

Medical Questionnaire B

(Please use block letters)

Please read the information regarding the underwriting conditions on page 3 before completing this "Medical Questionnaire B".

For administration use

Ref.	<input type="text"/>	Policy number	<input type="text"/>	-	<input type="text"/>
Date	<input type="text"/>	#	<input type="text"/>	<input type="text"/>	<input type="text"/>

Applicant (Please underline the names you wish to be indicated on your insurance card. Max. 28 fields)

First name(s)	<input type="text"/>																											
Family name(s)	<input type="text"/>																											
Occupation	<input type="text"/>																											
Date of birth (day/month/year)	<input type="text"/>	Nationality	<input type="text"/>																									
Age	<input type="text"/>	Sex (M/F)	<input type="text"/>	Height (cm)	<input type="text"/>	Weight (kg)	<input type="text"/>																					
				Height (inch)	<input type="text"/>	Weight (pounds)	<input type="text"/>																					

Other insurance

Do you have a health insurance with another company?	YES <input type="radio"/>	NO <input type="radio"/>																										
Company name	<input type="text"/>																											
Policy number	<input type="text"/>																											
Do you intend to continue being insured with the other company?	YES <input type="radio"/>	NO <input type="radio"/>																										
Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates?	YES <input type="radio"/>	NO <input type="radio"/>																										
If yes, please enclose complete information.																												

Policy number

--	--	--	--	--	--	--	--

--	--	--	--	--	--

Medical history

If you have or previously have had any of the following illnesses/disorders, please tick the appropriate box and provide details.
If you have any additional comments, please state details under "Further remarks" (question 8). All questions must be answered.

a) Tumours: Benign Malignant NO

Details: _____

b) Migraine Neurological Disorders Epilepsy NO

Details: _____

c) Mental illnesses NO

Details: _____

d) Eye diseases NO

Details: _____

e) Asthma Allergies Pulmonary Diseases NO

Details: _____

f) Cardiovascular Diseases Arterial Hypertension NO

Details: _____

g) Liver Diseases Pancreas Diseases NO

Stomach Diseases Intestinal Diseases

Details: _____

h) Diabetes Other Hormone Diseases NO

Details: _____

i) Urinary Tract and Kidney Diseases Diseases of the Sexual Organs NO

Details: _____

j) Rheumatism Muscle, Joint or Bone Diseases NO

Details: _____

k) Back Problems NO

Details: _____

l) Skin Diseases NO

Details: _____

m) Cosmetic Operations NO

Details: _____

n) Any other diseases, disorders, illnesses NO

Details: _____

o) Have you ever had any fertility treatment? YES NO

Details: _____

p) Have you ever been tested for HIV-antibodies? YES NO

If yes, what was the result? HIV-positive HIV-negative

Policy number

--	--	--	--	--	--	--	--

--	--	--	--

Applicant's signature

Your declaration

Claims and other benefits may not be payable, if you do not fully disclose any material fact which could influence our assessment and acceptance of this application, and if you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters.

If your health changes after the application has been signed but before Bupa Insurance Limited ("ihi Bupa") has approved the insurance, you must notify ihi Bupa immediately of such change. You may be required to provide ihi Bupa with medical reports in relation to this and any other pre-existing conditions.

In view of the following declaration, it is essential that complete information is supplied.

I declare that to the best of my knowledge and belief the information given by me is true and complete, and that, apart from the conditions fully disclosed to ihi Bupa, I and any children to be insured on my policy ("dependants") are in excellent health and do not suffer or have suffered from any recurring illness or physical debility. If insurance for dental treatment is required, neither myself nor my dependants are under or about to undergo dental treatment.

I declare that I (on my and my dependants' behalf) have read the Policy Conditions and this Medical Questionnaire B, and accept that the Policy Conditions together with the Policy Schedule (and the application forms) will represent the insurance contract with ihi Bupa. I also declare that I and my dependants do not have a permanent residency in the U.S.

I confirm that I (on my and my dependants' behalf) have read the Data Protection Notice below, and give explicit consent for ihi Bupa to use my and my dependants' personal information in the manner and for the purposes stated.

Data Protection Notice

Purpose: Personal data collected about you and your dependants will be used by ihi Bupa to process your claims, collect premium, provide reimbursements, administer your policy and to detect and prevent fraud or improper claims. If ihi Bupa does not accept your application, your information may be recorded by us.

Confidentiality: ihi Bupa complies with applicable data protection legislation and medical confidentiality guidelines. All correspondence concerning your policy will be sent to the policyholder. All insured persons on the policy may have access to correspondence and other information sent by ihi Bupa or accessed at www.ihi.com via the myPage login. ihi Bupa uses third parties to process data on its behalf and your data may be processed in or outside the EU. ihi Bupa may exchange your information within the Bupa group and with your intermediary.

Medical information: ihi Bupa may seek and exchange information about your and your dependants' health and treatment with those involved in your and your dependants' care (including your treating doctor and hospital) and their agents, and, if applicable, any person or organisation who may be responsible for meeting your and your dependants' treatment expenses, or their agents, as ihi Bupa deems necessary.

Telephone calls: In the interest of continuously improving our service to customers, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by ihi Bupa, or disclosed to others, for research or statistical purposes.

Fraud: Information, including recorded telephone calls, may be disclosed to others with a view to preventing or detecting fraudulent or improper claims.

Names and addresses: ihi Bupa does not make the names and addresses of customers available to other organisations (except as stated above).

Keeping you informed: ihi Bupa will, on occasion, keep you informed of its products and services which it considers may be of interest to you. Data protection legislation gives you the right to see documents and information ihi Bupa has recorded about you.

Contact address: If you do not wish to receive information about our products and services, or would like to see a copy of the information we hold about you, please write to the Bupa Group Information Protection Manager at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, England or at DataProtection@Bupa.com.

Date (day/month/year) _____ **Signature** _____

