MEDICAL QUESTIONNAIRE

BUPA GLOBAL

(Please use block letters)
Please read the information regarding the underwriting conditions in Section A before completing this "Medical Questionnaire".

A) UNDERWRITING CONDITIONS

Please see the below stated underwriting conditions for new applicants who would like to apply for cover and existing customers who want to apply for an upgrade in cover. Further we refer to the Policy Conditions stated in the product guide of the insurance product you are applying for.

Please note that you always have to complete a "Medical Questionnaire" for adopted children, children born as a result of fertility treatment and children born by a surrogate mother.

International Health and Hospital Plan: A "Medical Questionnaire" must be completed for each person aged 10 years or over applying for cover and any child under the age of 10 with a pre-existing condition or who is not in good health. All the "Medical Questionnaires" should be sent together with the "Application Form A" to the insurer.

International Swiss Medical: A "Medical Questionnaire" must be completed for each person applying for cover. All the "Medical Questionnaires" should be sent together with the "Application Form A" to the insurer*.

International Top Up Plan: A "Medical Questionnaire" must be completed for each person aged 16 years or over applying for cover, and any child under the age of 16 with a pre-existing condition or who is not in good health. All the Medical Questionnaires should be sent together with the "Application Form A" to the insurer.

Superior: A "Medical Questionnaire" must be completed for each person aged 10 years or over applying for cover or any child under the age of 10 with a pre-existing condition or who is not in good health. All the "Medical Questionnaires" should be sent together with the "Application Form A".

Worldwide Health Insurance: A "Medical Questionnaire" must be completed for each person aged 16 years or over applying for cover, and any child under the age of 16 with a pre-existing condition or who is not in good health. All the "Medical Questionnaires" should be sent together with the "Application Form A" to the insurer.

*Please be aware of the special underwriting condition for new applicants with a Sanitas agreement.

B) GENERAL INFORMATION

For administration use

Policy number — Date (dd/mm/yy)

Broker number

Applicant (Please underline the names you wish to be indicated on your insurance card. Max. 28 fields)

First name(s)

Family name(s)

Occupation

Date of birth (day/month/year) Age Sex (M/F)

Nationality

Other insurance

Do you have a health insurance with a Bupa group company or another insurance company? ☐ YES ☐ NO

Have you ever had a health insurance with a Bupa group company or another insurance company? ☐ YES ☐ NO

Company name

Policy number

Do you intend to keep your current insurance? ☐ YES ☐ NO

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? ☐ YES ☐ NO

If yes, please enclose complete information (Policy Conditions and policy documents)

Family doctor/treating physician

Name

Address

Telephone Fax

Email

Family name | Date of birth (dd/mm/yy)

C) MEDICAL INFORMATION QUESTIONNAIRE

This section asks for health and medical details - known (past and present) and suspected conditions. Please tick yes or no to every question 1-17 and provide answers to questions 18-22. If you tick yes to any of the questions 1-17 in this Medical Information Questionnaire, please give full details in Section D Additional Information. Please ensure that you tell us about any known or suspected conditions and symptoms even if professional advice has not yet been sought. If you already are an Bupa Global customer and you are applying to increase cover or you are applying to transfer from another Bupa group product, please include details of any conditions for which you have made claims since joining.

1) Heart or circulatory disorders		
eg high blood pressure, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, varicose veins, other related symptoms/diseases	☐ YES	☐ NO
2) Endocrine (glandular disorders)		
eg obesity, thyroid problems, diabetes type 1, diabetes type 2, colitis, liver diseases, liver cirrhosis other related symptoms/diseases	☐ YES	☐ NO
3) Breathing or respiratory disorders		
eg asthma, COPD, shortness of breath, pneumonia, bronchitis, tuberculosis, allergies (including hayfever and anaphylaxis), chest infections, other related symptoms/diseases	☐ YES	☐ NO
4) Stomach, intestines, liver or gall bladder problems		
eg stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, cirrhosis, abdominal pain, change in bowel habits, pancreatitis, hernias, liver inflammation, gall stones, haemorrhoids/piles, other related symptoms/diseases	☐ YES	☐ NO
5) Cancer, tumours or growths		
eg polyps, benign growths, any cancers or pre-cancerous conditions, other symptoms/diseases	☐ YES	☐ NO
6) Skin problems		
eg allergic conditions, rashes, psoriasis, acne, cysts, moles that itch or bleed, dermatitis, eczema, other related symptoms/diseases	☐ YES	☐ NO
7) Brain or nervous system disorders		
eg stroke, dementia, migraine, repeated headaches, multiple sclerosis, nerve pain (including sciatica and shingles), epilepsy/fits, meningitis, other related symptoms/diseases	☐ YES	☐ NO
8) Muscle or skeletal problems		
eg arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, gout, osteoporosis, inflammatory conditions, other related symptoms/diseases	☐ YES	☐ NO
9) Urinary or reproductive system problems		
eg kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence, pregnancy/childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, infertility/fertility treatment, endometriosis, sexually transmitted infections, polycystic ovaries, testicular or prostate disorders, abnormal smears, other related symptoms/diseases	☐ YES	☐ NO
10) Blood/infective/immune disorders		
eg abnormal blood tests, high cholesterol, anaemia, hepatitis A-B-C, malaria, any autoimmune disorder, HIV, other related symptoms/diseases	☐ YES	☐ NO
11) Eye, ear, nose, throat and dental problems		
eg cataracts, glaucoma, visual impairment, ear infections, deafness, tonsillitis, wisdom teeth problems, dental infections, gingivitis, other related symptoms/diseases	☐ YES	☐ NO
12) Psychiatric/psychological disorders		
eg compulsive or eating disorders, schizophrenia, depression, stress, anxiety, drug/alcohol dependency, other related symptoms/diseases	☐ YES	☐ NO
13) Cosmetic operations	☐ YES	☐ NO
14) Other diseases, disorders or Illnesses	☐ YES	☐ NO
15) Are you or have you been taking any medication, prescribed or otherwise?	☐ YES	☐ NO
16) Are you receiving any treatment of any kind, or do you require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in this application?	☐ YES	☐ NO
17) Have you experienced any signs or symptoms of any medical problem in the last six months, regardless of whether a healthcare professional has been consulted?	☐ YES	☐ NO

Family name | | | | | | | | | | | | | | | | | Date of birth (dd/mm/yy) | | | | | | |

C) MEDICAL INFORMATION QUESTIONNAIRE (continued)

18) Height — Metres/Centimetres _____ Feet/Inches _____

19) Weight — Kilogrammes _____ Stones/Pounds _____

20) For women only: Are you currently pregnant? ☐ YES ☐ NO

21) Smoking — Do you smoke? ☐ YES ☐ NO

If yes, how many cigarettes/day? _____

22) Do you use spectacles or contact lenses? ☐ YES ☐ NO

— if yes please indicate strength in diopter, left eye _____ right eye _____

D) ADDITIONAL INFORMATION

This section applies if you have indicated "Yes" to any questions in section C.
If you are unsure whether any details are relevant, you must include them.

Please enter the question number (Questions 1-17 that you have answered YES to on the Medical Information Questionnaire) _____

Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected, (eg right leg, left eye):

When did the symptoms start and when was treatment completed?

What treatment did you receive and when (please include dates, names and details of medications)?

What was the outcome of the treatment (eg ongoing, complete recovery, recurrent or likely to recur)?

Please enter the question number (Questions 1-17) that you have answered YES to on the Medical Information Questionnaire) _____

Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected, (eg right leg, left eye):

When did the symptoms start and when was treatment completed?

What treatment did you receive and when (please include dates, names and details of medications)?

What was the outcome of the treatment (eg ongoing, complete recovery, recurrent or likely to recur)?

23) Additional information: Do you have additional medical information? ◯ YES ◯ NO

All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

NB If you experience any additional symptoms other than the above described before you receive your policy documents, please notify us immediately. Failure to do so may affect your cover.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here ◯

If you have ticked here, please indicate how many pages you have attached to this Medical Questionnaire _____

Family name | | | | | | | | | | | | | | | | | Date of birth (dd/mm/yy) | | | | | | |

E) APPLICANT'S SIGNATURE

Your declaration
Claims and other benefits may not be payable, and in some cases the insurance may even be void, if you do not fully disclose any material fact which could influence our assessment and acceptance of this application. If you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters.

If your health changes after the application has been signed but before an insurance agreement has been entered into with Bupa Insurance Limited ("Bupa Global"), you must notify Bupa Global immediately of such change. You may be required to provide Bupa Global with medical reports in relation to this and any other pre-existing conditions.

In view of the following declaration, it is essential that complete information is supplied.
I declare that to the best of my knowledge and belief the information given by me is true and complete, and that, apart from the conditions fully disclosed to Bupa Global, I and any children ("dependants") to be insured on my policy are in excellent health and do not suffer or have suffered from any recurring illness or physical debility. If insurance for dental treatment is required, neither myself nor my dependants are under or about to undergo dental treatment.

I declare that I (on my and my dependants' behalf) have read the Policy Conditions and this Medical Questionnaire, and accept that the Policy Conditions together with the Policy Schedule (and the application forms) will represent the insurance contract with Bupa Global.

I also declare that I and my dependants are not permanently resident in the USA. I confirm that I (on my and my dependants' behalf) have read the Data Protection Notice below, and give explicit consent for Bupa Global to use my and my dependants' personal information in the manner and for the purposes stated.

Data Protection Notice
Purpose: Personal data collected about you and your dependants will be used by Bupa Global to process your claims, collect premium, provide reimbursements, administer your policy and to detect and prevent fraud or improper claims. If Bupa Global does not accept your application, your information may be recorded by us.

Confidentiality: Bupa Global complies with applicable data protection legislation and medical confidentiality guidelines. All correspondence concerning your policy will be sent to the policyholder and may be sent via your intermediary. All insured persons on the policy may have access to correspondence and other information sent by Bupa Global or accessed at www.ihi.com via the myPage login. Bupa Global uses third parties to process data on its behalf and your data may be processed in or outside the EU. Bupa Global may exchange your information within the Bupa group and with your intermediary. If you have had a health insurance with a Bupa group company or another insurance company Bupa Global may collect your medical information from this company and exchange information with the company in order to assess your current insurance application.

Medical information: Bupa Global may seek and exchange information about your and your dependants' health and treatment with those involved in your and your dependants' care (including your treating doctor and hospital) and their agents, and, if applicable, any person or organisation who may be responsible for meeting your and your dependants' treatment expenses, or their agents, as Bupa Global deems necessary.

Telephone calls: In the interest of continuously improving our service to customers, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Bupa Global, or disclosed to others, for research or statistical purposes.

Fraud: Information, including recorded telephone calls, may be disclosed to others with a view to preventing or detecting fraudulent or improper claims.

Names and addresses: Bupa Global does not make the names and addresses of customers available to other organisations (except as stated above).

Keeping you informed: Bupa Global will, on occasion, keep you informed of its products and services which it considers may be of interest to you. Data protection legislation gives you the right to see documents and information Bupa Global has recorded about you.

Contact address: If you do not wish to receive information about our products and services, or would like to see a copy of the information we hold about you, please write to the Bupa Group Information Protection Manager at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, England or at DataProtection@Bupa.com.

Date (day/month/year) _____ **Signature** _____

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