



The following questions must be answered by the Applicant and/or by the proposed family member for insurance. False declarations shall result in no coverage and the cancellation of the insurance policy under consideration in this application, as from the effective date, with no premium refund.

In case of positive answer (yes), kindly provide the company with details per family member, on the opposite form by first specifying the member's number as indicated on the members schedule, the chapter, the question number and the explanation details. e.g. "2-C-3: explanation..."

Chapter A: Insurance History (in case answer is "Yes", specify reason)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been accepted for life and/or health insurance on sub-standard terms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been declined for life and/or health insurance? | <input type="checkbox"/> | <input type="checkbox"/> |

Chapter B: Extra-professional Activities

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|---|--------------------------|--------------------------|
| 1. Do you want to be covered for all sport activities? (if "Yes", specify the sport currently practice or would intend to practice in the future) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ride motorcycles? (if "Yes", specify if you require coverage for motorcycle accident) | <input type="checkbox"/> | <input type="checkbox"/> |

Chapter C: Specific Medical History (if "Yes", specify diagnostic details, treatment received & recovery status)

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|---|--------------------------|--------------------------|
| 1. Have you ever been diagnosed, treated or felt any disorder, pain or had any symptoms related to the current treatment: | <input type="checkbox"/> | <input type="checkbox"/> |
| a) <u>Musculoskeletal &/or Connective Tissue System?</u> (e.g.: fractures, joint or cartilage problems, back problems, deformities, bone infections, osteoporosis, arthritis, rheumatism, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| b) <u>Cancer, Neoplasms, Tumors?</u> (specify type, location, treatment, whether malignant or benign) | <input type="checkbox"/> | <input type="checkbox"/> |
| c) <u>Blood & Blood Forming Organ Systems?</u> (e.g.: anemia, thalasemia, bleeding disorders, blood cell disease, spleen problems, lymph node problems, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| d) <u>Digestive System?</u> (e.g.: reflux, ulcers, diverticuli, bleeding-infection-obstruction-perforation of the esophagus, stomach, intestines or colon, problems of the teeth/gums/mouth/jaw, problems with the liver, gallbladder or pancreas, anal/rectal polyps?) | <input type="checkbox"/> | <input type="checkbox"/> |
| e) <u>Endocrine, Nutritional, Metabolic and/or Immunity System?</u> (e.g. diabetes, thyroid or pituitary gland problems, adrenal gland, ovary or testes problems, hormone problems, gout, multiple sclerosis, cystic fibrosis, metabolic disorders, immune problems, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| f) <u>Nervous System or sense Organs?</u> (e.g. ear injury/infection, vertigo, hearing problems, eye injury/disease, retina problems, glaucoma, vision problems, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| g) <u>Genitourinary System?</u> (e.g.: kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual cycle problems, salpingitis, ovarian cysts, prostate problems, impotence, testicle infections, sperm abnormalities, fertility problems, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| h) <u>Respiratory System?</u> (e.g. sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, asthma, pneumonia, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| i) <u>Cardio-Vascular System?</u> (e.g. stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, hypertension, heart valve disease, heart disease irregular heart beat, pulmonary embolism, phlebitis, varicosities, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| j) <u>Skin-Subcutaneous Tissue?</u> (e.g. dermatitis, acne, seborrhea, puritis, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever undergone surgery to remove a body organ or structure ? (specify body organ/ Structure, date & place of surgery?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently under any kind of treatment, or have you been under treatment during the last 12 months? (drugs or other) , if yes, kindly specify. | <input type="checkbox"/> | <input type="checkbox"/> |

Chapter D: Family Medical History (father, mother, siblings)

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|--|--------------------------|--------------------------|
| 1. Has any member of your family had symptoms or been diagnosed or received treatment for: | | |
| a) Inherited disorder or genetic disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Hemophilia? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Muscular Dystrophy? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Multiple Sclerosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Mental illness or disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Nervous system and / sense organ disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Cardio-Vascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Metabolic disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

