

## HEALTH QUESTIONNAIRE FOR COMPREHENSIVE HEALTH INSURANCE FOR FOREIGNERS

Insurance contract number

Client card number

## Policyholder

Surname, first name / Company (authorized person)

Date of birth / Company ID

## Insured

Surname, first name

Date of birth

## Legal representative of the Insured

Surname, first name

Date of birth

## Consents of the Policyholder/Insured (their legal representative)

In accordance with the provisions of Section 2828 of Act No. 89/2012 Sb., the Civil Code, as amended, I grant the Insurer the consent to obtaining data on my health or the health of the represented person, to determining and examining my health or the health of the represented person or the cause of my death or the cause of death of the represented person by the treating physicians and healthcare establishments if it is based on reasons related with determining the amount of the insurance risk or determining the amount of the premium or the investigation of the loss event. I have the prior consent of the Insured (their legal representative) to grant such consent regarding their health data.

In accordance with the provisions of Section 2788 of Act No. 89/2012 Sb., the Civil Code, as amended, the Insured shall answer the Insurer's questions truthfully and completely.

## Questions about the Insured

1. Are you currently treated\* for or suffering from health problems or were you treated in the past for a chronic or other serious disease (e.g. high blood pressure, diabetes, cancer, internal diseases, etc.)?  YES  NO
2. Do you regularly take or apply medications prescribed by your physician (excluding hormonal contraceptives and dietary supplements)? If your answer is YES, please tell us what medications you take and how often.  YES  NO
3. Were you born with a health problem? If YES, please specify.  YES  NO
4. Are you currently treated\* or were you treated in the past (or have you been in contact) for tuberculosis, AIDS, sexually transmitted diseases or other infectious diseases? If YES, please specify.  YES  NO
5. Are you currently treated\* or were you treated in the past for alcohol or substance addiction?  YES  NO
6. Do you suffer from mental illness? If YES, please specify the diagnosis.  YES  NO
7. Did you suffer an accident in the past that left permanent damage? If YES, please specify.  YES  NO

\* Treatment means a set of measures carried out to:

- a) affect the course of an existing disease; or
- b) monitor and capture the possible recurrence of a disease that was diagnosed in the past in the Insured. This concerns pharmacological (prescribing and administering medication), surgical, psychotherapeutic or physiotherapeutic measures, dispensarization (active monitoring of health status) at a specialist physician, regular examinations to determine the status of the diagnosed disease, etc.

## Declaration of the Policyholder/Insured (their legal representative)

I declare that I have answered truthfully and completely all of the Insurer's written questions in this questionnaire and I am aware that my answers to these questions are relevant to the Insurer's decision on whether insurance can be taken out and under what conditions. The Policyholder, who is not the Insured, declares that they have all information about their health condition from the Insured (their legal representative) to fill in the health questionnaire (if any) truthfully and completely.

I hereby declare that:

- a) I have been acquainted with the information on the processing of personal data before signing this document;
- b) after becoming acquainted with the information on the processing of personal data, I was given sufficient time to understand the information on the processing of personal data and to receive answers to any questions I may have had;
- c) I acknowledge and agree with the Insurer's information that information on the processing of personal data is and will be available to each party to the insurance on the Insurer's website: [www.maximapojistovna.cz/cs/ochrana-osobnich-udaju](http://www.maximapojistovna.cz/cs/ochrana-osobnich-udaju), or at the Insurer's place of business.

Date

podpis pojištěného/ zákonného zástupce