ydrogios

# ACCIDENT AND HEALTH PROPOSAL FORM

## POLICY HOLDER DETAILS

Name & Surname/Company Name

Identity Card/Passport/Comp. Reg. Number | Date of Birth

Occupation

Phones | Email

Correspondence Address:

Postal Code | Town

## INSURED DETAILS

Name & Surname

Identity Card/Passport | Date of Birth | Male | Female | Height | Weight

Home Address

Postal Code | Town | Occupation | Phones

Email | Marital Status: Single, Married

Relationship with Policy Holder

Correspondence Address:

Postal Code | Town

## CHOICE OF AN INSURANCE PLAN:

**Pllease indicate with √ the insurance policy you prefer:**

**Plans** Student | Silver | Gold | Platinum | World wide

**Coverage:** Hospital Care: | In-Patient and Out-Patient Care: | Customised Plan: | Second Medical Opinion:

**Deductible Amount for Hospital Care:** NO | YES | 500€ | 1000€ | 2000€ | 5000€ | 15.000€ | 20.000€ | OTHER

## PREMIUM PAYMENT METHODS:

Payment Frequency: Annually | Semi-Annually | Quarterly | Monthly

Method of Payment: Cash | Direct Debit

Premium: € | Deposit: | Date:

## PERIOD OF INSURANCE

from | to

## DEPENDANTS DETAILS:

Please note that only the spouse and legally unmarried children under the age of (18) or serving their Military Services or who are students in Cyprus and less than the age of (25) may be included as dependants in the insurance plan.

| S/N | FIRST NAME | SURNAME | DATE OF BIRTH | HEIGHT (cm) | WEIGHT (kg) | OCCUPATION | I.D NO | RELATION TO POLICY HOLDER |
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**All the questions below should be answered fully in respect of the insured and all the dependents that are proposed for this plan. Where your answer is YES, please supply full details in the table that follows:**

## INSURANCE HISTORY

1. Are you insured now or have you ever been insured under a Health Insurance Plan, with our Company or any other Insurance company? If so, please state the name of the Insurance Company with which you are or have been held covered. YES NO

2. Has any insurance company ever declined or accepted with any special conditions or extra premium, any application of your for Life, Health or Personal Accident Insurance? YES NO

3. Do you have any application pending acceptance for Life, Health or Personal Accident Insurance, by our Company or other insurance company? YES NO

| QUEST. NO. | INSURED PERSON | DETAILS |
|---|---|---|
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## WAY OF LIFE

1. Do you smoke? YES NO

If so, please state:

- For how many years you have been smoking
- Your daily consumption in tobacco

2. Please state your daily alcohol consumption

3. Do you travel abroad frequently for reasons other than recreational? YES NO

If so, please state how often, for how long and where you travel.

4. Do you intend to live abroad permanently? YES NO

5. Do you engage in any sport or other activity? YES NO

If so, please state whether you engage in a professional or amateur mode.

6. State if you are left-handed. YES NO

7. Are there any conditions in your profession, habits or other occupations that put you at risk? If Yes, please give details.

8. Do you drive a motor above 75CC? If yes, please give details.

| QUEST. NO. | INSURED PERSON | DETAILS |
|---|---|---|
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## MEDICAL HISTORY

Do you suffer now or have you ever suffered in the past from:

1. Heart Disorders or abnormal electrocardiogram? YES NO

2. Blood and blood vessel disorders, anemia, hypertension, chest pain or shortness of breath? YES NO

3. Lung and Bronchial disorders, or any other respiratory and/or chest disease? YES NO

4. Eye, Ear, Throat, Mouth or Sinus Disorders? YES NO

5. Disorders of the Urinary Track, gall bladder, renal colic, renal stones, blood, protein or sugar in the urine? YES NO

6. Diabetes Mellitus, Hyperlipidemia? YES NO

7. Disorders of the Thyroid gland, lymphnodes, tumors, cancer, Multiple Sclerosis and/or Parkinson's Disease? YES NO

8. Vertigo, fainting attacks, mental disorders, epilepsy, any disorders of the mental and nervous system or cerebral disease? YES NO

9. Rheumatic fever, arthritis, lumbago, gout or any other bone, joints, or spinal cord disorders, fractures or disabilities? YES NO

10. Cyst of Coccyx, hemorrhoids, hernia, any form of celes, fistula, varicose veins or other disorders of the circulatory system? YES NO

11. Any sexually transmitted disease (e.g. Syphilis or gonorrhea), or have you ever sought medical advice, treatment, or had clinical tests carried out in connection with these or any other viral diseases such as Hepatitis C and /or AIDS? YES NO

12. Have you ever had any blood transfusions or have received treatment with any blood products? Have you ever been rejected as a blood donor are you a Trait B Carrier? YES NO

13. Have you ever had X-rays, Electrocardiograms, Clinical Tests, or other diagnostic Tests, or General Medical Check-ups? If so, please state why these were carried out. YES NO

14. Have you ever been operated or hospitalized for any reason? YES NO

15. Have you ever taken any other intravenous drugs and/or medications without a medical prescription? YES NO

16. **For Female applicants only:**

- Please state any Breast and/or Genital Organs Disorders?

- Are you presently pregnant? YES NO
- If so, please state in which month.

17. **For Male applicants only:**

- Have you regularly served or are you now serving your Military Service? YES NO
- If not, please supply us with a photocopy of your release report. YES NO

18. **Family Medical History:**

Has any of your parents or siblings (whether alive or not) ever suffered or are suffering now from diabetes, heart disease, tumors or cancer, Huntington's Chorea, polycystic Kidneys, stroke, multiple sclerosis, neuropathies, hypertension or other hereditary disease? YES NO

19. Please state the name and address of your personal medical attendant.

| QUEST. NO. | INSURED PERSON | DETAILS |
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## DECLARATION:

We declare that besides the above, any other information optained from me/us remains the same as the information I/ we have already provided to you in my/our previous proposal.
We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which might increase the risk of YDROGIOS INSURANCE COMPANY (CYPRUS) LTD or influence the acceptance of this Proposal and should the above particulars alter in any way I/we will advise YDROGIOS INSURANCE COMPANY (CYPRUS) LTD as soon as practicable. I/we understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in YDROGIOS INSURANCE COMPANY (CYPRUS) LTD refusing to provide indemnity or voiding the policy in every respect. I/we hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

Signed In ______________________ on the ______________________

Insured's Signature ______________________ Policy Holder's Signature ______________________

## AGENT'S DECLARATION:

I hereby declare that all necessary explanations/clarifications have been given to the Insured person and the Proposer and that I do not know anything else that could affect the decision of the Company in connection with the insurability of the main insured person and of the insured dependants.

Date: ______________________ Agent's Full Name: ______________________

Agent's Signature: ______________________ Agent's Code Number: ______________________

**Head Office:**

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