Questionnaire for International Medical Expert Solution

assuHEALTH imes
INTERNATIONAL MEDICAL EXPERT SOLUTIONS

MEMBER INFORMATION

Applicant Name (First, Middle, Last)_____

National ID No. _____ Date of Birth (DD/MM/YYY): _____

Residence Address: _____

City:_____ Province:_____ Postal Code:_____

e-mail ID:_____

Telephone: Home _____ Work _____ Mobile _____

Gender: ☐ Male ☐ Female

Relationship with policyholder:
☐ Policyholder ☐ Spouse ☐ Dependent ☐ Other

HEALTH QUESTIONNAIRE (INSURED STATEMENT)

		YES	NO
1-	Have you ever suffered, or do you currently suffer from, hereditary, congenital (e.g. congenital heart defects) or autoimmune diseases (e.g. systemic lupus erythematous, autoimmune hepatitis)?	☐	☐
2-	Have you ever sought medical advice or been recommended treatment or had a positive test for a) Cardiovascular Disease (including myocardial infarction, heart failure, angina pectoris and cardiovascular surgery) b) Arterial Hypertension c) Any type of cancer or malignant growth including leukemia and Hodgkin's disease or any pre-cancerous condition d) Any type of tumor or cyst within the brain or skull e) Any type of lump or cyst within the last 24 months f) Stroke (including any type of damage to the brain arteries of the brain or brain surgery) g) Diabetes h) Epilepsy i) Neurological disease or disability j) A positive test for HIV/AIDS or Hepatitis B, C, D or E k) Disorder, disease or infection of the kidneys, liver, lungs	☐	☐
3-	Are you a candidate for, or a recipient of, an organ, bone marrow or stem cell transplant or are you currently on a donor waiting list and/or registered to donate an organ or bone marrow?	☐	☐

GENERAL QUESTIONNAIRE (FOR STATISTICAL PURPOSE ONLY)

1-	Do you have any health insurance which also covers the above diseases?	☐	☐
2-	Have any of your immediate family members (parents and siblings) has any heart or kidney disease or condition (e.g. polycystic kidney disease or condition), stroke, diabetes, hypertension, blood disorder, cancer or any known hereditary disease, condition or disorder?	☐	☐
3-	Have you smoked cigarettes, cigars, etc. within past 24 months?	☐	☐
4-	If YES, please indicate the number of cigarettes/cigars ☐ Less than 20 per day ☐ More than 20 per day		
5-	Height: _____cm Weight: _____kg		

I declare that the answers I have given are, to the best of my knowledge, true and the I have not withheld any material information that may influence the assessment or acceptance of this application. I agree that this form will constitute part of my application for insurance and that failure to disclose any material facts known to me may invalidate the contract.
By signing this form, I authorize my physician, health institutions or other organisation or person that has any information about my health and/or activities to provide the Insurer with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, treatment or disturbances. A photocopy of this authorisation has the same validity as the original.

_____ _____
Signature of Applicant Date