

# Insurance proposal



## ADMINISTRATIVE QUESTIONNAIRE

Please complete all the questions below **correctly and completely**.

Number: \_\_\_\_\_  
 Insurance Broker: **Inspecteur DKV AMD Pol Lescot**  
 Name / stamp broker: \_\_\_\_\_  
 Reference: \_\_\_\_\_

Account Manager: **892305**  
 Policy No.: \_\_\_\_\_

### 1. INSURANCE TAKER (Please mention the official (company) address of the insurance taker)

Mr  Ms  Mrs  Company

Name or company name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ Country: \_\_\_\_\_

First name: \_\_\_\_\_  
 Number: \_\_\_\_\_ Box: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Telephone/Mobile: \_\_\_\_\_

E-mail address: \_\_\_\_\_

IBAN: \_\_\_\_\_ BIC: \_\_\_\_\_ National number:<sup>(1)</sup> \_\_\_\_\_

Company number: \_\_\_\_\_

POLICY TO:  Insurance taker  Insurance broker  
 CORRESPONDENCE TO:  Insurance taker  Insurance broker  
 LANGUAGE CODE:  English  French  Dutch  German  
 PAYMENT:  Monthly (mandatory direct debit)  Quarterly  Biannually (-1%)  Annually (-3%)  
 PAYMENT METHOD:  Direct debit  Transfer  Insurance Broker

(1) See back of the identity card

### 2. INFORMATION REGARDING THE PERSON(S) TO BE INSURED

	Person 1				Person 2				Person 3				Person 4			
Name																
First name																
Date of birth (dd/mm/yyyy)																
Sex	M	F			M	F			M	F			M	F		
Language code	D	F	G	E	D	F	G	E	D	F	G	E	D	F	G	E
Civil status (1)	M	S	C		M	S	C		M	S	C		M	S	C	
Main occupation																
Additional occupation																
Amateur sport																
Professional sport																
Social status (2)	W	E	S	CS	W	E	S	CS	W	E	S	CS	W	E	S	CS
Social security status (3)	0	2	3	Other:	0	2	3	Other:	0	2	3	Other:	0	2	3	Other:

(1) Civil status:  
 M = married - S = single - C = cohabiting

(2) Social status: W = Worker - E = Employee -  
 S = Self-employed - CS = Civil Servant -  
 Other: Please specify

(3) Soc. Sec.: 0 = No Soc. Sec. -  
 2 = Small and major risks covered by Soc. Sec. -  
 3 = European Union - Other: Please specify

### Type of guarantees DKV

#### Health plans:

Inpatient Treatment Insurance

Long Term Care Insurance

#### Loss of income:

Insurance Guaranteed Income

Outpatient Treatment Insurance

Hospital Daily Indemnity

Working Disability Daily Indemnity



# Insurance proposal



## MEDICAL QUESTIONNAIRE – CONFIDENTIAL

Please answer all the questions below **correctly and completely**.

Policy No.:

### 1. INSURANCE TAKER (Please mention the official (company) address of the insurance taker)

Name or company name:

Street:

City:

Country:

First Name:

Number:

Box:

Zip Code:

Telephone/mobile:

### 2. INFORMATION REGARDING THE PERSONS TO BE INSURED

	Person 1	Person 2	Person 3	Person 4
Name				
First name				
National number <sup>(1)</sup>				
Street				
No. / box				
Zip code				
City				
Date of Birth (dd/mm/yyyy)				

(1) See back of the identity card

### 3a. MEDICAL QUESTIONNAIRE OF THE PERSONS TO BE INSURED

#### INSTRUCTIONS

- Please answer each question by circling 'yes' or 'no' and also enter a figure with questions 5.1, 5.2, 5.3, 6.2 and 10. Use section 3.b on the back for additional information.
- Answers that have been crossed out are considered negative responses.
- The answers to the questions in sections 3a and 3b and more specifically for the periods stated, are the **minimum required for the insurer and will help you with the spontaneous and complete submission of the medical history of the persons to be insured. The law stipulates that the insurance taker is obliged when taking out the contract to report accurately all elements known to him and that he must consider these essential to allow the insurer to assess the risk. This medical history is necessary for DKV Belgium N.V./S.A. to assess the risk and must be complete (e.g. see question 9 of section 3.a).**
- The medical information disclosed is treated in accordance with the regulations on the protection of privacy and medical confidentiality.
- You can always send us any documents that will help us assess the risk.

	Person 1		Person 2		Person 3		Person 4	
1. Have you been hospitalized over the past 7 years (incl. one-day clinic)?	No	Yes	No	Yes	No	Yes	No	Yes
2. Have you been ill, involved in an accident, had symptoms or have you undergone a medical (incl. dental) treatment without hospitalization over the past 3 years?	No	Yes	No	Yes	No	Yes	No	Yes
3.1. Do you have a handicap or chronic disease?	No	Yes	No	Yes	No	Yes	No	Yes
3.2. Has a blood and/or heart test or medical imagery (X-ray, CT-scan, MRI, ultrasound, etc.) revealed the presence of anomalies or ailments?	No	Yes	No	Yes	No	Yes	No	Yes
4.1. Are you currently taking medication? If yes, why?	No	Yes	No	Yes	No	Yes	No	Yes
4.2. Have you followed a diet, a psychotherapeutic treatment or a physiotherapeutic treatment, acupuncture, chiropractic, speech therapy or osteopathy during the past 12 months?	No	Yes	No	Yes	No	Yes	No	Yes
4.3. Are you currently under inpatient or outpatient treatment? Has a treatment, an examination been foreseen or recommended? Which?	No	Yes	No	Yes	No	Yes	No	Yes
5.1. Have you already been incapable of working for more than 3 weeks? Why? Percentage? When?	No	Yes	No	Yes	No	Yes	No	Yes
5.2. Are you currently partially or completely incapable of working, due to an accident or illness? Why? Since when? What percentage?	No	Yes	No	Yes	No	Yes	No	Yes
5.3. Are you currently invalid? Why? Since when? Percentage?	No	Yes	No	Yes	No	Yes	No	Yes
6.1. Are you currently under inpatient or outpatient stomatological or dental (incl. orthodontic) treatment? Has such a treatment been foreseen or recommended?	No	Yes	No	Yes	No	Yes	No	Yes
6.2. Are any natural teeth missing, have natural teeth already been replaced? How many teeth are missing and/or have been replaced (partially or completely), wisdom teeth not included?	No	Yes	No	Yes	No	Yes	No	Yes
7. Do you need the assistance of a third person for daily life activities? Has such assistance been foreseen or recommended? If yes, why? For what kind of activities? Number of hours per day?	No	Yes	No	Yes	No	Yes	No	Yes
8. Are you currently pregnant?	No	Yes	No	Yes	No	Yes	No	Yes
9. Is there any other information to be given as to your state of health?	No	Yes	No	Yes	No	Yes	No	Yes
10. What is your current height and weight? If you are pregnant, please give your weight just before your current pregnancy.	cm	kg	cm	kg	cm	kg	cm	kg

**3b. SPECIFICATIONS AS TO THE MEDICAL QUESTIONNAIRE (question 1 to 10)**

	Nature of the illness, symptom, accident, handicap, treatment, examination, working disability, invalidity, assistance of (a) third person(s).	Year, period of treatment, admission, working disability, invalidity, assistance of (a) third person(s)		Have any: examinations and/or treatments been foreseen or recommended; any sequelae; working disability and/or physiological or economical invalidity (please mention the assigned or foreseen percentages)?
		FROM	UNTIL	
Person 1 Question No.:				
Person 2 Question No.:				
Person 3 Question No.:				
Person 4 Question No.:				

**4. SENDING THE MEDICAL QUESTIONNAIRE**

If you so wish, you can detach this medical questionnaire and send it in an envelope marked confidential to: DKV Belgium N.V./S.A., for the attn. of the advising doctor, Bischoffsheimlaan 1-8, 1000 Brussels. The same goes for every candidate insured person who, if he so wishes, may request a new copy of the medical questionnaire from his insurance broker or via the website [www.dkv.be](http://www.dkv.be) and return it separately.

**STATEMENTS OF THE PERSON(S) TO BE INSURED**

- I know that the insurance proposal consists of an administrative and medical questionnaire and that it aims at the conclusion of an insurance contract with DKV Belgium N.V./S.A. The insurance conditions are determined upon issuance of the policy, provided that the company has previously received the administrative and the medical questionnaire and the signed supplement of the insurance contract (if any), drawn up according to the Landverzekeringsovereenkomst (Law on the Land Insurance Agreement).
- I declare that all information provided is correct, adequate, not exaggerated and I authorize the insurer to collect and to process this information in order to conclude and execute the contract. Therefore I declare that all information is exact and complete. I also take note of the fact that this information has a binding effect, even if it has been provided and/or completed by a third person.
- I know that the signature of the insurance proposal engages neither the insurance taker nor the insurer to conclude the contract. I know that, if the insurer has not sent an offer, has not initiated an inquiry or has not refused the conclusion of the contract within 30 days of the receipt of the proposal, he is obliged to conclude the contract under penalty of compensation. The signature of the insurance proposal does not imply that coverage begins.
- I undertake to communicate in writing to the insurer any change with regard to the information provided, which arises before the policy has been established.
- The Medi-Card® is granted upon the conclusion of a plan IS2000, H or H+. As soon as I have received this card, I commit to abide by these plans' Tariff Insurance Conditions when using the Medi-Card®.
- During the term of the contract and by virtue of the prevailing legislation, I undertake to inform the insurer as soon as possible in writing of any change with regard to the social status and the legal health insurance status. In case of subscription of a plan of the type 'working disability' with the insurer, I undertake to inform the insurer as soon as possible in writing of any change with regard to the insured professional activities.
- I agree with the fact that DKV Belgium N.V./S.A. with registered office in Belgium - Bd Bischoffsheimlaan 1-8, 1000 Brussels, as holder of this file, processes this information with the aim of customer service, risk evaluation, policy issue and administration, administration of claims, statistics and promotion. I declare having been informed of the right to object – on request and free of charge – to the use of personal data for promotional purposes; there is a right of access and for correction as regards this data.
- Any complaint as to the insurance contract should be addressed to the Ombudsman of DKV Belgium N.V./S.A.: ombudsman@dkv.be and in the second instance to the Ombudsman der Verzekeringen (square de Meeûs square 35, 1000 Brussels) without prejudice to the right of the insurance taker to start legal proceedings.

Signature of the adult person(s) to be insured or his (their) legal representative:  
  
  
  
Date: ...../...../.....