Medical questionnaire

INSTRUCTIONS: An answer is expected for each question. Any extra information regarding the state of your health may be added in the « Complementary information » section you will find after the questionnaire.

Insured
Last name : ____________________ First name : ____________________ Date of birth : ____/____/________
Occupation : ____________________ Email : ____________________
Height : _________ m Weight : _________ kg

Spouse
Last name : ____________________ First name : ____________________ Date of birth : ____/____/________
Occupation : ____________________ Email : ____________________
Height : _________ m Weight : _________ kg

Children
1- First name : ____________ Height : ______ m Weight : ______ kg 3- First name : ____________ Height : ______ m Weight : ______ kg
2- First name : ____________ Height : ______ m Weight : ______ kg 4- First name : ____________ Height : ______ m Weight : ______ kg

Tobacco consumption

	Insured		Spouse	
Do you smoke?	Yes	No	Yes	No
Cigarettes/day				
Cigars/day				
Pipes/day				

Have you ever smoked?	Yes	No	Yes	No
If yes, for how many years? (insured and spouse)				
When did you stop and why? (insured and spouse)				

Alcohol consumption

	Insured		Spouse	
Do you drink alcohol?	Yes	No	Yes	No
Beer (glasses/day)				
Wine (glasses/day)				
Spirits (drinks/day)				

	Insured	Spouse	Child 1	Child 2	Child 3	Child 4	*Note : if you need more space for your answers, please use the "complementary information" section you will find below.*
1- Do you have or have you ever had a congenital or hereditary disorder?	Yes No	Yes No	Yes No	Yes No	Yes No	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 occupation?	Yes No	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No	Details of surgery? Dates(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	Yes No	Yes No	Yes No	Yes No	Yes No	Details :
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Please give reasons?
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	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No	Details:

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317 218 188 RCS Paris –S.A.S (Simplified joint-stock company) with a share capital of 150 000 €
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In case of a complaint, please write to ACS Complaint Service at our postal address.
ACS is controlled by the ACPR, 4 place de Budapest, CS 92459, 75436 Paris Cedex 09 France

	Insured	Spouse	Child 1	Child 2	Child 3	Child 4	***Note*** *: if you need more space for your answers, please use the "complementary information" section you will find below.*
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... 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 ?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	If you answered 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.
10- Do you plan to get hospitalized in the upcoming 12 months?	Yes No	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No	Nature of disability: Rate (please attach notification):
14- Are you currently covered by any medical or Life policy ? Has any medical or Life insurance application been declined, rated, restricted, or cancelled?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	

Complementary information

You can use the section below if, in the previous section, you couldn't complete all the details regarding a medical condition. **Please do not forget to note the question number and the person concerned**. This will help us process your application promptly.

Question # _____ Person: ___________________________	**Question # _____ Person: ___________________________**

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Question # _____ Person: ___________________________	**Question # _____ Person: ___________________________**
Question # _____ Person: ___________________________	**Question # _____ Person: ___________________________**

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 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.

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) __________________

Read and approved

____

Signature of the insured members aged 18 years old or more