médis

Holder's Médis Number:

☐☐☐☐☐☐☐☐☐ ☐☐

Full name of insured Person: _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

Sex: F ☐ M ☐

Individual Medical Questionnaire

Address: _____

Postcode: _____ City: _____

IBAN: ☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ Taxpayer No: ☐☐☐☐☐☐☐☐☐

Insurance Policy Holder (For Company/Group, fill in respective name): _____

Insurance Holder: _____

Policy No: _____ Employee No: _____ Date of Inclusion: ☐☐☐☐☐☐☐☐

Degree of Kinship: Holder ☐ Spouse ☐ Descendant ☐ Ascendant ☐ Other ☐

Document filing is mandatory

Very Important: Make sure you answer all questions with YES or NO by marking the desired answer with a cross. Whenever you answer YES, please describe the situation in as much detail as possible. The incomplete completion of this questionnaire will determine that it will not be accepted and will give rise to a request for clarification that may considerably delay the analysis and final decision by the Insurer's Medical Directorate. This questionnaire is an integral part of the Insurance Proposal and will also include the Insurance Agreement that will be concluded. For this reason, we draw your attention to the provisions of the Legal Regime of the Insurance Contract, approved by Decree-Law No. 72/2008 of April 16, which determines, for the Policyholder or Insured, the duty, prior to the conclusion of the contract, to declare accurately all the circumstances that it knows and reasonably must have significant for the assessment of the risk by the Insurer, even those whose mention is not requested in questionnaires provided by the Insurer. Failure to comply with this duty may result, among other consequences, in the immediate termination of the insurance contract, the loss of any premium paid and the non-liability of the Insurer for the coverage of claims and the consequent payment of compensation.

Biometrics Indicators and habits

Height (m, cm) ☐☐☐ Weight (Kg) ☐☐☐ Blood Pressure ☐☐☐ max ☐☐ min

Do you drink alcohol? Yes ☐ No ☐ If yes indicate daily consumption? _____

What do you drink? _____

Do you smoke? Yes ☐ No ☐ If yes, indicate the number of cigarettes per day? _____

How long have you smoked (years)? _____

Personal Background – Do you have ever been diagnosed with any of the following diseases?

A - Cardiovascular Diseases? Yes ● No ● If Yes, which

- ☐ Cardiac Insufficiency (1)
- ☐ Pericarditis (1)
- ☐ Thrombophlebitis (1)
- ☐ Hypertension (1)
- ☐ Infarction or Angina Pectoris (1)
- ☐ Valve Diseases (1)
- ☐ Endocarditis (1)
- ☐ Other _____
- ☐ Arrhythmias or Blocks / Pacemaker
- ☐ Miocardiopathy (1)
- ☐ Varicose Veins

B – Respiratory Diseases ? Yes ● No ● If Yes, which

- ☐ Respiratory Insufficiency(1)
- ☐ Chronic Bronchitis(1)
- ☐ Bronchiectasis(1)
- ☐ Pneumotorax(1)
- ☐ Respiratory Allergic Diseases
- ☐ Emphysema(1)
- ☐ Pulmonary Fibrosis(1)
- ☐ Other _____
- ☐ Asthma(1)
- ☐ Pulmonary Tuberculosis(1)
- ☐ Pleurisy(1)

C – Digestive Tract Diseases? Yes ● No ● If Yes, which

- ☐ Oesophageal Diseases(1)
- ☐ Gastro Duodenal Ulcer
- ☐ Crohn's Disease(1)
- ☐ Inguinal Hernia
- ☐ Hiatus Hernia
- ☐ Diverticulosis
- ☐ Ulcerative Colitis(1)
- ☐ Digestive Haemorrhage(1)
- ☐ Chronic Gastritis
- ☐ Intestinal Polyps(1)
- ☐ Haemorrhoids
- ☐ Other _____

D –Diseases of Liver, Bile Ducts and Pancreas? Yes ● No ● If Yes, which

- ☐ Chronic Liver Disease or Cirrhosis(1)
- ☐ Pancreatitis(1)
- ☐ Other _____
- ☐ Hepatitis B, C, D or E(1)
- ☐ Gallstones

E –Genitourinary Diseases? Yes ● No ● If Yes, which

- ☐ Renal insufficiency(1)
- ☐ Chronic Nephritis(1)
- ☐ Prostate Disease(1)
- ☐ Hemodialysis
- ☐ Kidney Stones
- ☐ Male infertility
- ☐ Renal Transplant
- ☐ Urinary Tract Disease(1)
- ☐ Other _____

Personal Background – Do you have or have you ever been diagnosed with any of the following diseases? (Cont)

F – Bone, Musculoskeletal and Connective Tissue Diseases ?	**Yes** ●	**No** ●	**If Yes, which**	
☐ Polymyositis (Dermatomyositis)(1)	☐ Spondylosis		☐ Kyphosis	☐ Sciatica
☐ Anakylosing Spondylitis(1)	☐ Disk Herniation		☐ Painful Shoulder(1)	☐ Rheumatoid Arthritis(1)
☐ Systemic Sclerosis (Dermatosclerosis)(1)	☐ Scoliosis		☐ Low Back Pain	☐ Fractures(2)
☐ Systemic Lupus Erythematosus(1)	☐ Arthritis		☐ Osteoporosis	☐ Other _____

G – Skin Diseases ?	**Yes** ●	**No** ●	**If Yes, which**
☐ Contact Dermatitis	☐ Seborrhoeal Eczema		☐ Acne
☐ Atopic Dermatitis	☐ Fungal Infection of the Skin		☐ Urticaria / Angioedema
☐ Stasis Dermatitis / Leg Varicose Ulcer	☐ Psoriasis		☐ Other _____

H - Nervous System diaseses?	**Yes** ●	**No** ●	**If Yes, which**	
☐ Depression	☐ Multiple sclerosis(1)		☐ Scizophrenia(1)	☐ Other _____
☐ Parkinson Diseases(1)	☐ Epilepsy(1)		☐ Bipolar Disorder(1)	
☐ Thrombosis / Cerebrovascular Accident	☐ Dementia(1)		☐ Cranial or Spinal Cord Trauma(3)	

I - Blood Diseases?	**Yes** ●	**No** ●	**If Yes, which**	
☐ Anaemia(1)	☐ Leukaemia (Acute / Cronic)(1)		☐ Multiple myeloma(1)	☐ Haemophilia(1)
☐ Lymphoma (Hodgkin's / Non-Hodgkin's)(1)	☐ Myelodysplasia(1)		☐ Pupura (1)	☐ Other _____

J - Endocrine Diseases?	**Yes** ●	**No** ●	**If Yes, which**	
☐ Tyroide Disease(1)	☐ Hypophiseal Tumor(1)		☐ Diabetes Mellitus Type 2	☐ Other _____
☐ Adrenal Disease(1)	☐ Diabetes Mellitus Type 1(1)		☐ Nervous Anorexia(1)	

K - Metabolic Disorders?	**Yes** ●	**No** ●	**If Yes, which**	
☐ Increase Uric Acid (Gout)	☐ Increase Triglycerides		☐ Increase Cholesterol	☐ Other _____

Personal Background – Do you have or have you ever been diagnosed with any of the following diseases? (Cont)

L - Eye Diseases? Yes ● No ● If Yes, which

- ☐ Impaired Visual Acuity / Use of Graduated Spectacles or Contact Lenses (Myopia, Astigmatism, Hyperopia)
- ☐ Strabismus
- ☐ Retinal Diseases
- ☐ Cataract
- ☐ Glaucoma
- ☐ Other _____

M - Ear, Nose and Troat Diseases ? Yes ● No ● If Yes, which

- ☐ Repeating or Chronic Otitis Atopic
- ☐ Sinusitis
- ☐ Recurring Tonsillitis and Adenoiditis
- ☐ Dizziness
- ☐ Nasal Septum Deviation
- ☐ Impaired Hearing / Use of Hearing Aids
- ☐ Others _____

N – Gynaecological Disorders? Yes ● No ● If Yes, which

- ☐ Benign Breast Nodes
- ☐ Uterine Tumour (Benign)(1)
- ☐ Endometriosis
- ☐ Adnexal Tumour (Benign)(1)
- ☐ Uterine Prolapse
- ☐ Female Infertility
- ☐ Others _____

O – Infectious Diseases? Yes ● No ● If Yes, which

- ☐ HIV or AIDS Carrier(1)
- ☐ Syphilis
- ☐ Tuberculosis of the Lymphatic Glands, Kidney or Another Organ(1)
- ☐ Others _____

P – Neoplasias? Yes ● No ● If Yes, which

- ☐ Lung (1)
- ☐ Stomach (1)
- ☐ Kidney (1)
- ☐ Uterus (1)
- ☐ Colon (1)
- ☐ Breast (1)
- ☐ Thyroid
- ☐ Prostate (1)
- ☐ Skin (1)
- ☐ Other _____

Q – Congenital Diseases? Yes ● No ● If Yes, which

- ☐ Cardiac
- ☐ Renal
- ☐ Pulmonary
- ☐ Digestive
- ☐ Neurological
- ☐ Other _____

If you have marked any disease up to this point, please indicate _____

Personal Background – Do you have or have you ever been diagnosed with any of the following diseases?

Clarifications / Further information

1. **In points "A, B, C, D, E, F, H, I, J, N, O and P", for diseases marked with (1), please indicate:**

   Year of appearance:_____ Duration_____ Examinations performed and treatment:_____

   Describe the situation:_____

2. **If you have marked the option "Fractures", in point "F", please indicate:**
   Location of the fracture_____ Treatment:_____

   Sequels:_____

3. **If you have marked the option "Cranial or Spinal Cord Trauma", in point "H", please indicate:**
   If you have neurological sequels:_____

   If you have marked the option "Other", please indicate: Which:_____
   Year of appearance_____ Duration_____
   Examinations performed and treatment:
   Describe the situation:_____

Family Background

Have any of your Parents or Siblings already died? ☐ Yes ☐ No

If Yes, which: ☐ Father ☐ Mother ☐ Sibling Age(s) _____

Specify the cause(s): _____

Does anyone in your Family suffer from a Serious and / or Chronic Disease? ☐ Yes ☐ No

If Yes, which: _____

DECLARATIONS, DATE AND SIGNATURES

Authorisation to collect personal data:

I authorize the Insurance Company to collect personal data relative to my state of health from medical doctors or other health professionals and from public or private entities such as hospitals, clinics, health centers and forensic medicine institutes, including after my death, with a view to confirming or to complement the information provided on after subscription contract, for the purpose of assessing the insurance subscription risk or management of the subsequent contractual relationship, namely for the purpose of determining the origin, cause and evolution of any disease and I understand that this authorisation is essential for the conclusion and operation of this insurance contract.

Autorisation to process personal data:

I authorise the Insurance Company to process the personal data provided, as well as the information collected from other entities, with a view to managing the contractual relationship, without prejudice to the right to consult, amend or delete said data by written communication addressed to the Insurance Company responsible for their processing.

I authorise the medical doctors and other health care providers I may use, within the scope of the insurance contract, to provide to the clinical services of the Insurance Company and receive from them any information related to the services provided and covered by the professional secrecy, as well as its processing.

I authorise the recording of telephone conversations undertaken within the scope of the insurance contract, for the purpose of management of the contractual relationship.

I also authorise the information relative to the benefit statement, containing information relative to the health care provider, date on which the medical act was performed and the value of the expenses incurred, to the Policy Holder.

_____ / / _____	_____
Location and date	The Insured Person

The present document is a translation of the Portuguese version. In case of discrepancy between the versions, the Portuguese version shall prevail. Does not exempt consultation of the legally required pre-contractual and contractual information.

Insurance Intermediary: Banco Comercial Português, S.A. - Registered Office: Praça D. João I, nº 28, 4000-295 Porto – Share Capital 3.000.000.000 Euros – Single registration and TIN 501525882. Insurance agent, registered under nr. 419527602, with the Insurance and Pension Funds Supervision Authority - Registration Date: 21/01/2019. Authorisation for the brokerage distribution of the life and non-life insurance - Ocidental - Companhia Portuguesa de Seguros de Vida, S.A., Ageas Portugal - Companhia de Seguros, S.A. and Médis - Companhia Portuguesa de Seguros de Saúde, S.A. and Ageas – Sociedade Gestora de Fundos de Pensões S.A.. For information and further registration details, please consult: www.asf.com.pt. The Insurance Intermediary is not authorised to sign insurance contracts on behalf of the Insurer or receive any insurance premiums payable to the Insurer. The Insurance Intermediary does not assume liability regarding any risks covered by the insurance contract, which shall be fully assumed by the Insurer.

Insurer: Ageas Portugal – Companhia de Seguros, S.A. Head office: Praça Príncipe Perfeito 2, 1990-278 Lisboa. Tax number 503 454 109. Comercial Registry Office of Porto. Share Capital of 7.500.000 Euros. ASF Register 1129, www.asf.com.pt

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