Health Questionnaire

WIENER STÄDTISCHE
VIENNA INSURANCE GROUP

Offer number Insurance plan

INSURED	
First name and surname	Street and house number
Unique master citizen number (JMBG) *If not applicable, please write N/A*	Postcode
Occupation	City
Date of birth	Phone number
Relationship to policyholder	Mobile number
	Email

NOTE: If you answer YES to any of the questions below, please give us full details of your condition (diagnosis, how long you were treated (from-to), your current state of health).

1. Have you ever had or do you currently have any of the following?

1.1. A malignant or other tumour, cyst ☐ YES ☐ NO

1.2. Any cardiovascular disease (high blood pressure, arrhythmia, tachycardia, congenital heart disease, heart attack, angina pectoris, aneurism, atherosclerosis, varicose veins, thrombosis, etc.) ☐ YES ☐ NO

1.3. Please provide your highest measured blood pressure: / mmHg

1.4. Blood or blood-clotting disorder immune and lymph system diseases (leukaemia, lymphoma, HIV, AIDS, systemic connective tissue disorders, thrombophilia, etc.) ☐ YES ☐ NO

1.5. Any disorder of the lungs or respiratory system (chronic bronchitis, chronic obstructive pulmonary disease, bronchial asthma, emphysema, pulmonary embolus, tuberculosis, etc.) ☐ YES ☐ NO

1.6. Any disorder of the digestive system (indigestion, bloating, burping, stomach and duodenum ulcers, Chron's disease, ulcerative colitis, any type of hepatitis, cirrhosis, gallbladder or biliary diseases, pancreatic disorders, etc.) ☐ YES ☐ NO

1.7. Any gynaecological disorder or breast condition (polycystic ovaries, vaginitis, other vaginal, uterine, ovarian or breast conditions, any form of sterility or infertility, etc.) ☐ YES ☐ NO

1.8. Any disorder of the uro - genital system (any disorder of the kidneys, bladder, or prostate, testicular disorder, etc.) ☐ YES ☐ NO

1.9. A neurological disease (stroke or TIA, multiple sclerosis, epilepsy, migraines, other types of headache, vertigo, etc.) ☐ YES ☐ NO

1.10. Any form of psychiatric disorder, or a mental health problem ☐ YES ☐ NO

1.11. Disorder of the ears (hearing loss, deafness, chronic ear disease, frequent ear infections, problems with the tonsils or third tonsils, etc.) ☐ YES ☐ NO

1.12. Disorder of the eyes (glaucoma, optic nerve, retinal or macular disease, cataract, etc.) ☐ YES ☐ NO

1.13. An eyeglass prescription (dioptre) *If the answer is YES, please specify:* ☐ YES ☐ NO

1.14. A skin condition or mucous membrane disorder (allergies, skin changes, skin disorders, a growth, a mole that has bled, changed colour or increased in size, etc.) ☐ YES ☐ NO

1.15. Any endocrine disorder (any disorder of the thyroid, adrenal or pituitary glands, etc.) ☐ YES ☐ NO

1.16. Any metabolic disorder (diabetes, high levels of fat in the blood, high cholesterol, triglycerides, gouty arthritis, insulin resistance, etc.) ☐ YES ☐ NO

1.17. Any musculoskeletal disorder (degenerative and rheumatic bone, joint and spinal disorders, rheumatoid arthritis, discus hernia, sciatica, etc.) ☐ YES ☐ NO

1.18. An autoimmune disease (systemic lupus erythematosus, etc.) ☐ YES ☐ NO

1.19. Any infectious disease ☐ YES ☐ NO

1.20. Any other health issues/medical conditions resulting from a previous illness, disease, poisoning, accident, injury (please name) ☐ YES ☐ NO

1.21. A disoreder of an organ or a system of organs that is not already mentioned in this questionnaire ☐ YES ☐ NO

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2. Have you been admitted to hospital, clinic or another institution for an illness or injury-related treatment or investigation/tests (in the last 5 years)? ☐ YES ☐ NO
If the answer is YES, please provide the details:

2.1. Are you currently undergoing investigation/tests, or being monitored for a medical condition, or waiting for results of a diagnostic procedure? ☐ YES ☐ NO

3. Have you been told that you might need to be admitted to hospital, or are you scheduled for an operation in the near future? ☐ YES ☐ NO
If the answer is YES, please give details:

4. Have you ever done, or do you currently do any of the following?

4.1. Smoke ☐ YES ☐ NO

4.2. Drink ☐ YES ☐ NO

4.3. Take recreational drugs ☐ YES ☐ NO
If YES, what type of recreational drugs and how often?

If you no longer take drugs, when did you stop?

5. Have you ever received chemotherapy, radiotherapy or immunotherapy? ☐ YES ☐ NO

6. Do you take any medicines on regular basis?
If the answer is YES, please give details:

7. Are you currently in perfect health? ☐ YES ☐ NO

8. Are you exposed to any of the following at work or in your spare time?

8.1. Any specific risks (radiation, explosives or harmful substances, etc.) ☐ YES ☐ NO
If the answer is YES, please specify:

8.2. A risk of getting injured (e.g. due to working at height or underwater, heavy lifting, working in high or low temperatures, etc.) ☐ YES ☐ NO
If the answer is YES, please specify:

9. Do you currently hold a voluntary health insurance policy with another insurance company? ☐ YES ☐ NO
If the answer is YES, please give the name of the insurance company:

10. Have you ever been declined (refused cover) or offered non-standard insurance terms by an insurance company? ☐ YES ☐ NO
If the answer is YES, please give the name of the insurance company and the reason for its decision:

11. Your height cm

12. Your weight kg

If necessary, Wiener Städtische osiguranje may ask you to give it permission to contact healthcare facilities for information and medical records on your health.

INSURED'S DECLARATION

I hereby confirm that:
- All the information and answers to the above questions are correct;
- I am aware of the consequences of giving incomplete or false answers;
- I am familiar with the Terms and Conditions governing this insurance policy.

Place, date

Insured's signature