

Health declaration for life insurance that excludes occupational disability

The English translation has no legal force and is provided to the customer for convenience only. The Dutch health declaration should be filled in. Policy number Name of insured person You have been sent a health declaration form You have been sent this health declaration form because you have applied for life insurance. Please fill in this form fully and accurately. The medical advisor will read your answers and then advise the insurer on whether he can accept your application, and if so, under which conditions. Note: please read the Explanation before filling in this health declaration. Fill in all answers fully and accurately This is important. It is also compulsory and ensures that you can avoid the following situations: - the insurer stops the insurance in the future; the insurer does not pay out in the event of death; - the insurer does not pay out in the event of occupational disability. Mention all your complaints, even if you do not consider them important, or if you have not seen a doctor about them. Have you answered Yes to a question? Then you must explain it in more detail. You can do so by filling in the appendix to question 3. Fill in a separate sheet for each disorder or illness. If you need more space, use another separate sheet. Indicate clearly which question the sheet refers to. If your health changes You may experience changes to your health. If they occur after you have filled in the declaration but before the insurance enters into effect, you must inform the insurer immediately. Have you received: - definitive confirmation of acceptance? - the insurance policy? a statement of acceptance? If so, the insurer has accepted your application definitively. Read more in the Explanation under the heading 'Have there been changes to your health?' 1 General information Who are you? Male Female Last name First name¹ Address Post code Town-city Date of birth What is your profession? How many hours do you work per week? hours Your work consists of physical labour hours administration hours management/supervision hours travelling hours other: Who is your general practitioner? Name Address Post code Town/city

Blad 1

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Do you wish to receive an explanation from the medical advisor?												
The medical advisor will estimate your health risk on the basis of this health declaration. He/she may advise the insurer to refuse your application for insurance or to make it subject to special conditions. If the medical advisor does so, he/she will send you a letter explaining the medical recommendation.												
If you do not wish to receive this letter, tick the box beside the letter:												
Do you want to be the firs	t to hear the	e recommendatio	n?									
*	nters into effec	ct. Please inform the			ed 'the right of first notification'. It may the you want to be the first to hear the medical n							
2 Personal information												
How tall are you?				cm								
What do you weigh?				kg								
Do you smoke?				No	Yes							
				What do you	smoke?							
At what age did you start s	smoking?			How much d	o you smoke each day on average?							
Did you smoke in the past	?			No	Yes							
				What did you	ı smoke?							
At what age did you start s	smoking?			How much d	id you smoke each day?							
At what age did you stop	smoking?											
Do you drink alcohol?				No	Yes							
				Which drinks	?							
					did you start drinking? lasses do you drink on an kly basis?							
Have you ever drunk alcoh	iol?			No	Yes							
				Which drinks	?							
					did you start drinking?							
				average wee	•							
					did you stop drinking?							
Do you use drugs?				No	Yes							
				Which drugs	do you use?							
					did you start using drugs? o you use drugs on an kly basis?							
Have you ever used drugs	?			No	Yes							
				Which drugs	did you use?							
				At what age	did you start using drugs?							
				How often di average wee	d you use drugs on an kly basis?							
				At what age	did you stop using drugs?							
3 Your health												
Tick the box beside the letter if	you have or h	ave had one or more	e of th	ne following dis	orders, illnesses, complaints and/or ailment	S.						
Have you ticked the box beside mentioning doctors/specialists		•	•	* *	ndix to question 3 for each disorder, illness, onal disability.	complaint or ailment,						
Blad 2												

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		lso tick Yes if you:				
		ed or called a health care professional or doctor; itted to hospital, a psychiatric institution or any other nursing institution;				
- ha	ve und	ergone an operation; sing or have ever used medication;				
		nder medical supervision.				
	A	Disorder, illness or complaint related to the brains or nervous system, such as stroke, TIA, CVA, seizures, epilepsy, muscle diseases, inflammation of the optic nerve, headache, dizziness.				
	В	Disorder, illness or complaint related to mental health, such as depression, schizophrenia, psychosis, ADD, emotional exhaustion, overwork, anxiety disorders, insomnia, hyperventilation, burnout.				
	С	Disorder, illness or complaint related to the heart and blood vessels, such as heart attack, constriction or pain in the chest, high blood pressure, constriction or inflammation of the blood vessels, embolism.				
	D	Raised cholesterol, diabetes, thyroid gland disorders, gout, metabolic or storage disorders, hormonal disorders.				
	E	Disorder, illness or complaint related to the lungs or airways, such as asthma, COPD, shortness of breath, pleurisy, bronchitis, chronic cough, embolism.				
	F	Disorder, illness or complaint related to the oesophagus, stomach, bowels, liver, gallbladder, pancreas.				
	G	Disorder, illness or complaint related to the kidneys, bladder, urinary tract, reproductive organs.				
	Н	Tiredness complaints sleep apnoea syndrome, STDs (sexually transmitted diseases), HIV infection, other infectious diseases.				
	1	Benign or malignant swellings or tumours, malignant disease, cancer, blood disease, anaemia.				
	J	Disorder, illness or complaints related to the muscles, limbs or joints (including knee, hip, hands, shoulders), rheumatism (acute or chronic), poliomyelitis, child paralysis				
	K Disorder, illness or complaints related to the skin, varicose veins, leg ulcers, fistulas, thrombosis.					
	L Disorder, illness or complaints and/or ailments that do not fall under the above categories.					
Hav	e von a	answered Yes to one or more of the above questions?				
	No					
	Yes	Fill in a separate appendix to question 3 for each disorder, illness, complaint and/or ailment. This is important				
4 S	Signati	ire				
You		e as follows:				
		You have read the Explanation to the health declaration. This Explanation constitutes an integral part of this form. You have answered all the questions and your answers are true and complete, as are any appendices that you may add. Otherwise, any rights				
	•	You have read the Explanation to the health declaration. This Explanation constitutes an integral part of this form.				
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