup>Health

## Medical Questionnaire medical care

Please tick box that is applicable. If 'yes' is ticked always give an explanation. If you need more space please use an annex and write your name and the Ref. N° on the annex as well. **All questions must be answered.**

1. Name \_\_\_\_\_  
 date of birth \_\_\_\_\_ gender  M  F  
 length (in cm) \_\_\_\_\_  
 weight (in kg) \_\_\_\_\_

2. Have you received treatment during the last three years from:

- a specialist  No  Yes
- a physiotherapist  No  Yes
- an alternative healer  No  Yes

What for? \_\_\_\_\_  
 When? (mm-yyyy) \_\_\_\_\_  
 Are there still complaints or is treatment still being received at the moment?  No  Yes

3. Were you ever admitted to a hospital, rehabilitation centre, psychiatric or other nursing institution?  No  Yes

What for? \_\_\_\_\_  
 When? (yyyy) \_\_\_\_\_  
 Period \_\_\_\_\_

4. Is it expected that you will undergo medical treatment in the near future?  No  Yes

For what? \_\_\_\_\_  
 When? (mm-yyyy) \_\_\_\_\_

5. Are medicines being used?  No  Yes, who?

Which medicine? \_\_\_\_\_  
 What for? \_\_\_\_\_  
 Daily dosage \_\_\_\_\_

6. Are you suffering or have you suffered from any of the following illnesses or disorders? Please tick the appropriate box  and underline the illness/condition referred to.

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, precise, period
- disease of the heart	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- constrictions of the chest or palpitations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- shortness of breath or raised blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- asthma, bronchitis, tuberculosis, prolonged coughing or other lung affection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- diseases of stomach, liver or gall-bladder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- diseases of kidneys, urinary passages or genitals	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- rheumatism, hernia, muscle, joint or bone diseases	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- strain, psychological disorder, problems of nervous system, stress condition, fainting or vertigo	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
- diabetes, thyroid gland, varicose veins or open leg	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

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- diseases of ears, eyes or skin  No  Yes \_\_\_\_\_
- back problems  No  Yes \_\_\_\_\_
- any other illness, disease or defect not mentioned above  No  Yes \_\_\_\_\_

7. Has your blood ever been examined, for instance for blood or kidney diseases, diabetes, fat content (cholesterol), hepatitis A or B, sexually transmittable diseases such as syphilis or AIDS?

No  Yes

What for? \_\_\_\_\_

For how long? \_\_\_\_\_

Result? \_\_\_\_\_

8. Do you wear glasses/lenses?

No  Yes Dioptré L \_\_\_\_ R \_\_\_\_

Do you wear a hearing aid?

No  Yes Loss (dB) L \_\_\_\_ R \_\_\_\_

Do you have dentures, crowns, braces,...

No  Yes Describe \_\_\_\_\_

When was your last dentist visit? \_\_\_\_\_

**9. Additional questions for female applicants:**

Are you pregnant?

No  Yes

Presumable date of childbirth (dd-mm-yy) \_\_\_\_\_

How is the pregnancy proceeding? \_\_\_\_\_

Have complications ever occurred in the past during pregnancy or childbirth?

No  Yes, which and when? \_\_\_\_\_

10. Has a company ever refused to give you insurance, terminated it or imposed special conditions on it?

No  Yes, company \_\_\_\_\_  
at (dd-mm-yy) \_\_\_\_\_  
Policy number \_\_\_\_\_

What was the reason for the refusal or termination?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Who is the general practitioner of the insured?

Name of general practitioner \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

1. I declare that I have answered all the questions truthfully and to the best of my knowledge. If this form has been completed on my behalf, I agree that I have satisfied myself as to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the insurer shall be entitled to retain all premiums paid prior to the insurance year by virtue of a breach of this declaration.
2. I am also aware that I have a legal obligation to notify the insurer of any fact material to this insurance, which appears between the date of this declaration and the beginning of the policy.
3. As of now, I authorize my general practitioner to transmit to the doctor of the company the certificate mentioned the cause of my death.

Signed, at \_\_\_\_\_, on \_\_\_\_\_

The insured person, with signature preceded by "read and approved"

## Protection of privacy

The communicated facts can be processed by the insurance company with a view to customer service, the acceptance of risks, the administration of contracts and claims, as well as the payment of insurance sums. To render an optimal service, these facts can be communicated to the companies of our group or to related companies and service providers.

The involved persons give their explicit permission for the processing of the health related facts when it is necessary for acceptance, administration and execution of the contract by the administrators acting in the scope of this contract. This processing has been determined by the Belgian Privacy code of 8 December 1992.

All information will be handled with the greatest discretion.

The involved persons have the right to peruse these facts, and to have them corrected. They also can resist, free of charge, against the processing of these facts for direct marketing.

For this purpose a dated and signed request accompanied with a recto/verso copy of the identity card shall be sent to the customer service department of the Company.

Further information can be obtained at the customer service department of the Company.