Formular drucken

CONVITUS PERSONALVORSORGE MASSGESCHNEIDERT

Health Declaration

Last and First Name			
OASI Number			
Profession			
Date of Birth		◯ Male	◯ Female
Employer			
Pension Fund			

Important Information

Elips Life reserves the right to review the application for insurance coverage through a medical examination. If the following statements prove false or incomplete, the company has no obligation to provide benefits in case it withdraws from the contract within a period of four weeks after having taken notice of the concealment(s) of facts.

Authorization

I authorize Elips Life to process all data which the company receives due to the insurance agreement and to exchange all information necessary with reinsurance companies, other insurance companies, public authorities and other party. I thus release hospitals, physicians, public authorities, insurance companies and other insurance institutions from their professional discretion and authorize them to provide all necessary information to Elips Life or to its medical service.

Date Privacy Statement

Elips Life relies on an open, transparent and customer-friendly approach to data protection. It goes without saying that Elips Life will keep your data secure an handle it with strict confidentiality. Elips Life is very careful to ensure that the data protection requirements stipulated by law are met in full.

Place, Date

Signature of the person to be insured

CONVITUS PERSONALVORSORGE MASSGESCHNEIDERT

Health Declaration

Last and First Name: _____

Date of Birth: _____

1. Are you at present fully able to work? ◯ yes ◯ no

   If not, please indicate the degree of your inability to work _____ %

2. Hight _____ cm Weight _____ kg

3. Do you smoke? ◯ yes ◯ no

   If yes, kind of tobacco and daily amount _____

4. Do you drink alcohol (1 unit = 1dl wine, 3dl beer, 4cl spirit)? ◯ yes ◯ no

   If yes, weekly amount _____

5. Have you been absent from work for more then two consecutive weeks during the last 12 months due to illness or accident? ◯ yes ◯ no

   If yes, why? _____

6a. Have you been under medical treatment in a hospital, sanatorium or similar institution during the last five years or is a clinical treatment planned? ◯ yes ◯ no

6b. Do you suffer or have you suffered from any serious illness or disorders (physical, mental or psychic) during the last five years? Do you suffer from long term consequences of an accident, an illness or a physical infirmity (p.ex. ankylosis, limb loss, bone anchorage, etc.)? ◯ yes ◯ no

If 6a. and/or 6b. yes, please furnish the detailed information on:

Nature of illness/accident and treatement	From	To	Doctor, hospital (with address and department)

7. Have you ever received abnormal results regarding a medical examination: X-Ray, ECG, AIDS test, urinanalysis or blood test or other specific medical examinations? ◯ yes ◯ no

   If yes, which? _____

8. Are you taking or did you have to take prescription drugs regulary? ◯ yes ◯ no

   If yes, which ones? _____

   Attending physician: _____

9. Have you ever applied for insurance coverage that was declined or modified (p.ex. additional premium, reduction of the insurance period, reduction of coverage)? ◯ yes ◯ no

   If yes, why? _____

10. Do you currently and at the inception date claim or receive benefits from the Invalidity Insurance, the Military Insurance or from an Insurance Company (please attach a copy of existing decisions)? ◯ yes ◯ no

    If yes, why? _____

11. Who is your family doctor

    Name, address, phone: _____

    Name, address, phone: _____

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Place, Date

_____

_____

Signature of the person to be insured