ABN·AMRO

Health declaration for occupational disability insurance or life insurance that covers 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 an occupational disability insurance or for a life insurance policy that also covers occupational disability. 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 in the event of death;
- the insurer does not pay 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 have to provide a more detailed explanation. 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?

Last name		☐ Male ☐ Female
First name[1]		
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:	hours

Who is your general practitioner?

Name	
Address	
Post code	
Town/city	

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, place a tick here: ☐

Do you want to be the first to hear the recommendation?

You are entitled to be the first person to hear the medical recommendation. This is called 'the right of first notification'. It may then take a while longer before your insurance policy enters into effect. Please inform the insurer in writing if you want to be the first to hear the medical recommendation. You can read how to do this in the Explanation in the appendix.

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 smoking?		How much do you smoke each day on average?	
Did you smoke in the past?	☐ No ☐ Yes	What did you smoke?	
At what age did you start smoking?		How much did you smoke each day?	
At what age did you stop smoking?			
Do you drink alcohol?	☐ No ☐ Yes	Which drinks?	
		At what age did you start drinking?	
		How many glasses do you drink on an average weekly basis?	
Have you ever drunk alcohol?	☐ No ☐ Yes	Which drinks?	
		At what age did you start drinking?	
		How many glasses did you drink on an average weekly basis?	
		At what age did you stop drinking?	
Do you use drugs?	☐ No ☐ Yes	Which drugs do you use?	
		At what age did you start using drugs?	
		How often do you use drugs on an average weekly basis?	
Have you ever used drugs?	☐ No ☐ Yes	Which drugs did you use?	
		At what age did you start using drugs?	
		How often did you use drugs on an average weekly basis?	
		At what age did you stop using drugs?	

3 Your health

Cross the box beside the letter if you have or have had one or more of the following disorders, illnesses, complaints and/or ailments.

Have you placed a cross beside a letter? If so, please answer the questions in the appendix to question 3 for each disorder, illness, complaint or ailment, mentioning doctors/specialists that you have consulted, permanent injuries or occupational disability.

Note!
You must also cross Yes if you:
- have visited or called a health care professional or doctor;
- been admitted to hospital, a psychiatric institution or any other nursing institution;
- have undergone an operation;
- are still using or have ever used medication;
- are still under 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.

☐ **B** Disorder, illness or complaint related to mental health, such as depression, schizophrenia, psychosis, ADD, emotional exhaustion, overwork, anxiety disorders, insomnia, hyperventilation, burnout.

☐ **C** 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.

☐ **H** Tiredness complaints sleep apnoea syndrome, STDs (sexually transmitted diseases), HIV infection, other infectious diseases.

☐ **I** 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, pelvic instability or fibromyalgia. Crooked spine, back complaints, backache, lumbago, slipped disc or CANS (formerly known as RSI). You must also tick the box if you have ever broken a bone or child paralysis

☐ **K** Disorder, illness or complaints related to the skin, varicose veins, leg ulcers, fistulas, thrombosis.

☐ **L** Disorder, illness or complaints related to the nose, throat, sinuses, larynx or vocal cords, eyes or ears (such as a hearing complaint).

☐ **M** Disorder, illness or complaints and/or ailments that do not fall under the above categories.

Have you 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 Your work

a. Have you been absent from work for two weeks or longer during the past five years due to illness or accident?

Or have you only been able to work shorter hours?	
☐ No ☐ Yes	Please fill in:
For how long did you not work?	
Why did you not work?	
When did you not work?	
From	to
Are you currently working?	

b. Are you now able to work at full capacity?

☐ Yes

☐ No

Is this due to a disorder, illness or complaint or ailment?

☐ Yes

☐ No

If you crossed a disorder, illness, complaint or ailment when answering question 3, please fill in the following question

c. Are you or were you unable to perform specific aspects of your job due to the disorder, illness, complaint or ailment that you crossed when answering question 3?

☐ Yes

☐ No

Which aspect of your job are you/were you no longer able to do?	
Since when?	
Is this still the case?	☐ No ☐ Yes

5 Your glasses or contact lenses

Do you wear glasses or contact lenses stronger than -8? Or did you do so in the past?

☐ No

☐ Yes Fill in:

Strength of left lens _____ Strength of right lens _____

6 Signature

You declare 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 derived from this agreement may expire.
- The insurer will assess whether or not to accept your application, partly on the basis of the recommendation from the medical advisor. You consent to this. This applies to your current application for insurance, but the insurer will also use your answers if you apply for a similar type of insurance at a later date.

Place	
Date	
Your signature (or that of your parent or guardian if you are under 16 years of age	
Number of appendices	

Have you filled in the form completely and added your signature and the date?
Send the form to your insurer's medical advisor.

Please write Confidential on the envelope

Appendix

Appendix to question 3 of the health declaration

Name of insured person

Date of birth

Complaint

Letter that you crossed with a Yes in question 3:
Which disorder, illness, ailment or complaint are you or were you suffering from?
When did you develop it? Or during which period did you have it?

From To

General practitioner

Have you consulted a general practitioner about this in the past three years? ☐ No ☐ Yes
If so, when?
Are you still under medical supervision? ☐ No ☐ Yes
Do you still have complaints? ☐ No ☐ Yes

Doctor or healthcare professional

Have you seen a doctor or healthcare professional about this? ☐ No ☐ Yes

For example:
Medical specialist
Physiotherapist
Manual therapist
Health centre employee
Psychologist
Psychotherapist
Practitioner of complementary medicine, such as a homeopath or acupuncturist

If so, what is the name of the doctor or medical specialist?

What is their specialism?

When did you consult them?

Are you still under medical supervision? ☐ No ☐ Yes

Do you still have complaints? ☐ No ☐ Yes

Medicines

Has one of your doctors prescribed medicines for you? ☐ No ☐ Yes
If so, please state the medicines.

Are you still using them?

☐ Yes, in the following dosage:

☐ No, I stopped using them on:

Admission to hospital

Have you ever been admitted to a hospital, psychiatric institution, or another nursing institution? ☐ No ☐ Yes

If so, when were you admitted?

To which hospital?

Which doctor treated you?

What is their specialism?

Have you undergone an operation? ☐ No ☐ Yes

If so, when were you operated on?

In which hospital?

Which doctor treated you?

What are they specialised in?

Permanent effects after an accident

Is your disorder, illness, ailment or complaint the result of an accident? ☐ No ☐ Yes

If so, when did this accident occur?

What are the medical consequences?