KOMPANIJA
DUNAV OSIGURANJE a.d.o.
11000 Beograd, Makedonska br 4
Registration: Business Registers Agency
No. of registration entry: 1992/2005
ID No.: 07046898
Taxpayer's no. (PIB) 100001958

QUESTIONNAIRE

FOR INDIVIDUAL VOLUNTARY HEALTH INSURANCE

1.Mandatory

Insured: **Personal ID No.:**

Date of birth: **Sex (M/F):** **Occupation:**

Contact telephone:

Address:

LBO number: **Name of healthcare institution where you receive your treatment and name of your chosen doctor:**

Please answer the questions below and if your answer is „yes", provide the details:

1. Body weight (kg) and height (cm):
2. Do you have any family member (mother/father/brothers/sisters) who died before turning 60 or had diabetes, heart attack, high blood pressure, brain stroke, kidney disease, cancer, multiple sclerosis, mental disorders, other hereditary diseases? *(YES/NO)
3. Do you use alcohol, tobacco, drugs, or any other intoxicating substances? (beginning/type/quantity per day): *(YES/NO)
4. Do you want pregnancy healthcare: *(YES/NO)
5. Are you currently under continuous supervision of a doctor and do you use permanent medical therapy?(disease/ medications/institution): *(YES/NO)
6. Do you have congenital or acquired deformity or any other consequences of illness or accident? (since when /disability percent /cause): *(YES/NO)
7. In the past 10 years, have you undergone any specialist treatments, surgeries, sought consultations, stayed in rehabilitation centres and the like? (institution/ reason/period and duration): *(YES/NO)
8. Do you suffer or have you ever suffered from the diseases of the heart, blood, stomach, liver, gall, pancreas, lungs, skin, bones/joints, kidneys, genital organs, blood sugar, blood disorder, mental illnesses, epilepsy or nervous system disorders?? *(YES/NO)
9. Are you exposed to any special hazards at work or in your free time (e.g. radiation, toxic fumes and the like)? *(YES/NO)

*(YES/NO)

10. **Is there any materially relevant fact about your health that you would like to point out and that was not specified?**

Inception date of insurance: **effective until** **year.**

*The Insurer will treat personal information in accordance with the Law on Personal Data Protection.

2. Optional

The fields below are not mandatory, and the Insurer will create for you the most favourable proposal. You just need to specify if you wish one or more variants of the proposal.

Do you wish more variants of the proposal: *(YES/NO)

Sum insured: EUR *(1.000 / 2.000 / 3.000 / 5.000 / 10.000 / 20.000 / 100.000 EUR)

Hospital treatment cover excluded: *(YES/NO)

Preventive healthcare cover excluded (general check-up and the like): *(YES/NO)

Participation (deductible): % *(0, 15, 20, 30) Participation buy-back (0%) is possible only when the sums insured are higher than, or equal to the sum of 5.000 EUR

Previous health condition – included: *(YES/NO) It can be included only when the sums insured are higher than, or equal to the sum of 5.000 EUR

Level of service standard – examination by a professor: *(YES/NO)

Selection of service providers: *(Within and out of the network /Within the network)

Service level for the network of clinics: *(Classic – participation(%): network 1(0), network 2(20), network 3(30)
/Super – participation(%): network 1(0), network 2(10), network 3(20)
/VIP – participation(%): network 1(0), network 2(0), network 3(0))

Note:

I declare and confirm with my signature that the answers given to all the questions are correct, true, and complete. I am aware that intentional misrepresentation of facts constitutes a violation of the contractual obligation and can be a reason for the cancellation of insurance contract or for the reduction of Insurer's liability in proportion between the premium paid and the premium that should have been paid according to the actual risk. I declare and confirm with my signature that I have agreed that the Insurer may collect and process my health information in accordance with the Law on Personal Data Protection, which is necessary for the conclusion, implementation and execution of the insurance contract. I hereby authorize all doctors or healthcare providers/collaborators to provide to the Insurer any information/confirmation of my health condition. I hereby authorize the Insurer to inform the healthcare service providers about my health condition, but only when this is necessary for the fulfilment of obligations under the insurance contract.

In , date

INSURED INSURER

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