Health Declaration

Last and first name _____ **Date of birth** _____

1.	Are you at present fully able to work? **If not**, please indicate the degree of your inability to work_____ %	❑ yes ❑ no
2.	Height _____ cm Weight _____ kg	
3.	Do you smoke? **If yes**, kind of tobacco and daily amount_____	❑ yes ❑ no
4.	Consumption of alcohol (1 unit = 100 ml wine, 300 ml beer, 40 ml spirits) **If yes**, how many units per week? _____	❑ yes ❑ no
5.	Have you been absent from work for more than two consecutive weeks during the last 12 months due to **If yes**, why? _____	❑ yes ❑ no
6a	Have you been under medical treatment in a hospital, sanatorium or similar institution during the last five years or is a clinical treatment planned?	❑ yes ❑ no
6b	Do you suffer or have you suffered from any serious illness or disorders (physical, mental or psychic) during the last five years? Do you suffer from long term consequences of an accident, an illness or a physical infirmity (e.g. ankylosis, limb loss, bone anchorage, etc.)?	❑ yes ❑ no

If you answered yes to 6a and/or 6b, please furnish detailed information on:

Nature of illness/accident and treatment	From	To	Doctor, hospital (with address and department)

7.	Have you ever received abnormal results regarding a medical examination: X-Ray, ECG, AIDS test, urinalysis or b **If yes**, which? _____	❑ yes ❑ no
8.	Are you taking or did you have to take prescription drugs regularly? **If yes**, which ones? _____ Attending physician _____	❑ yes ❑ no
9.	Have you ever applied for insurance coverage that was declined or modified (e.g. additional premium, reduction of the insurance period, reduction of coverage)? **If yes**, why? _____	❑ yes ❑ no
10.	Do you currently and at the inception date claim or receive benefits from the Disability Insurance, the Military Insurance or from an insurance company (please attach a copy of existing decisions)? **If yes**, why? _____	❑ yes ❑ no
11.	Which doctor is most familiar with your medical history? Please provide more than one address, if applicable: Name, address and telephone number: _____ Name, address and telephone number: _____	

Important Information

Elips Life reserves the right to review the application for insurance coverage through a medical examination. If the following statements prove false or incomplete, the company has no obligation to provide benefits in case it withdraws from the contract within a period of four weeks after having taken notice of the concealment(s) of facts.

_____ _____

Place, Date Signature of the person to be insured