

## Supplementary Health Insurance Medical Questionnaire

Individual subscriber: Name - First name

Person to be insured: Name - First name

Address

Date of birth (d - m - y)

Sex M F

Organisation or institution

Nationality

### I. Please provide us with the following information

- your blood pressure (if known) max min

- your weight (kg) height (cm)

### 2. Describe your actual state of health

3. Do you suffer from any chronic, mental or physical disabilities? Yes No

If so, please specify.

Do you benefit from a 100% reimbursement by the JSIS? Yes No

If so, based on which pathology?

### 4. Have you undergone a surgical intervention or medical treatment (in the past 10 years)?

Yes No

If so, please indicate the date(s), the nature of the intervention or the treatment and the consequences for your state of health.

### 5. In the following 6 months, do you need

- to be hospitalised? Yes, indicate the reason

No

- to undergo a surgical intervention? Yes, describe the nature of the intervention and the diagnosis below.

No

6. Are you being medically treated at this moment (medicinal or other)? Yes No

If so, please specify treatment and reason.

