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CONCISE HEALTH DECLARATION FOR APPLICATION OF DISABILITY COVER

Name and first name :		
Birthdate :		
Street:	Nr. :	Box :
Postcode :	City:	

If necessary the insurer has the right to demand additional medical formalities.

CONFIDENTIAL STATEMENT OF THE INSURED	YES	NO	
1. Are you currently in good health ?	<input type="checkbox"/>	<input type="checkbox"/>	If NO, reason :
2. Are you currently unable to work ? Partially or totally ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, reason:
3. Have you during the last 5 years			
- suffered from a serious medical complaint ?*	<input type="checkbox"/>	<input type="checkbox"/>	If YES, date: specification:
- interrupted your professional activity for more than 30 days due to illness ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, date: reason:
- been hospitalized or did you undergo any surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, date and reason :
4. Do you take medicines ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, which ones ? Reason:
5. What is your weight and length ?	<input type="checkbox"/>	<input type="checkbox"/>	Kg: Cm:
6. Did you undergo an AIDS test ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, date and result:

* Serious medical complaint : a mental illness, an illness of the nervous system, a disorder of the bronchial tubes, the cardiovascular system, the digestive system, the kidneys, urethra and bladder, the sense organs, the skin and/or the bones, the joints or the back.

For the purpose of a smooth handling of the contract I agree with the handling of my medical data (article 7 of the Act of 08 December 1992 regarding the protection of the privacy).

Signed inDate.....

Signature of the member preceded by the words "seen and approved":