HEALTH QUESTIONNAIRE

You would like to enroll to the "Loss of salary insurance - Non-professional Illnesses & Accidents" proposed by GPAFI and subscribe to the Disability group insurance contract No. MGENIB1100433NNP taken out by AMFI-GPAFI with the Insurer MGEN Vie. **To submit your membership application, you must first complete a health questionnaire.**

IMPORTANT: The answers to this questionnaire must be handwritten by the person to be insured, who must read and answer all questions. A detailed, complete and exact answer must be given to all the questions asked failing which the application will not be considered.

1. APPLICANT (PERSON TO BE INSURED)

Last name: _____ First name: _____

Date of birth: ____/____/_____

Name and contact details of the attending physician: _____

_____

2. MEDICAL QUESTION

- Please check "YES" or "NO" for each question asked.
- For each "YES" answer, please specify any additional information related to the question number, the date of the event or result, the date of recovery or consolidation, the nature of the hospitalization, the duration of the illness or hospitalization, the after-effects and any other additional information.
- You can also provide additional details on a blank sheet of paper and attach it to your health questionnaire.

a. Are you currently on sick leave for more than five (5) working days? ☐ Yes ☐ No

_____

_____

b. In the last four (4) years, have you been on sick leave for more than thirty (30) consecutive working days?

☐ Yes ☐ No

_____

_____

c. In the next six (6) months, is an hospitalization planned, including day hospitalization? ☐ Yes ☐ No

_____

_____

d. In the last five (5) years, have you been treated or are you currently being treated for:

i. Heart disease or blood vessel disease: ☐ Yes ☐ No

If yes which one? _____

_____

ii. Cancer: ☐ Yes ☐ No

If yes which one? _____

_____

iii. A cerebrovascular accident (CVA): ☐ Yes ☐ No

iv. An osteoarticular problem: ☐ Yes ☐ No

If yes which one? _____

v. **Neurological diseases such as multiple sclerosis, Parkinson's disease:** ☐ **Yes** ☐ **No**

If yes which ones: _____

_____

vi. **Psychiatric conditions such as depression, burn out, generalized anxiety,...:** ☐ **Yes** ☐ **No**

vii. **A diabetes or other chronic disease:** ☐ **Yes** ☐ **No**

If yes which one? _____

_____

3. ADDITIONAL INFORMATION ON YOUR HEALTH CONDITION

_____

_____

_____

_____

4. PERSONAL DATA PROTECTION

Health data, the processing of which is necessary for the performance of obligations specific to MGEN Vie and exercise of the rights of the insured persons themselves may be processed in connection with the conclusion, administration, and execution of the said contract. This data is intended exclusively for GPAFI and the medical advisor of MGEN Vie. The exercise of these rights is carried out by mail, to the attention of the medical advisor: gpafi@vyv-ib.com.

5. STATEMENT

By your signature below you certify:

- giving your consent to the processing of your personal data, in particular those related to your health, which are necessary for the administration and execution of your insurance contract. You may withdraw your consent at any time, without this affecting the lawfulness of the processing, prior to the withdrawal, based on the consent;
- having provided all the requested information completely, truthfully and accurately (all answers to the questions are mandatory);
- recognizing that in the occurrence of a claim or any request for intervention, the conscious and voluntary production of incorrect or fraudulent documents will result in a loss of coverage without refund of premiums already paid.

WHERE TO SEND THE HEALTH QUESTIONNAIRE?

Please ensure first that you have answered all the questions asked. Sign the health questionnaire and send it to the following address:

By email: gpafi@un.org
or
By post: GPAFI, Palais des Nations, 1211 Geneva 10, Switzerland

Certified accurate. **Done in Geneva.** **On ____/____/_____**	**Signature of the Applicant preceded by the words "read and approved":**

This health questionnaire is valid for three (3) months from the date of signature of the Applicant.