vidanova
PENSION FUND

Abbreviated health declaration

for life insurance purposes

1 General information

Name of the insured ______________________ Date of birth ______________

Gender ☐ Male ☐ Female

General practitioner ______________________ Address practitioner ______________________

2 Personal information

Wat is your height? _______ cm

Wat is your weight? _______ kg

Do you smoke? ☐ No ☐ Yes

Since when and how many cigarettes per day?
Since________________,__________cig. per day

Do you use drugs or have you used drugs? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes,___glasses per day

3 Your state of health

Do you suffer or have you suffered from one or more of the following conditions, diseases and/or disabilities (this also includes complaints)?

NB!
You must also check "Yes" if you:
- *has consulted a general practitioner, care provider or doctor;*
- *have been admitted to a hospital, sanatorium, psychiatric institution or other nursing facility;*
- *have had surgery;*
- *still taking medication or have taken medication;*
- *is still under control.*

A.	diseases of the brain or nerves, such as stroke, seizures, muscle diseases?	☐ No ☐ Yes
B.	disorders or complaints of a psychological nature?	☐ No ☐ Yes
C.	increased blood pressure, tightness or pain in the chest, palpitations, diseases of the heart or blood vessels?	☐ No ☐ Yes
D.	increased cholesterol, diabetes?	☐ No ☐ Yes
E.	diseases of the lungs or respiratory tract?	☐ No ☐ Yes
F.	disorders of esophagus, stomach, intestines, liver, gallbladder, pancreas?	☐ No ☐ Yes
G.	disorders of kidneys, bladder, urinary tract, genital organs?	☐ No ☐ Yes
H.	malignancies, tumors?	☐ No ☐ Yes
I.	blood disease, thrombosis, embolism, metabolic diseases?	☐ No ☐ Yes
J.	diseases, conditions and/or defects (this also includes complaints) that cannot be placed under the above categories?	☐ No ☐ Yes

Have you checked "Yes" one or more times above? ☐ No ☐ Yes
If so, please also complete the attachment.

4 Blood tests

Has your blood ever been tested for anemia, for example. ☐ No ☐ Yes
If so, what was your blood tested for?

Blood disease, diabetes, kidney disease, fat content (for example cholesterol) or jaundice (hepatitis)? ______________________

With what result? ☐ Good ☐ Deviant

Explanation: ______________________

4 AIDS/ HIV

Do you have AIDS? ☐ No ☐ Yes

Have HIV antibodies been detected in your blood (are you seropositive)? ☐ No ☐ Yes

Have you used intravenous drugs in the past 5 years? ☐ No ☐ Yes
If so, have you always used sterile equipment (needles and syringes)? ☐ No ☐ Yes

vidanova
PENSION FUND

Are you currently, or have you been treated in the past 5 years, for a sexually transmitted disease? ☐ No ☐ Yes
If so, which condition? ____

The answers you provide may give rise to a request for further information.

The undersigned declares that the answers to the above questions and any attached attachment(s) have been given by him/her and have been stated truthfully and completely, that he/she is aware that an inaccuracy or incompleteness in this health declaration may lead to forfeiture of the rights under the agreement and that he/she has no objection to the use of medical data for the acceptance of the insurance(s) applied for with the associated application form.

Place: ______________________ **Date:** ___________________ **Signature:** ______________________________

vidanova PENSION FUND

Appendix to question 3 of the abbreviated health declaration

Complete this appendix for each category that you answered "Yes" to question 3.
Do you have more than one condition? Then request an extra attachment.

Name of the insured________________________________ Date of birth ____________________________

Letter of the category you answered "Yes" to question 3: _______

Which condition, disease, defect or complaint included
are you suffering or have suffered? ____

In what period(s) did you have or had this condition, illness or disability?
or complaint included? ____________________to ________________________

General practitioner

Have you consulted a doctor for this in the last 3 years?

☐ No
☐ Yes ⇒ When did you visit your GP? _________________
Are you still under control? ☐ No ☐ Yes

Doctor or care provider

Have you consulted one of the following doctors or care providers for this: *medical specialist, physiotherapist, manual therapist, clinic employee, psychologist, psychotherapist, practitioner of alternative medicine such as homeopathy, acupuncture*?

☐ No
☐ Yes ⇒ Which doctor or care provider did you visit
(name and specialty) ___________________________
When did you visit this doctor or
care provider? __________________
Are you still under control? ☐ No ☐ Yes
Do you still have complaints? ☐ No ☐ Yes

Medicines

Has one of your doctors prescribed medication
For this?

☐ No
☐ Yes ⇒ What medications have been prescribed?
____
Are you still using this? ☐ Yes ⇒ In what dosage?
____
☐ No ⇒ Since when did you stop?
____

Hospital admission

Have you been admitted to a hospital, sanatorium, psychiatric institution or other Nursing facility for this?

☐ No
☐ Yes ⇒ When were you admitted? ___________________
In which hospital? ______________________________
Which doctor treated you?
(name and specialty)? ___________________________
____

Have you had surgery?

☐ No
☐ Yes ⇒ When did you have surgery? __________________
In which hospital? ______________________________
Which doctor treated you?
(name and specialty)? ___________________________
____

vidanova
PENSION FUND

Lasting consequences after an accident

Is this condition, disease or defect, as well as complaint the result of an accident that has left you with permanent physical or psychological consequences ?

☐ No

☐ Yes When did this accident happen? ________________

What are the medical consequences? ______________

____

____