

International Health Insurance Questionnaire

Date _____

YOUR CONTACT

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PLEASE COMPLETE THIS QUESTIONNAIRE

PERSONAL INFORMATION

CLASS 2 office based with less than 15% of work period spent outside of the office environment less than 50% of work period DEPENDENT(S) INFORMATION CLASS 4 working outside of an office environment for 50% or more of the work period DEPENDENT 1 FIRST NAME: DATE OF BIRTH mm/dd/yy	FIRST NAME:		LAST NAME:					
ANNUAL INCOME (USD):	DATE OF BIRTH mm/dd/yy		GENDER I MALE I FEMALE					
EMAIL:	OCCUPATION:		EFFECTIVE DATE OF COVERAGE:					
ADDRESS:	ANNUAL INCOME (USD):							
PHONE: HOST COUNTRY: HOME COUNTRY: HOST COUNTRY: HOME COUNTRY: HOST COUNTRY: OCCUPATION CLASS CODE if Long Term Disability benefit is elected only CLASS 1 working outside of an office environment for at least 15% but less than 50% of work period CLASS 1 100% office-based CLASS 3 working outside of an office environment for 50% or more of the work period Spent outside of the office environment CLASS 4 working outside of an office environment for 50% or more of the work period DEPENDENT 1 LAST NAME: DATE OF BIRTH mm/dd/yy GENDER MALE I FEMALE FULL-TIME STUDENT: I YES INO RELATIONSHIP TO INSURED: HOME COUNTRY: COUNTRY OF RESIDENCE: HOME COUNTRY: DEPENDENT 2 LAST NAME: DATE OF BIRTH mm/dd/yy GENDER I MALE I FEMALE FULL-TIME STUDENT: I YES INO NO RELATIONSHIP TO INSURED: HOME COUNTRY: DATE OF BIRTH mm/dd/yy GENDER I MALE I FEMALE FULL-TIME STUDENT: I YES INO NO RELATIONSHIP TO INSURED: HOME COUNTRY: DATE OF BIRTH mm/dd/yy DEPENDENT 3 FIRST NAME: LAST NAME: DATE OF BIRTH mm/dd/yy DEPENDENT 3 GENDER I MALE I FEMALE FULL-TIME STUDENT: I YES INO NO	EMAIL:							
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RELATIONSHIP TO INSURED:	DEPENDENT 4 FIRST NAME:	LAST NAME:		DATE OF BIRTH mm/dd/yy				
	GENDER MALE FEMALE	FULL-TIME STUDE	NT: 🗆 YES 🗆 NO					
	RELATIONSHIP TO INSURED:							



PRIMARY INSURED MEDICAL QUESTIONNAIRE

NAME OF THE INSURE	D MEMBER:								
DATE OF BIRTH mm/dd/	уууу		HEIGHT	M	FT. WEIGHT	KG	LBS.		
1. Have you ever receiv	ved any treatment (incl	uding taking pills, injec	tions or other medica	tion) for, co	nsulted a physician f	or, or been di	agnosed as ł	naving: Yes	No
 b) Asthma, chronic cc c) High blood pressur d) Pain in chest, strok e) Ulcer, liver disorde f) Arthritis, rheumatis g) Cancer, tumor, leu h) Diabetes, sugar in i) Urine, kidney or bla j) Anemia, bleeding of k) Difficulty with eyes l) Acquired Immune I m) A positive HIV (Hui 	bugh, shortness of breatl re? If yes, provide BP readilities, angina, heart disorder, r, colitis, chronic diarrhe m, gout, neck or back pi kemia, enlarged, glands urine or thyroid disorder adder disorder? or blood disorder? or ears? Deficiency Syndrome (A man Immune Deficiency	ngs for the past 12 months r or circulatory problems? a, hepatitis or any digestiv roblems, disc disease, joir or lymph nodes? ? IDS) or AIDS Related Cor	ve disorder? nt or bone disorder? mplex (ARC)?	quor o	7				
	• • •	nking alcohol or to drink		9000.	-				
b. If you have recent Name of insurance	tly applied for another e company:	n insurance or been offe insurance policy, please			_policy #:				
	Its: and results of last check	up:							
 b. Received or applie c. Had a urinary tract 	al checkup, consulted a d for disability benefits fo infection or any sexually	-	ctitioner, submitted to a	ın ECG, bloo	d tests, x-rays or othe	tests?			
c. You used tobacco	notified due to health rea for more than 5 consecu products?	asons? Itive days due to illness or							
 8. a. Are you presently b. You engage in any 9. For women: a. Are you pregnant? b. Have you ever had 10. In the past 12 month 	under medical treatme y of the following activ any complications of pr hs have you experience	cocaine, heroin, or other ent by diet, medicine, or ities: skydiving, scuba o egnancy? ed any symptoms that y ive full details below	other means? diving, vehicle or boat you have not yet soug	racing, or a	viation except as a p attention for?	assenger?			
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DEPENDENT MEDICAL QUESTIONNAIRE

NAME OF DEPENDENT:	RELATIONSHIP TO PARIMARY INSURED:						
DATE OF BIRTH mm/dd/yyyy	HEIGHT	M	FT. WEIGHT	KG	LBS.		
1. Have you ever received any treatment (including taking pills, injections	or other medica	tion) for, con	sulted a physician fo	or, or been di	agnosed as ha	ving:	
 a) Dizzy spells, epilepsy, and neurological disorder, psychiatric or mental b) Asthma, chronic cough, shortness of breath, or convulsion? c) High blood pressure? <i>If yes, provide BP readings for the past 12 months</i> d) Pain in chest, stroke, angina, heart disorder or circulatory problems? e) Ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive f) Arthritis, rheumatism, gout, neck or back problems, disc disease, joint of Cancer, tumor, leukemia, enlarged, glands or lymph nodes? 	disorder?	2				Yes 	
 h) Diabetes, sugar in urine or thyroid disorder? i) Urine, kidney or bladder disorder? j) Anemia, bleeding or blood disorder? k) Difficulty with eyes or ears? l) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Comp 	lex (ARC)?						
 m) A positive HIV (Human Immune Deficiency Syndrome) test? 2. a. Indicate your average weekly consumption of alcohol? Beer oz 	·Wine oz ·	Liquor d	17				
b. Have you ever been advised to stop drinking alcohol or to drink less	?		-				
 a. Have you ever been refused life or health insurance or been offered if b. If you have recently applied for another insurance policy, please provide Name of insurance company: 			policy #:				
4. a. Do you have an annual check-up? If yes provide results:							
Within the past 5 years, have you:5. a. Except for an annual checkup, consulted a doctor or other health practition b. Received or applied for disability benefits for 3 months or longer?c. Had a urinary tract infection or any sexually transmitted disease?	ner, submitted to	an ECG, bloo	d tests, x-rays or othe	tests?			
 Within the past 12 months, have: 6. a. Your duties been modified due to health reasons? b. You been off work for more than 5 consecutive days due to illness or injury c. You used tobacco products? If "Yes" indicate the number per day:	y?						
 7. a. Within the past 10 years have you used cocaine, heroin, or other narce 8. a. Are you presently under medical treatment by diet, medicine, or other b. You engage in any of the following activities: skydiving, scuba diving 9. For women: a. Are you pregnant? b. Have you ever had any complications of pregnancy? 10. In the past 12 months have you experienced any symptoms that you have had any complexity of the presence of the pres	r means? J, vehicle or boa	t racing, or a	viation except as a p	assenger?			
For each "Yes" answer above, please give full details below Attack	n a separate signed	and dated shee	t of paper if necessary				
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