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Helsana

Health declaration for Helsana Business Salary/Accident

☐ New contract
☐ Policy changes

Firm

Postcode, town

Contract no. | Beginning | Grouping

Person to be insured | Surname, first name

☐ male ☐ female | Street, no.

Date of birth | Postcode, town

Income to be insured | CHF | per year

Requested insurance cover | ☐ Illness | ☐ Accident

Each of the following questions must be answered personally by the applicant or their legal representative. The person to be insured can submit the completed form in a sealed envelope to the above-mentioned Helsana general agency for the attention of the medical risk assessment.

1 Have you taken out other insurances for loss of salary (daily allowance) in case of incapacity to work? ☐ Yes ☐ No
If yes:

Insurer (except SUVA/UVG)		Amount in CHF	
	☐ Accident ☐ Illness		☐ per day ☐ monthly ☐ yearly
	☐ Accident ☐ Illness		☐ per day ☐ monthly ☐ yearly

Questions on illness and accident cover

2 a) Occupation in the above-mentioned firm | Which one?

Working hours h per week | Income CHF ☐ monthly ☐ yearly

b) Present gainful employment/unemployment | Which one?

Income CHF ☐ monthly ☐ yearly

c) Other gainful employment | Which one?

Working hours h per week | Income CHF ☐ monthly ☐ yearly

d) Do you practice any sports? ☐ Yes ☐ No

If yes, what kind?

e) In your spare time, are you subject to any danger* or do you practice any sports agonistically? ☐ Yes ☐ No

*e.g. motor sports, paragliding, parachuting, mountaineering, canyoning

If yes, which ones?

3 a) Are you unable or unfit to work? ☐ Yes ☐ No

If yes, to which extent (degree)? %

b) Did you have to interrupt your occupation (work/housework/education) for a period of longer than 3 weeks during the past 5 years? ☐ Yes ☐ No

If yes, please describe in question 11.

c) Do you have a disability or congenital defect or do you draw an annuity or daily allowance? ☐ Yes ☐ No
(e.g. from IV, MV, SUVA/UVG or other insurances)

If yes, which ones?

Since when? | Disability degree:

4 In the past 5 years, did you have an accident and/or do you still suffer from any consequences of an accident? ☐ Yes ☐ No

If yes, please describe in question 11.

Please see overleaf

5 Are you infected with HIV? ☐ Yes ☐ No

6 a) Do you or did you drink alcohol regularly*? ☐ Yes ☐ No
*more than 0.5 l wine or 1 l beer or 1.5 dl spirits per day

b) Do you smoke more than 20 cigarettes, 6 cigars or 4 pipes per day? ☐ Yes ☐ No

c) Do you or did you take drugs? ☐ Yes ☐ No

If yes, which ones?

How often? from to

7 Do you take/did you take medication* regularly or were you prescribed to take any during the past 10 yearst? ☐ Yes ☐ No
*except birth control pill

If yes, which ones?

from to

8 Physique Height (cm) Weight (kg)

Questions on illness cover

(If you are applying only for accident cover, you can skip the questions on illness cover.)

9 a) Are you receiving medical treatment/examination at the moment (physician, naturopath or therapist) or is it under consideration? ☐ Yes ☐ No

If yes, why?

b) Have you ever been advised to have a medical check-up/examination and not done so? ☐ Yes ☐ No

If yes, why?

10 In the last 10 years, have you had any medical/naturopathic/therapeutic treatment/check-ups/examinations either as an in- or outpatient for any physical or mental problems?

For example because of illness or disorder:

a) of the respiratory system? ☐ Yes ☐ No
b) of the heart, the blood vessels or the cardiovascular system? ☐ Yes ☐ No
c) of the brain or nervous system? ☐ Yes ☐ No
d) of the digestive system? ☐ Yes ☐ No
e) of the urinary tract or reproductive organs? ☐ Yes ☐ No
f) of the skin or allergies? ☐ Yes ☐ No
g) of the muscles, bones, joints or spinal column? ☐ Yes ☐ No
h) of the metabolism or endocrine system? ☐ Yes ☐ No
i) of the blood or infectious illnesses? ☐ Yes ☐ No
j) of the eye, ear or nose? ☐ Yes ☐ No
k) cancer? ☐ Yes ☐ No
l) any other illness/physical handicap/congenital defect not mentioned in the above list ☐ Yes ☐ No

If you answer one question with «Yes», please give details in question 11.

11 **Further details (illness and accident)**

If you answered one of the questions under 3b), 4 or 10 with «Yes», please give exact details.

Question	Type of illness/disorder (diagnosis), type of complaint or result/reason of treatment/examination/check-up	Year/Date from–to	Name and address of the physician/therapist/hospital	cured with no aftereffects
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

12 General practitioner or physician best informed to provide details on your health

Surname

Street, no.

Postcode, town

With my signature I hereby confirm that I have completed the above questions completely and to the best of my knowledge.

With my signature I hereby release hospitals, doctors, independent examining doctors as well as medical and independent examining staff, authorities, officers and other insurance companies from their legal or contractual duty of confidentiality towards the Helsana Group (Helsana Insurance Company Ltd, Helsana Supplementary Insurances Ltd, Progrès Insurance Company Ltd, Helsana Accidents Ltd, Helsana Investment Ltd, Helsana and Procare Providence Ltd) and enable them to provide the necessary information in connection with the requested insurance policy. I enable the risk assessment departments to examine the health insurance file for basic and supplementary insurance and to use it to this end.

The details given will be used only for risk assessment for the requested insurance cover and for clarification of any breach of the disclosure obligations. These data are processed and stored in a database or kept on paper only for as long as expressly required by legal or contractual provisions as well as for reconsideration for an application that has previously been turned down.

Place and date | Signature of applicant/legal representative | Signature of agent, if applicable