PATRIMONIA PREVOYANCE MODERNE

Confidential/Private
Fondation Patrimonia
To the medical advisor
Rue Saint-Martin 7
1003 Lausanne

Detailed Health Assessment Questionnaire

In order to protect the confidentiality of the information contained in this document, we would be grateful if you could return it directly to our Medical Advisor at the above address.

To be completed if you have answered yes to one of the 4 questions in the Entry Declaration

Company / branch: _____

Personal data of the insured person

Gender: ❑ Male ❑ Female

Surname: _____

Forename: _____

Date of birth: _____ / _____ / _____

Address: _____

_____

Questionnaire on your state of health

Please answer each of the questions below separately, accurately and completely:

❶ Are you completely fit for work at present? ❑ Yes ❑ No
Are you perfectly healthy at present? ❑ Yes ❑ No

❷ Are you physically disabled as a result of the loss, inability to use or functional disorders of any of your limbs or organs? ❑ Yes ❑ No

❸ Are you taking medication? ❑ Yes ❑ No
Which ones? _____
What for? _____
How often? _____

❹ Are you currently receiving medical treatment? ❑ Yes ❑ No

❺ Do you consume or have you ever consumed drugs (narcotics, alcohol)? ❑ Yes ❑ No

❻ Have you suffered from cardiovascular disease, high blood pressure, tuberculosis, respiratory diseases, ulcers, cancer, albuminuria, diabetes, kidney, stomach, gall bladder or liver infections, joint or back pain, epilepsy, depression or neurological disorders, vision or hearing problems during the last 10 years? ❑ Yes ❑ No

Patrimonia Foundation

Adress of Headquarters :
Le Lumion
Route François-Peyrot 14
CH-1215 Geneva 15
www.patrimonia.ch
info@patrimonia.ch

Mailing address :
Branch of Lausanne
Rue Saint-Martin 7
CH-1003 Lausanne
T.main number +41 58 806 0800

❼ Have you been unfit for work for more than 4 weeks due to illness or accident during the last 10 years?

❑ Yes ❑ No

❽ Do you have or have you had any diseases or disorders of the immune system or infectious disease such as AIDS, HIV infections, sexually transmitted infections, hepatitis, tropical diseases or others? ❑ Yes ❑ No

❾ Has an application for insurance, affiliation to a health insurance scheme or an extension to insurance cover ever been deferred, refused or subjected to stricter conditions? ❑ Yes ❑ No

When? _____ Why? _____

At which company? _____

If you have answered one of questions 2-9 in the affirmative or if you have a medical condition that you have not mentioned, please provide the following information:

Question no.	Type of illness, injury, disability, what operation?	Date, duration? Recovery? After-effects?	Treating physicians, hospitals (address of the treating physician at the hospital/department)

Observations

_____

_____

_____

Declarations

I authorise all the doctors, hospitals and other institutions to provide, for the purposes of this insurance, information about my state of health to the medical department of the insurer and consent to the use of these data to the extent that is necessary to determine the risk. The questions must be answered completely and truthfully. If important facts concerning the risk have been concealed or incorrectly stated, the insurer is entitled to withdraw from the contract.

Place and date:

Signature of the policyholder (or the legal representative):

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