Group insurance (Hospitalisation)

Information concerning the application form

Confidentiality of the medical data

This questionnaire is personal and confidential. In order to guarantee such confidentiality please be so kind as to :

- always fill out and sign the document yourself
- send the original back **under closed envelope** to the **medical advisor of AG Insurance**.

For administrative reasons, the information relating to the family members to be insured may be filled in on the same document.

Each family member may, however, use a separate document if he so wishes.

The questionnaire is the basis of the acceptance. Therefore it is very important that all persons reply clearly and legibly to all questions to avoid all future disputes.

Confidential

A. Identity

1 **Name and company number of the employer :** _____

2 Name and first name of member of personnel : _____

Street : _____ N° : _____ B : _____ Date of birth : _____/_____/_____

Postal Code : _____ City : _____ Sex : ☐ Fem. ☐ Male Date of entry into service : _____/_____/_____

Professional e-mail address : _____

Language : ☐ NL ☐ FR ☐ EN ☐ DE

3 Family members (if they are to be insured, in accordance with the plan rules) Date of marriage/legal cohabitation : _____/_____/_____

Name of **spouse/partner :** _____ First name : _____ Date of birth : _____/_____/_____

Last name and given names of the children :			**Family allowance**	
1st child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐
2nd child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐
3rd child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐
4th child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐
5th child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐
6th child : _____	Gender : ☐ M ☐ F	Date of birth: _____/_____/_____	Yes ☐	No ☐

B. Medical questionnaire

1 Are alle persons to be insured in excellent health and in perfect physical condition ? Yes ☐ No ☐

If **not**, specify below :

Name of the person concerned	_____	_____	_____	_____
a) the nature of the ailment or bodily injuries suffered	_____	_____	_____	_____
b) the date of occurence	_____	_____	_____	_____
c) the medical treatment prescribed	_____	_____	_____	_____

2 Have any of the persons to be insured been ill or injured in an accident or consulted a doctor during the past 5 years ? Yes ☐ No ☐

If **yes**, please indicate below :

Name of the person concerned	_____	_____	_____	_____
a) the nature of the ailment or injury	_____	_____	_____	_____
b) the date of occurence	_____	_____	_____	_____
c) the treatment followed or to be followed and its duration	_____	_____	_____	_____

3 Have any of the persons to be insured been hospitalised the past 10 years ? Yes ☐ No ☐

If **yes**, please indicate below :

Name of the person concerned	_____	_____	_____	_____
a) the nature of the ailment or injury	_____	_____	_____	_____
b) the date and length of the hospitalisation	_____	_____	_____	_____
c) degree of disability, if any	_____	_____	_____	_____

4 Is a birth expected ? Yes ☐ No ☐ If **yes**, estimate date of birth _____/_____/_____

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5 Please specify the height, weight and blood pressure of the persons to be insured

	Height (cm)	Weight (kg)	Blood pressure
Example	178	76	12/08
Employee			
Spouse/partner			
1st child			
2nd child			
3rd child			
4th child			
5th child			
6th child			

Important :

The persons to be insured undertake to ask their doctor in charge any information concerning their state of health required for the acceptance of the affiliation and for the execution of the scheme and to communicate this information to the medical advisor of AG Insurance.

The undersigned agree(s) that AG Insurance handles the above-mentioned data, in compliance with the Belgian Privacy Law, with a view to offer and manage insurance services in general, including the drawing up of statistics. The information concerning the health state may only be treated on the responsibility of a health care professional and the acces to these data is limited to the persons who need this information for the fulfilment of their duties.

The policyholder acknowledges to be aware of the severe consequences – nullity of the contract leading to refusal to pay out the insured amounts – of any intentional omission or intentional inaccuracy as to the risk assessment elements by the policyholder or the insured (Art 58 of the law of 4 april 2014 on Insurance).

The undersigned declares to have kept copy of this questionnaire.

Made out in _____, on _____

Signature of the member of the personnel, Signature of the persons (of age) to be insured,

0079-2280736E-20072016