

## HEALTH INSURANCE FOR FOREIGN NATIONALS ■ 808 SAFETY ■ 880 SIMPLE

First name		Last name		Nationality
Temporary residential address in SR (street, house no., postal code, town)			E-mail: Phone number:	
Date of birth (DDMMYYYY)	Birth ID no.	Sex. <input type="checkbox"/> male <input type="checkbox"/> female	Height (cm)	Weight (kg)
Weight change over past 12 months      +      kg / –      kg		I request insurance for period from:      to:		

In the section below, mark true data with a cross ☒ and complete detailed data according to the template.

1. State the purpose of your stay	What work activity do you perform in SR?
2. Have you had or do you have any of the listed or other medical conditions? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, indicate: .....	
What ..... when started ..... when ended .....	
What ..... when started ..... when ended .....	
(e.g.: <b>pains</b> (head, abdomen, chest, spine, joints or other parts of the body, when urinating, other...), <b>heart palpitation, laboured breathing, dizziness, bleeding</b> (from the nose, airways, blood in the urine, in the stool, other...), <b>coughing and sneezing attacks, morning cough, vomiting, diarrhoea, skin changes, swelling, convulsions, disorders</b> (sight, hearing, memory, other...), <b>problems with alcohol, drugs, insomnia, increased sleepiness, mental exhaustion and disorders, other symptoms.</b>	
3. In the past, have you been treated or have you had a surgery to: heart, blood vessels, brain, nervous system, kidneys, urinary and digestive tracts, or cancer? <input type="checkbox"/> no <input type="checkbox"/> yes	
Did you in the past or do you suffer from mental, infectious, congenital or sexually-transmitted diseases, immune system disorders, tuberculosis? <input type="checkbox"/> no <input type="checkbox"/> yes	
In past 5 years, have you been examined, monitored or treated for other disease or problems, suffered an injury or poisoning? <input type="checkbox"/> no <input type="checkbox"/> yes	
Provide details (in case of cardiovascular disease indicate current blood pressure value) .....	
When first time ..... When last time .....	
What treatment was used? <input type="checkbox"/> outpatient <input type="checkbox"/> hospitalisation <input type="checkbox"/> operation <input type="checkbox"/> medication <input type="checkbox"/> other (specify) .....	
Has the examination, monitoring or treatment been completed? When? ..... With what recommendations? .....	
What consequences or difficulties remain? .....	
4. In next 2 years, are you planning or are you recommended for examination, treatment, therapy, operation, hospitalisation, preventive or control check? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, specify your plan or recommendation .....	
When ..... Where ..... Reason .....	
5. Do you take any medication? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, specify which: .....	
6. What sports do you do? ..... <input type="checkbox"/> professionally <input type="checkbox"/> registered in club <input type="checkbox"/> recreationally Do you compete? <input type="checkbox"/> no <input type="checkbox"/> yes Do you attend a sports school? <input type="checkbox"/> no <input type="checkbox"/> yes	
7. WOMEN ONLY: Are you pregnant? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, which week of gestation? <input type="text"/> week	
Is your pregnancy monitored by a doctor? <input type="checkbox"/> no <input type="checkbox"/> yes Is your current pregnancy high-risk? <input type="checkbox"/> no <input type="checkbox"/> yes	

## Client statement

If pre-printed boxes are insufficient, use a separate annex!

I hereby declare that I have understood the questions given in this medical questionnaire, all the answers to them are true and complete, and I have not withheld any facts. I am aware of the possible consequences in case of withheld serious circumstances or incorrect information about the state of health of the insured (withdrawal from the policy, rejection of insurance indemnity). I am aware that, under the Insurance Act, the insurer may process my personal data and the personal data of the insured, including information about their state of health, to the extent necessary to assess the risk when concluding or amending an insurance policy and when settling insured events. I authorise the insurer to obtain information about my state of health from doctors and/or medical facilities where I have been or will be provided medical care. At the same time, I give the insurer consent to the provision of advisory services by telephone when completing the questionnaire, including cases when some of the above answers are not complete, sufficient or unambiguous. This statement was not made under duress or time constraint, or under other unfavourable conditions that could cause incorrect or incomplete information disclosure, and in witness thereof I attach my signature.

In ..... on .....

client's signature

Recipient (first and last name, workplace, contact phone) .....

## Client's consent to personal data processing

1. I hereby grant my consent to Union poisťovňa, a.s., with its registered office at Karadžičova 10, 813 60 Bratislava, for the processing of my personal data in the scope of first name, last name, birth registration number, date of birth, information on occupation, state of health, height, weight, purpose of stay, smoking, and other medical interventions received, for the purpose of registering potential clients in concluding an insurance policy in the future. Personal data will not be made available or provided to other entities or published..
2. Consent to the processing of personal data pursuant to point 1 is given for a maximum period of 2 years and can be withdrawn at any time. Withdrawing consent has no effect on the legality of processing based on the consent given prior to its withdrawal. The consent can be withdrawn in writing by sending a letter to the company's address or email to the email address [dataprotection@union.sk](mailto:dataprotection@union.sk).

3. **Data subject** is the applicant for insurance..

## 4. Recipients of personal data

### Personal data may be provided to:

- company digitising the issuer's document: NUPSESO, a.s., business ID: 36525791,
- company performing activities of an archiving centre and registry administration: IRON MOUNTAIN SLOVAKIA, s.r.o., corporate ID: 36232734.

## 5. Rights of the data subject:

Regarding personal data processing, the data subject has the following rights in respect the insurer:

- 5.1. The right to obtain confirmation that personal data relating to the data subject is being processed and, if so, the right to access such personal data, together with the information contained in this notice.
- 5.2. The right to have the insurer correct the incorrect personal data and to supplement the incomplete personal data.
- 5.3. The right to erasure of personal data (right to be forgotten), if such data is no longer needed for the purposes for which it was obtained or otherwise processed.
- 5.4. The right that the insurer restrict personal data processing, if:
  - the data subject contests the accuracy of personal data during the period of verification of their accuracy;
  - processing is unlawful and the data subject objects to the deletion of personal data and requests instead to restrict its use;
  - the insurer does not need the personal data for processing but the data is needed by the data subject to prove, enforce or defend claims.
- 5.6. The right to object to the processing of personal data by the insurer.
- 5.7. The right to file a complaint with the Office for Personal Data Protection, if the data subject believes that the processing of personal data of the data subject on the part of the insurer is in contravention of personal data protection laws.
- 5.8. The right to object to the insurer and not to submit to the insurer's decision that would have legal effects for or a significant impact on the data subject, where such decision is issued solely on the basis of automated processing of personal data. The data subject has the right to request the insurer review the issued decision by a method different from the automated form of processing, and the insurer is obliged to comply with such request so that the insurer's staff has decisive role in reviewing the decision. Within 30 days of receiving such request, the insurer will inform the data subject of the manner of review and the result of the finding.
- 5.9. The right to request proof of identity of the person responsible for collecting personal data.
- 5.10. Where personal data has not been obtained from the data subject, the data subject has the right to obtain information as to from which source such personal data originate, or whether the data originate from publicly available sources.

If the data subject does not have full legal capacity, the rights of such data subject may be exercised by a legal guardian.

If the data subject is not alive, the rights the data subject had under the personal data protection laws may be exercised by a close person.

The data subject may exercise their rights:

- a) in writing at the address of the insurer's registered office or at the electronic address [dataprotection@union.sk](mailto:dataprotection@union.sk);
- b) personally in the written record, from which it must be clear who has exercised the right, what is being claimed, and when and who has drawn up the written record, signature of such person and signature of the data subject; the insurer is obliged to hand over a copy of the written record to the data subject;
- c) with the processor pursuant to point a) or b), where such processor is required to promptly hand over such request or written record to the insurer.

## 6. Personal data will not be published.