International Health Insurance Questionnaire

Date ____________________________________

YOUR CONTACT

James D. Smith // Global Benefits LLC
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james@globalbenefitsusa.com

PLEASE COMPLETE THIS QUESTIONNAIRE

PERSONAL INFORMATION

FIRST NAME: ______________________________ **LAST NAME:** ______________________________

DATE OF BIRTH *mm/dd/yy* ______________________________ **GENDER** ☐ MALE ☐ FEMALE

OCCUPATION: ______________________________ **EFFECTIVE DATE OF COVERAGE:** ______________________________

ANNUAL INCOME (USD): ______________________________

EMAIL: ______________________________

ADDRESS: ______________________________ **CITY/PROVINCE/POSTAL CODE:** ______________________________

PHONE: ______________________________

HOME COUNTRY: ______________________________ **HOST COUNTRY:** ______________________________

OCCUPATION CLASS CODE *if Long Term Disability benefit is elected only*

☐ **CLASS 1** 100% office-based

☐ **CLASS 2** office based with less than 15% of work period spent outside of the office environment

☐ **CLASS 3** working outside of an office environment for at least 15% but less than 50% of work period

☐ **CLASS 4** working outside of an office environment for 50% or more of the work period

DEPENDENT(S) INFORMATION

DEPENDENT 1

FIRST NAME: ____________________ **LAST NAME:** ____________________ **DATE OF BIRTH** *mm/dd/yy* ____________________

GENDER ☐ MALE ☐ FEMALE **FULL-TIME STUDENT:** ☐ YES ☐ NO

RELATIONSHIP TO INSURED: ______________________________

COUNTRY OF RESIDENCE: ______________________________ **HOME COUNTRY:** ______________________________

DEPENDENT 2

FIRST NAME: ____________________ **LAST NAME:** ____________________ **DATE OF BIRTH** *mm/dd/yy* ____________________

GENDER ☐ MALE ☐ FEMALE **FULL-TIME STUDENT:** ☐ YES ☐ NO

RELATIONSHIP TO INSURED: ______________________________

COUNTRY OF RESIDENCE: ______________________________ **HOME COUNTRY:** ______________________________

DEPENDENT 3

FIRST NAME: ____________________ **LAST NAME:** ____________________ **DATE OF BIRTH** *mm/dd/yy* ____________________

GENDER ☐ MALE ☐ FEMALE **FULL-TIME STUDENT:** ☐ YES ☐ NO

RELATIONSHIP TO INSURED: ______________________________

COUNTRY OF RESIDENCE: ______________________________ **HOME COUNTRY:** ______________________________

DEPENDENT 4

FIRST NAME: ____________________ **LAST NAME:** ____________________ **DATE OF BIRTH** *mm/dd/yy* ____________________

GENDER ☐ MALE ☐ FEMALE **FULL-TIME STUDENT:** ☐ YES ☐ NO

RELATIONSHIP TO INSURED: ______________________________

COUNTRY OF RESIDENCE: ______________________________ **HOME COUNTRY:** ______________________________

PRIMARY INSURED MEDICAL QUESTIONNAIRE

NAME OF THE INSURED MEMBER:____

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 medication) for, consulted a physician for, or been diagnosed as having:

		Yes	No
a)	Dizzy spells, epilepsy, and neurological disorder, psychiatric or mental disorder?	☐	☐
b)	Asthma, chronic cough, shortness of breath, or convulsion?	☐	☐
c)	High blood pressure? *If yes, provide BP readings for the past 12 months*	☐	☐
d)	Pain in chest, stroke, angina, heart disorder or circulatory problems?	☐	☐
e)	Ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder?	☐	☐
f)	Arthritis, rheumatism, gout, neck or back problems, disc disease, joint or bone disorder?	☐	☐
g)	Cancer, tumor, leukemia, enlarged, glands or lymph nodes?	☐	☐
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 Complex (ARC)?	☐	☐
m)	A positive HIV (Human Immune Deficiency Syndrome) test?	☐	☐

2. a. Indicate your average weekly consumption of alcohol Beer_____oz ; Wine_____oz ; Liquor_____oz

b. Have you ever been advised to stop drinking alcohol or to drink less? ☐ ☐

3. a. Have you ever been refused life or health insurance or been offered it on special term? ☐ ☐

b. If you have recently applied for another insurance policy, please provide: date:________________ policy #: ___________________

Name of insurance company:______________________________

4. a. Do you have an annual check-up? ☐ ☐

If yes provide results:____

If no, provide date and results of last check up:_______________________________________

Within the past 5 years, have you:

5. a. Except for an annual checkup, consulted a doctor or other health practitioner, submitted to an ECG, blood tests, x-rays or other tests? ☐ ☐

b. Received or applied for disability benefits for 3 months or longer? ☐ ☐

c. Had a urinary tract infection or any sexually transmitted disease? ☐ ☐

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:_____________________________

7. a. Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines? ☐ ☐

8. a. Are you presently under medical treatment by diet, medicine, or other means? ☐ ☐

b. You engage in any of the following activities: skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger? ☐ ☐

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 not yet sought medical attention for? ☐ ☐

For each "Yes" answer above, please give full details below *Attach a separate signed and dated sheet of paper if necessary*

QUESTION _________ **DATE**________________________________ ________________________________

DETAILS ____

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DETAILS ____

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DETAILS ____

QUESTION _________ **DATE**________________________________**N** ________________________________

DETAILS ____

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 medication) for, consulted a physician for, or been diagnosed as having:

		Yes	No
a)	Dizzy spells, epilepsy, and neurological disorder, psychiatric or mental disorder?	☐	☐
b)	Asthma, chronic cough, shortness of breath, or convulsion?	☐	☐
c)	High blood pressure? *If yes, provide BP readings for the past 12 months*	☐	☐
d)	Pain in chest, stroke, angina, heart disorder or circulatory problems?	☐	☐
e)	Ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder?	☐	☐
f)	Arthritis, rheumatism, gout, neck or back problems, disc disease, joint or bone disorder?	☐	☐
g)	Cancer, tumor, leukemia, enlarged, glands or lymph nodes?	☐	☐
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 Complex (ARC)?	☐	☐
m)	A positive HIV (Human Immune Deficiency Syndrome) test?	☐	☐

2. a. Indicate your average weekly consumption of alcohol? Beer_____oz ; Wine_____oz ; Liquor_____oz

b. Have you ever been advised to stop drinking alcohol or to drink less? ☐ ☐

3. a. Have you ever been refused life or health insurance or been offered it on special term? ☐ ☐

b. If you have recently applied for another insurance policy, please provide: date:________________ policy #: _________________

Name of insurance company:_____________________________

4. a. Do you have an annual check-up? ☐ ☐

If yes provide results:____

If no, provide date and results of last check up:_______________________________________

Within the past 5 years, have you:

5. a. Except for an annual checkup, consulted a doctor or other health practitioner, submitted to an ECG, blood tests, x-rays or other tests? ☐ ☐

b. Received or applied for disability benefits for 3 months or longer? ☐ ☐

c. Had a urinary tract infection or any sexually transmitted disease? ☐ ☐

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:_____________________________

7. a. Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines? ☐ ☐

8. a. Are you presently under medical treatment by diet, medicine, or other means? ☐ ☐

b. You engage in any of the following activities: skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger? ☐ ☐

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 not yet sought medical attention for? ☐ ☐

For each "Yes" answer above, please give full details below *Attach a separate signed and dated sheet of paper if necessary*

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