

Health declaration for Helsana Business Salary/Accident

<input type="checkbox"/> New contract <input type="checkbox"/> Policy changes	Firm _____ Postcode, town _____ Beginning _____ Grouping _____ Surname, first name _____ Street, no. _____ Postcode, town _____ CHF _____ per year <input type="checkbox"/> Illness <input type="checkbox"/> Accident
Contract no. _____	
Person to be insured	
<input type="checkbox"/> male <input type="checkbox"/> female	
Date of birth _____	
Income to be insured _____	
Requested insurance cover	

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	
<input type="checkbox"/> Accident <input type="checkbox"/> Illness	<input type="checkbox"/> per day <input type="checkbox"/> monthly <input type="checkbox"/> yearly	
<input type="checkbox"/> Accident <input type="checkbox"/> Illness	<input type="checkbox"/> per day <input type="checkbox"/> monthly <input type="checkbox"/> yearly	

Questions on illness and accident cover

2 a) Occupation in the above-mentioned firm Working hours _____ h per week	Which one? Income CHF _____ <input type="checkbox"/> monthly <input type="checkbox"/> yearly
b) Present gainful employment/unemployment	Which one? Income CHF _____ <input type="checkbox"/> monthly <input type="checkbox"/> yearly
c) Other gainful employment Working hours _____ h per week	Which one? Income CHF _____ <input type="checkbox"/> monthly <input type="checkbox"/> yearly
d) Do you practice any sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____
e) In your spare time, are you subject to any danger* or do you practice any sports agonistically? <small>* e.g. motor sports, paragliding, parachuting, mountaineering, canyoning</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which ones? _____
3 a) Are you unable or unfit to work?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? (e.g. from IV, MV, SUVA/UVG or other insurances)	<input type="checkbox"/> Yes <input type="checkbox"/> No 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 0.5l wine or 1l beer or 1.5dl 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
 If yes, which ones?
 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

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? Yes No

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
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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, Helsana Accidents Ltd, Helsana Investment Ltd, Helsana and Procure 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 _____