

# Medical Questionnaire B

(Please use block letters)

A Medical Questionnaire B must be completed for each person applying for cover. All the Medical Questionnaires B should be sent together with the Application Form A to the insurer.

## For administration use

Ref. _____	Policy Number _____	# _____	 <p><b>SWISS-SURE COMPANY LIMITED</b> 11/F Lam Che Bldg., 10 Wing Lok St., Central, Hong Kong Tel: 2543 8428 Fax: 2541 8147 E-mail: info@swiss-sure.com.hk www.swiss-sure.com</p> <p><small>CIB Member of "The Hong Kong Confederation of Insurance Brokers"</small></p>
Date _____	_____	_____	

## Applicant (Please underline the names you wish to be indicated on your insurance card, max. 29 fields)

First name(s) _____	Occupation _____
Family name(s) _____	
Date of birth (day/month/year) _____	Nationality _____
Age _____ Sex (M/F) _____	Height (cm) _____ Weight (kg) _____ / Height (inches) _____ Weight (pounds) _____

## Other insurance

Do you have a health insurance with another company? NO  YES

Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Do you intend to continue being insured with the other company? NO  YES

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? NO  YES  If yes, please enclose complete information.

## Medical history

If you have or previously have had any of the following illnesses / disorders, please tick the appropriate box and provide details. If you have any additional comments, please state details under "Further remarks" (question 8). All questions must be answered.

<p><b>a)</b> Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>b)</b> Migraine <input type="radio"/> Neurological Disorders <input type="radio"/></p> <p>Epilepsy <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>c)</b> Mental Illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>d)</b> Eye Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>e)</b> Asthma <input type="radio"/> Allergies <input type="radio"/></p> <p>Pulmonary Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>f)</b> Cardiovascular Diseases <input type="radio"/></p> <p>Arterial Hypertension <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>g)</b> Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/></p> <p>Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>h)</b> Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p>	<p><b>i)</b> Urinary Tract and Kidney Diseases <input type="radio"/></p> <p>Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>j)</b> Rheumatism <input type="radio"/></p> <p>Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>k)</b> Back Problems <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>l)</b> Skin Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>m)</b> Cosmetic Operations <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>n)</b> Any other diseases, disorders, illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>o)</b> Have you ever had any fertility treatment? YES <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>p)</b> Have you ever been tested for HIV-antibodies?</p> <p style="text-align: right;">YES <input type="radio"/> NO <input type="radio"/></p> <p>If YES, what was the result:</p> <p style="text-align: center;">HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/></p>
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Policy Number

\_\_\_\_\_

1. Do you take or have you taken any kind of medicine on a regular basis? YES  NO

If YES, please state type and daily dosage \_\_\_\_\_

Diagnosis \_\_\_\_\_ Expense per month \_\_\_\_\_

2. Have you ever been hospitalised or received treatment for any illness? YES  NO

If YES, please state name of hospital / clinic / doctor. (You can use Further Remarks (question 8) if you have more info.)

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Diagnosis \_\_\_\_\_ Dates \_\_\_\_\_

3. Do you suffer from any side effects or consequences of the above conditions? YES  NO

If YES, please enclose complete information.

4. Do you use spectacles or contact lenses - if so please indicate strength \_\_\_\_\_

5. For women only: are you currently pregnant? YES  NO

#### 6. Family Doctor

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

7. Do you have additional medical information? YES  NO

All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. Further remarks, if any: \_\_\_\_\_

#### 9. Applicant's signature

I hereby accept that the Company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the application, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. I also accept that all correspondence concerning the insurance will be sent to the person registered as policyholder and that all insured on the policy have access to correspondence etc. from the Company on its webpage via login. The Company may choose to have data processed in or outside the EU. The Company can exchange the information within the Group and with my intermediary.

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports.

I, the undersigned, solemnly declare that I and co-insured children are in excellent health and do not, apart from the aforementioned, suffer or have suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give Bupa Denmark, filial of Bupa Insurance Limited, England permission to seek and exchange any information from treating doctors and hospitals concerning my/our state of health as the Company deems necessary. If insurance for dental treatment is required: I am not under or about to undergo dental treatment, and hereby give the company permission to seek information from treating dentists concerning any dental treatment.

I declare that I and any persons to be insured have received and read the Policy Conditions and accept that the Policy Conditions together with the policy schedule and the application will represent the insurance contract with the Company if the application is accepted. I also declare that I and any persons to be insured on this policy are not residents of the U.S.

Date (day/month/year) \_\_\_\_\_ Signature \_\_\_\_\_