

Supplementary Health Insurance Medical Questionnaire



individual subscriber: Name - First name					
Person to be insured: Name - First name					
Address					
Date of birth (d - m - y)		Sex	М	F	
Organisation or institution			Nation	nality	
I. Please provide us with the following in	nformation				
- your blood pressure (if known) max	min				
- your weight (kg)	height (cm)				
2. Describe your actual state of health					
3. Do you suffer from any chronic, ment	al or physical disabilit	ies?		Yes	No
If so, please specify.					
Do you benefit from a 100% reimbursement by the JSIS?				Yes	No
If so, based on which pathology?					
4. Have you undergone a surgical inter-	vention or medical tre	eatmen	t (in th	e past 10	years)?
Yes No					
If so, please indicate the date(s), the natu	ure of the intervention	or the t	reatme	ent and th	ne consequences for your state of health.
5. In the following 6 months, do you nee	ed				
- to be hospitalised? Yes, indicate	the reason				
No					
- to undergo a surgical intervention? Ye	es, describe the no	ature of	the int	tervention	n and the diagnosis below.
No					
6. Are you being medically treated at this	s moment (medicinal or	r other)	? Y	⁄es	No
If so please specify treatment and reason	nn				

Are you being paramedically treated now (physiotherapy, osteopathy, speech therapy)?				
Yes	No			
If so, please specify treatment and reason.				
Are you	pregnant?	Yes	No	
If yes, what is the expected due date (if already known)?				
is an offe (https://	e. The issuance of false claims, the provence punishable by Law. I hereby conf	visions of mi irm that I ho privacy). If I p	e information is to the best of my knowledge and belief correct isleading information or the withholding of information related thereto ave read and fully understood Cigna's Data Protection Notice provide Cigna with personal information relating to others,	
Signed in	n	On		
Signatur	re of the person to be insured, preced	ed by the h	andwritten words: 'Read and approved'	