pk:rück

Print

Health declaration – To be filled by the insured person

Contact information

First name: _____ Surname: _____

Street: _____ Postal code, city: _____

Telephone: _____ E-mail: _____

Date of birth: _____ OASI number: _____

Employer: _____ Occupation: _____

Welfare institution: _____

Health information

1. Are you fully fit for work? If not, what is the extent of your **in**ability to work? _____% What is the reason for your **in**ability to work? _____	○ yes	○ no
2. If your answer to one of the following questions is **YES**, we would ask you to fill out the next page:		
2.1. Have you been fully or partially **un**fit for work for more than 3 weeks continuously during the last 5 years?	○ yes	○ no
2.2. Have you, over the past 24 months, had more than 4 consultations or instances of treatment with a physician or psychologist/psychiatrist (**not** including vaccinations, influenza, visits to the dentist and routine gynaecological check-ups)?	○ yes	○ no
2.3. Are you currently undergoing treatment by a physician or psychologist/psychiatrist which has not yet definitively ended?	○ yes	○ no
2.4. Have you, over the past 24 months, taken prescription drugs (apart from contraception) for longer than 4 weeks or had such drugs prescribed for you?	○ yes	○ no
2.5. Have you consumed illegal drugs over the past 24 months?	○ yes	○ no
2.6. Have you ever received pensions and/or daily benefits for more than 6 weeks due to illness or an accident?	○ yes	○ no
3. Has an HIV test ever produced the result of HIV positive for you?	○ yes	○ no
4. Please specify your height (_____cm) and your weight (_____kg).		
5. Does or has your pension fund ever applied a reservation for health reasons or charged an additional premium? If yes, for what reason? _____ If yes, please enclose a copy of the reservation/additional premiums.	○ yes	○ no

Declaration

I hereby confirm that I have answered the above questions truthfully and completely. I authorise the doctors/physicians who treated and examined me, to disclose confidentially all information on my state of health needed to the medical services of PKRück.

Place, date: _____ Signature: _____

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Questions 2.1 to 2.4

What is/was the diagnosis, or which complaints do/did you have?	Since when?	Has the treatment been terminated?	Are there any consequences or are relapses/complications to be expected?	Name and address of the physician/hospital providing treatment:
1		○ yes, since _____ ○ no		
2		○ yes, since _____ ○ no		
3		○ yes, since _____ ○ no		

Question 2.4

Name of the prescription drug:	Dose:	Since when?	Has the treatment been terminated?	Name and address of the physician/ hospital providing treatment:
1			○ yes, since _____ ○ no	
2			○ yes, since _____ ○ no	
3			○ yes, since _____ ○ no	

Quesiton 2.5

Which illegal drugs have you consumed/do you consume?	How much and how often?	Please specify the duration.
1		
2		

Question 2.6

For what reason did you receive pensions and/or daily benefits?

from to

Name and address of the physician who is best informed about your state of health:

Place, date

Signature: