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 18-21.
For any of the medical conditions listed below (questions 1-13), please answer yes if the applicant:

- *has seen a doctor or other healthcare professional in the last three years, or*
- *has been admitted to hospital, had an operation or procedure in the last seven years, or*
- *had an investigation (eg a scan/blood tests) in the last seven years*

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) Circulatory disorders		
eg high blood pressure, chest pains, aneurysms, varicose veins, deep vein thrombosis	☐ YES	☐ NO
2) Endocrine (glandular disorders)		
eg obesity, thyroid problems, diabetes type 1, diabetes type 2, colitis, liver diseases, liver cirrhosis	☐ YES	☐ NO
3) Breathing or respiratory disorders		
eg asthma, COPD, shortness of breath, pneumonia, bronchitis, tuberculosis, allergies (including hayfever and anaphylaxis), chest infections	☐ 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	☐ YES	☐ NO
5) Benign tumours, growths or pre-cancerous conditions		
eg polyps, benign growths, breast nodules or cysts, lipomas	☐ YES	☐ NO
6) Skin problems		
eg allergic conditions, psoriasis, acne, cysts, moles that itch or bleed, dermatitis, eczema	☐ YES	☐ NO
7) Brain or nervous system disorders		
eg dementia, migraine, repeated headaches, multiple sclerosis, nerve pain (including sciatica and shingles), epilepsy/fits meningitis	☐ 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	☐ 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	☐ YES	☐ NO
10) Blood/infective/immune disorders		
eg abnormal blood tests, high cholesterol, anaemia, hepatitis A-B-C, malaria, any autoimmune disorder, HIV	☐ 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	☐ YES	☐ NO
12) Psychiatric/psychological disorders		
eg compulsive or eating disorders, schizophrenia, depression, stress, anxiety, drug/alcohol dependency	☐ YES	☐ NO
13) Cosmetic operations	☐ YES	☐ NO
Please also answer the following questions:		
14) Is anyone to be covered taking any medication, prescribed or otherwise?	☐ YES	☐ NO
15) Has anyone to be covered ever had a history of the following:		
Cancer	☐ YES	☐ NO
Heart condition eg angina, heart attack, heart failure, abnormal heartbeat	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Prosthetic implants and appliances in his/her body eg shunts, pacemakers, joint replacements	☐ YES	☐ NO
16) Is anyone to be covered receiving any treatment of any kind or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in questions 1 - 13?	☐ YES	☐ NO
17) Has anyone to be covered experienced any signs or symptoms of any medical problem in the last six months, regardless of whether a health care 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 — Kilograms _____ 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? _____

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 the notes section at the end of this form, or attach 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 Global, you must notify Bupa Global immediately of such a change. You may be required to provide Bupa Global with medical reports in relation to this and any other pre-existing conditions. Failure to notify Bupa Global may result in the cancellation of your insurance policy.

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 agree that any cover which I may purchase shall not be renewed at the policy anniversary should I become a permanent resident of the USA (or in the case of an additional person becoming a permanent resident of the USA, their cover under the policy shall not be renewed at the policy anniversary). I agree that I am required to immediately notify the Company in writing if I or any additional person (as the case may be) become a permanent resident of the USA, failing which the Company may terminate the insurance with immediate effect or (where permitted to continue the insurance until such date) with effect from the policy anniversary. 'Permanent resident' shall mean a person residing in the USA who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in the USA, and 'USA' shall include the Commonwealth of Puerto Rico for this purpose. I confirm that I have read the Data Protection Notice below and brought it to the attention of my dependants.

Privacy notice

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. Fuller details can be found in our Full Privacy Notice available at: www.ihi.com/privacy. If you do not have access to the internet and would like a paper copy of the Full Privacy Notice, please contact the Bupa Global service team on +45 70 23 00 42. Alternatively you can email or write to the team via ihi@ihi.com or Bupa Global, Palægade 8, DK-1261 Copenhagen K, Denmark. If you have any questions about how we handle your information, please contact us at ihi@ihi.com

Information about Bupa Global

In this privacy notice, references to "we" or "us" or "our" are to Bupa Global. For company contact details, visit

www.ihi.com/legal-information

1 Scope of our privacy notice

This privacy notice applies to anyone who interacts with us in relation to our products and services ("you", "your"), via any channel (e.g. email, website, telephone, app).

2 Ways in which we obtain personal information

We obtain personal information from you and from certain third parties (e.g. those acting on your behalf, like brokers, healthcare providers). Where you provide us with information about other individuals, you must ensure that they have seen a copy of this privacy notice and are comfortable with you doing this.

3 Categories of personal information

We process two categories of personal information about you and/or, where applicable, your dependants, namely standard personal information (e.g. information we use to contact you, identify you or manage our relationship with you); and special categories of information (e.g. health information, information about race, ethnic origin and religion that allows us to tailor your care, and information about crime in connection with screening).

4 Purposes and lawful grounds of our processing personal information

We process your personal information for the purposes set out in our Full Privacy Notice, including to administer our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and in order to protect the rights, property, or safety of Bupa Global, our customers, or others. The legal ground upon which we process personal information depends on what category of personal information we process. Standard personal information is normally processed by us on the basis that it is necessary for the performance of a contract, our or a third party's legitimate interests or it is required or permitted by applicable law.

5 Processing for Profiling and Automated Decision Making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will be of interest (including discounts on our products and services). This may involve evaluating information about you and, in some cases, using technology to provide you with automatic responses or decisions. You can read more about this in our Full Privacy Notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision-making. Further details are available in our Full Privacy Notice.

6 Sharing your information

We share your information within the Bupa Group, with relevant policyholders (including your employer if you are covered under a group scheme), with funders commissioning services on your behalf, those acting on your behalf (e.g. brokers and other intermediaries) and with others who help us provide services to you (e.g. healthcare providers) or from whom we need information to handle or verify claims or entitlements (e.g. professional associations). We also share your information in accordance with the law.

All correspondence concerning your policy, including documents containing sensitive information such as medical details, 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, including documents containing sensitive information such as medical details, sent by Bupa Global or accessed at www.ihi.com via the myPage login.

7 Transfers outside of the European Economic Area (EEA)

Bupa Global deals with many international organisations and uses global information systems. As a result, Bupa Global transfers your personal information to countries outside of the European Economic Area ("EEA"), that is the EU member states and Norway, Liechtenstein and Iceland, for the purposes set out in this privacy notice.

8 How long we retain your personal information

Bupa Global retains your personal information in accordance with retention periods calculated in accordance with the criteria detailed in the Full Privacy Notice available on our website.

9 Your rights

You have rights to have access to your information and to ask us to rectify, erase and restrict use of your information. You also have rights to object to your information being used, to ask for the transfer of information you have made available to us, to withdraw consent to the use of your information and not to be subject to automated decision-making which produces legal effects concerning you or similarly significantly affects you.

10 Data Protection Contacts

If you have any questions, comments, complaints or suggestions in relation to this notice, or any other concerns about the way in which we process information about you, please contact us at ihi@ihi.com. You also have the right to make a complaint to your local supervisory authority for data protection.

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

F) AUTHORISED PERSON

I hereby authorise (full name and relation)

Name of Person (in full):	
Relation to insured person:	
Date of birth:	
Address:	
Email:	
Phone number (including country code):	

To contact Bupa Global on my behalf in relation to policy administration, including but not limited to claims assessment and preauthorisation of treatment, and I give my consent for Bupa Global to exchange information, including medical information with the authorised person for the purpose of such policy administration. I understand that I have the right to withdraw the authorisation at any time by contacting Bupa Global.

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