Additional Questionnaire

Confidential Medical Information

IMPORTANT NOTE: PLEASE READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE QUESTIONNAIRE

1) This questionnaire should be filled out for each beneficiary reporting health problems. (One questionnaire per person.)
2) Fill out every field without exception with the appropriate answer. Do not leave any field blank. A line drawn through a field is not acceptable as an answer.
3) For any paired organ or limb, indicate right or left side.

First name: ______________________ Tax identifier/passport number/residency card: ______________________

Last name: ______________________ Weight and height: ______________________

	Further description of each reported medical condition			
	1	2	3	4
Please describe the problem and indicate if it is: a present problem - A ☐ or a past problem - P ☐	☐ A ☐ P	☐ A ☐ P	☐ A ☐ P	☐ A ☐ P
Date of: onset / end	–	–	–	–
1° Cause (e.g., due to illness, after an accident, born with it, due to pregnancy, etc). Please specify				
2° Exact location (e.g., left leg, right arm, ears, etc). Please specify				
3° Treatment, if any. Please indicate type: medical, surgical, etc. Please specify				
4° Prostheses or implanted surgical material (e.g., osteosynthesis - pins, screws, meshes, etc). Please specify				
5° Planned diagnostic tests and/or treatments. Please specify				
6° Present state of reported medical condition, specifying any consequences (e.g., cured, minor discomfort, limp, etc).				

7° Optical refraction defect. Please specify (short sight, long sight, astigmatism, etc). ______________ Right eye dioptres: ______________ Left eye dioptres: ______________

8° Remarks on contracting of deductibles (this space for the use of Sanitas)

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I, the undersigned, declare that the information given is accurate and that I have not omitted any information about state of health. Nevertheless, I authorise SANITAS, Sociedad Anónima de Seguros, (hereinafter referred to as "SANITAS") to ask physicians and institutions for - and I accordingly authorise such persons to provide to SANITAS - any data on the health of the persons included under the policy that SANITAS may deem expedient for proper appraisal and assessment of the risks to be covered, to prevent fraud, and to attend to the claims put forth by the insured parties. For these purposes SANITAS may have on file all those persons' data, including any data on their health. The applicant acknowledges that for the purposes of arranging insurance SANITAS reserves the right to accept or reject this application or any part of it. Furthermore, pursuant to laws and regulations on personal data protection, the insured party expressly gives his/her consent for all personal data regarding him/her to be added to files held by SANITAS in order to carry on the Company's activities, ensure the effectiveness of contractual relations, hold information on the reasons for any policy termination, prevent fraud and send advertising, commercial offers and other items that may be of his/her interest, from the Company and from third parties with whom the Company works in partnership, such that the Company is authorised to process the data so as to send the person under this application the information best suited to his/her needs. For the purpose of preventing fraud only, the Insured parties expressly consent to SANITAS keeping such data as are strictly necessary, even after the contractual relationship has ended. You may exercise your statutory rights of challenge, access, rectification and erasure of these data at the Company's head office at Calle Ribera del Loira 52, 28042 Madrid, Customer Relations Department. The Policyholder accepts responsibility for informing the other Insured parties declared under the Policy about the inclusion of their data in the files mentioned above. Unless otherwise advised in writing within thirty days from the date of this application, we shall deem you to be in agreement with our sending you advertising and sharing your data with other companies on the terms set out above.

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IN THE EVENT OF ORGAN AND/OR MATTER EXTRACTION, AN ANATOMICAL PATHOLOGY REPORT MUST ALSO BE PROVIDED, AND A MEDICAL REPORT ON THE PRESENT SITUATION. IF YOU HAVE ANY MEDICAL REPORTS ON THE HEALTH PROBLEMS DISCLOSED ABOVE, PLEASE ENCLOSE THEM WITH THIS FORM.

Date: _____ /________ /_____

Signature: