Health Questionnaire

Adeslas

DO NOT WRITE IN THE SHADED BOXES

PERSONAL DATA OF THE APPLICANT

Name and surnames _____ Tax ID No. _____

DETAILS OF THE PERSON TO BE INSURED (*)

Name and surnames _____ Tax ID No. _____

Age _____ Gender _____ Weight _____ Height _____ Relationship with the applicant _____ Order no. _____

(*) In the case of a minor or disabled person, this questionnaire will be filled in by the legal representative

DETAILS OF THE LEGAL REPRESENTATIVE

Name and surnames _____ Tax ID No. _____

HEALTH-RELATED INFORMATION

Num.	QUESTION	ANSWER	OBSERVATIONS
1	Do you suffer or have you suffered any illness in the last five years?	Yes ☐ No ☐	Please specify which, date, treatment and evolution
	Have the illnesses you have suffered until now left any lesions or sequelae?	Yes ☐ No ☐	Please specify
2	Have you been operated on or admitted into hospital at any time?	Yes ☐ No ☐	Please specify date and reason
3	At what date and for what reason did you visit the doctor the last time?	DATE …….../…….../…….	Reason Please specify speciality and next date for visit
4	Have you suffered or do you suffer any physical defect, deformity, disability or congenital lesion?	Yes ☐ No ☐	Please specify which, date, treatment and evolution
5	Have you suffered any o traumatism or accident?	Yes ☐ No ☐	Please specify date, treatment and sequelae
6	Are you currently under medical control or following any kind of treatme nt?	Yes ☐ No ☐	Please specify which
	From what you know about your current state of health:		
	a) Do you know whether you will need any study or treatment within the next year?	Yes ☐ No ☐	Please specify which
	b) Will you need to be admitted into hospital within that time period?	Yes ☐ No ☐	Please state the reason
7	Are you or have you been a smoker?	Yes ☐ No ☐	Please specify amount per day
	Do you consume or have you consumed alcoholic drinks regularly?	Yes ☐ No ☐	Please specify amount per day and type of drinks
	Do you consume or have you consumed narcotics?	Yes ☐ No ☐	Please specify the type of products

The undersigned states, under their responsibility, that their answers to the questions made are truthful and complete, authorising SegurCaixa Adeslas to undertake any verification deemed convenient on the origin and evolution of the illnesses or ailments that may, given the case, require assistance under this Policy. The undersigned authorises the Company, if any illness has been suffered, to contact the intervening doctors.

SegurCaixa Adeslas may reach a decision on the Policy within a month from the time it knows of the deponent's reservations or inaccuracies in filling in the questionnaire, although this right can not be based on the Insurer's lack of knowledge on the Policy Holder's state of health information that is not included in the above questions.

If fraud or serious fault exits in filling in this questionnaire, SegurCaixa Adeslas shall in any case and from now on be freed of the obligations established for it by the insurance policy (Art. 10 Law on Insurance Contracts)

Date _____ Signature _____

OBSERVATIONS

Date	Accepted	Rejected	Delegation	Application Number

SegurCaixa Adeslas, S.A. de Seguros y Reaseguros, as the data processing controller, shall process the provided personal data to carry out a risk assessment in compliance with the provisions of the Insurance Contract Act. The data provided shall not be assigned to third parties. You can find more information about the data protection policy of SegurCaixa Adeslas, and especially how to exercise your rights of access, rectification, deletion and others, on the following web page: www.segurcaixaadeslas.es/es/proteccion-de-datos

The Insurer SegurCaixa Adeslas, S.A. de Seguros y Reaseguros - Paseo de la Castellana, 259 C (Torre de Cristal), 28046 Madrid (Spain). Registered in the Commercial Registry of Madrid, book 36733, sheet 213, page M-658265. VAT No.: A28011864.

S.AS.F.001/09

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