Union
Poisťovňa

FOREIGNERS' INDIVIDUAL HEALTH INSURANCE ON THE TERRITORY OF THE SLOVAK REPUBLIC

Health History Questionnaire under Policy NO. ☐☐☐☐☐☐☐☐

Name	Surname	Date of birth (DDMMYYYY)
Temporary address (street, no., postal code, city)		Nationality
Height (cm) / Weight (kg)	Weight changes over the past 12 months +kg -kg	Sex ☐ man ☐ woman

Insurance is required for the period from ☐ **to** ☐

Mark appropriate data in the following part with x and specify details, please, according to the pattern.

1. **Do you smoke?** ☐ no ☐ yes If so, how many years do you smoke? ☐ How many cigarettes do you smoke a day on average? ☐
2. **Do you drink alcohol?** ☐ no ☐ yes If so, specify the type and average quantity per week: ☐
3. **Do you take other addictive substances?** ☐ no ☐ yes If so, specify the name of the substance: ☐ weekly quantity: ☐
4. **Do you practise a sport?** ☐ no ☐ yes If so, what kind of sport? ☐ Are you a professional athlete? ☐ no ☐ yes
5. **Give the purpose of your stay:** ☐ **What is your profession in Slovakia?** ☐
6. **Do you have or have you observed any of the following symptoms over the past 12 months?**
(provide answer to every question) If so, specify when for the last time:

a) heart palpitation	☐ no	☐ yes	☐	m) skin changes	☐ no	☐ yes	☐
b) chest pain	☐ no	☐ yes	☐	n) excessive urination	☐ no	☐ yes	☐
c) cough and sneezing episodes	☐ no	☐ yes	☐	o) urination pain	☐ no	☐ yes	☐
d) morning cough	☐ no	☐ yes	☐	p) headache	☐ no	☐ yes	☐
e) nose and respiratory airway bleeding	☐ no	☐ yes	☐	q) psychical fatigue	☐ no	☐ yes	☐
f) heavy breathing	☐ no	☐ yes	☐	r) sleeplessness/sleepiness	☐ no	☐ yes	☐
g) pain in abdomen and pelvis	☐ no	☐ yes	☐	s) increased temperature	☐ no	☐ yes	☐
h) anorexia	☐ no	☐ yes	☐	t) edemas	☐ no	☐ yes	☐
i) heartburn, indigestion and vomiting	☐ no	☐ yes	☐	u) joint or backbone pain	☐ no	☐ yes	☐
j) diarrhoea	☐ no	☐ yes	☐	v) spasms	☐ no	☐ yes	☐
k) constipation	☐ no	☐ yes	☐	x) sight disorder	☐ no	☐ yes	☐
l) blood in stool	☐ no	☐ yes	☐	y) hearing disorder	☐ no	☐ yes	☐

z) other ☐ no ☐ yes If so, when the last time and what kind of symptoms ☐

7. **Have you been examined, monitored or treated for any illness/disorders over the past 2 years?** ☐ no ☐ yes If so, specify:

What health disorder? ☐

When first? ☐ When last? ☐ Name of health facility? ☐

What method was used to treat the problem? ☐ out-patient, ☐ in-patient, ☐ surgery, ☐ drugs, ☐ other method (specify): ☐

What recommendations have you received? ☐

Was the examination/monitoring/treatment finished? ☐ no ☐ yes If so, when? ☐

What after effects has the disease/disorder led to? ☐

8. **Are you planning within the next 12 months an examination/treatment/medication/surgery/hospitalisation/preventive check/control check or has the same been recommended to you?** ☐ no ☐ yes If so, specify what you are planning or what has been recommended to you ☐

When? ☐ Where? ☐ Reason? ☐

9. **Are you regularly taking any medicine?** ☐ no ☐ yes If so, specify which? ☐

Use a separate supplement if boxes above are not sufficient, please.

10. **Are you visiting any of the following doctors/other health specialists?** (psychologist, neurologist, rheumatologist, psychiatrist, pneumologist, orthopaedian, immunologist, internist, general practitioner, gynaecologist, other) ☐ no ☐ yes Which specialists and how often?

11. **Have you had an accident, injury or poisoning?** ☐ no ☐ yes If so, specify what When?

Consequences

12. **Have you had an HIV test?** ☐ no ☐ yes If so, specify when What was the result?

Question 13, 14 – APPLIES TO WOMEN ONLY

13. **Have you observed over the past 12 months or you currently have?**

a) breast changes? ☐ no ☐ yes b) bleeding other than your cycle? ☐ no ☐ yes

14. **Are you pregnant?** ☐ no ☐ yes If so, specify:

Week of pregnancy? Is your current pregnancy a complicated/risk one? ☐ no ☐ yes

Have you suffered from spontaneous miscarriage in the past? ☐ no ☐ yes Have you suffered from pregnancy with complication in the past? ☐ no ☐ yes

15. **Have you ever had or do you suffer from?**

movement disorders? (such as backbone, joints, muscles pain, arthritis, rheumatism, orthopedic disorders)**, respiratory system disorders?** (e.g. asthma, chronic bronchitis, pneumonia, other)**, digestive system disorders?** (such as abdomen pain, ulcers, gallstones, pancreatitis, hernia, diarrhea, other)**, cardiovascular diseases?** (such as thorax pain, cough, heart attack, high blood pressure, cardiac arrhythmia, stroke, arteriosclerosis, other)**, nervous and psychical disorders?** (such as headache, epilepsy, neurosis, depression, other)**, renal and urinary disorders?** (such as urinary stones, bladder inflammation, other)**, tumors?** (leukemia, melanoma, other)**, blood disease?** (such as anemia, hemophilia, other)**, endocrine or metabolic disorders?** (such as diabetes, gout, high cholesterol, struma goitre, other)**, immunity system or infection diseases?** (such as hepatitis, malaria, tuberculosis, allergy, other)**, skin problems?** (such as eczema, allergies, psoriasis, other)**, reproductive organ disorders?** (such as prostate for men, gyneacologic diseases or breast diseases for women, venereal diseases, other)**, sight or hearing disorders?** (such as glaucoma, hearing loss, other)**, Other than above mentioned diseases or disorders?** ☐ no ☐ yes If so, specify:

What? When they began? When they ended ?

Were they / are they treated? ☐ no ☐ yes If so, specify: How and by whom?

What? When they began? When they ended ?

Were they / are they treated? ☐ no ☐ yes If so, specify: How and by whom?

In case that you suffered or suffer from cardiovascular disorders give the actual blood pressure: /

Use a separate supplement if boxes above are not sufficient, please!

Agreement of the client with administration of personal data

1. By this I give my agreement to the company Union poisťovňa, a.s. with its residence on Bajkalská 29/A, 813 60 Bratislava, to administer my personal data in the scope name, surname, identification number, date of birth and information on my profession, health condition, height, weight, purpose of stay, hobbies, on using alcohol, other addictive substances, smoking and on provided healthcare services for the purpose of risk assessment connected with closing policy and subsequent activities according to § 2 par. 1 of the Law No. 95/2002 Z.z. on insurance in a valid wording.
2. I agree that Union poisťovňa, a.s. can administer these data also in case the policy will not be signed, for the purpose of registration of potential clients for closing of a new policy in future. Personal data will not be available or provided to other subjects or published.
3. The agreement given according to item 2 is given for the period of max. 2 years and it can be removed anytime by a written in a written request. In case that the client will be accepted to insurance according to the policy mentioned in the heading of the first page of this questionnaire, the agreement is given for the period of insurance of the client and subsequently 10 following years after cancellation of the insurance. The client also agrees that possible exclusion from insurance cover was given in the policy. Removing of the agreement does not have a retrospective effect.
4. Rights of the client
   - 4.1. The client has the right to require from Union the following on the base of a written request:
     - a) information on the state of administration of one's personal data in IT system,
     - b) exact information on the resource from which Union obtained personal data for administration,
     - c) a copy of data which are subject of administration,
     - d) correction of incorrect, incomplete data or data which are not actual, which are subject of administration,
     - e) destroying of personal data, if purpose of their administration was fulfilled; if the subject of administration are official documents containing personal data, he /she can ask for their returning
     - f) destroying of personal data, which are the subject of administration, in case the law was breached.
   - 4.2. Rights of the client can be limited only according to the item 4.1 letter d) and e), if such limitation follows from the special law or if by its use protection of the client would be breached, or rights and freedom of other persons would be breached.
   - 4.3. The client can object against Union anytime on the base of a free written request or personally, if the matter is urgent
     - a) against administration of personal data for other purposes than those included in items 1 and 2,
     - b) and not to obey decision of Union, which should have legal consequences or significant impact on them, if such decision is made exclusively on the base of acts of automatic administration of data. The related person has the right to ask Union to investigate the made decision by a method different from automatic form of administration, while Union is obliged to meet the requirement in such a way that the decisive task in investigation of the decision will have the responsible employees of Union. The related person will be informed about the way of investigation and results of Union within 30 days from receiving the requirement.
   - 4.4. In case of suspicion that the clients data are administered without authorization the client has the right to inform the Personal Data Protection Office of the Slovak Republic.
   - 4.5. If the client does not have competency for legal acts in full range according to the Civil Code, his rights can be exercised by his legal representative.
   - 4.6. If the client is no longer alive, his rights according to the law on personal protection can be exercised by a close person according to the Civil Code.

Declaration of the client:

By signing the form herein, I confirm my full understanding of the questions in the questionnaire. All my replies are true, full and no facts have been withheld. At the same time, I expressly grant my consent to Union to survey my health data, and to doctors, health facilities where health care was/shall be provided to me, to provide data to my insurer regarding my health condition and I hereby authorise the insurer to obtain data about my health condition from doctors and/or health facilities where health care was/shall be provided to me.

....

Place and time of filling this health questionnaire Signature of the client

Name and surname of the representative, who verified whether all data in the health questionnaire are fully filled and who verified identity of the client:

.....

Representative´s workplace: ..... Contact to the representative (tel., fax, e-mail) .....