Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
_____
_____

10- Do you plan to get hospitalized in the upcoming 12 months? ☐ yes ☐ no
If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? ☐ yes ☐ no
If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? ☐ yes ☐ no
Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? ☐ yes ☐ no
Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? ☐ yes ☐ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? ☐ yes ☐ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

Please handwrite the following formula:

I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.