## Insured health statement



insurance policy number:	
information on the insured:	
Name and Surname Street and house number:	
Postal code Place:	
OIB Profession:	
Phone GSM	
e-mail @@	M F
Questions for insured :	
1] Have you suffered or been treated for stroke, epilepsy, high blood pressure, rheumatoid arthritis, cancer, kidney stones, gastric / duodenal ulcer, Alzheimer's disease, depression, vascular disease, multiplex sclerosis, melanoma, mental illness, bronchitis / asthma / COPD, coronary insufficiency, diabetes, liver and kidney disease? If your answer is Yes please attach medical records.	YES NO
2] Have you had or have elevated / lowered sugar, high cholesterol, elevated triglycerides, lowered or elevated blood cells. If your answer is Yes please attach medical records.	YES NO
<sup>3]</sup> Have you had or have any illnesses not mentioned before. If your answer is Yes please attach medical records.	YES NO
4] Do you take or have you taken any medications therapy. If you take an <u>y, please say which ones</u>	YES NO
5] Do you have any planned surgery? If yes specify for what reason,	YES NO
6] For women: are you pregnant? If your answer is Yes please attach medical records of your pregnancy	YES NO
7] Did you suffer any accident? If your answer is yes specify which and when.	YES NO
<ul> <li>B) Do you have a birth defect, physical deformity or a consequence of illness or injury?</li> <li>If your answer is Yes please attach medical records.</li> </ul>	YES NO
9] Have you ever applied for a disability benefit, receiving a disability pension or accident, incapacity or sickness benefit? If your answer is Yes please attach medical records.	YES NO
10] Is your working ability is currently limited? If yes please specifiy a reason	YES NO
11] Are you exposed to dangerous in your profession [e.g. working with explosives, radiation, containment in hazardous areas, etc.]? If Yes, please specify which ones?	YES NO
12] Do you play any of the sports? If yes, please indicate which one and whether you are engaged in recreational, amateur or professional activities?	YES NO
13] Heigh? kg.	
14] Name of family doctor and name of primary care institution	
Place/date:Signature of the insur <u>ed:</u>	