Medical Questionnaire



(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 terms and conditions stated in the membership 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*.

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.

A to the insurer.																												
B) General Info	orm	nat	ion																									
For administratio	n us	se .																										
Membership number	ВІ	-					_					_																
Date	D	D	М	М	Υ	Υ	Υ	Υ																				
Broker number																												
Applicant details																												
First name (s)																												
Family name (s)																												
Occupation																												
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Date of birth	D	D	М	М	Υ	Υ	Υ	Υ	Ag	ie					Ма	le		\bigcirc	Fer	male	!							
Date of birth Nationality	D	D	М	М	Υ	Υ	Υ	Y	Ag	ie					Ма	le			Fer	male	:							
	D	D	М	М	Y	Y	Y	Y	Ag	ie					Ма	le			Fer	male								
Nationality						grou					anoth	ner ii	nsur	ance			y?		Fer	male) Ye	es		1	No
Nationality Other insurance	nsura	nce	with	n a B	upa		up c	omp	any	or a					con	npan		any?		male) Ye			_	No
Nationality Other insurance Do you have a health in	nsura	nce	with	n a B	upa		up c	omp	any	or a					con	npan		any?		male							_	
Nationality Other insurance Do you have a health in Have you ever had a health in the second secon	nsura	nce	with	n a B	upa		up c	omp	any	or a					con	npan		aany?		male							_	
Other insurance Do you have a health in Have you ever had a health in Company name	alth	nce	with	n a B	upa ith a	Bup	up c	omp	any	or a					con	npan		any?		male					es			

If yes, please enclose complete information (terms and conditions and insurance documents)

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Family name											Date of birth	D	D	М	М	Υ	Υ	Υ	Υ

C) Medical History

This section asks for health and medical details, past and present about yourself.

Please tick Yes or No to every question. If you tick Yes to a question, please give full details in section D.

If you do not provide us with full details we may cancel your cover or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

You must also tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

Whether you are changing your benefits, or a returning Bupa customer, you must complete the medical history section in full so that we have an up to date record of your health.

For any of the medical conditions listed below (questions 1-13), please answer yes if you have:

Seen a doctor, therapist or consultant in the last three years

Seen a doctor, therapist or consultant in the last three years Been admitted to hospital, had an operation or procedure, or had an investigation (e.g. a scan/blood tests) in the last seven years	
1) Circulatory disorders e.g. high blood pressure, high cholesterol, chest pains, aneurysms, varicose veins	
or deep vein thrombosis	(V) (N)
2) Endocrine (glandular) disorders e.g. diabetes (Type 1 or Type 2), thyroid problems, Addison's disease or obesity	\bigcirc
3) Breathing or respiratory disorders e.g. shortness of breath, asthma, chronic obstructive pulmonary disease, chest infections, pneumonia, bronchitis, tuberculosis, emphysema, sleep apnoea or allergies (including hayfever and anaphylaxis)	\bigcirc
4) Stomach, intestines, liver or gall bladder problems e.g. stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias	\bigcirc
5) Benign tumours, growths or pre-cancerous conditions e.g. polyps, benign growths, non-cystic breast lump, fibrocystic breast disease or lipomas	Y N
6) Skin problems e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions	Y N
7) Brain or nervous system disorders e.g. dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles), Parkinson's disease, motor neurone disease, cerebral palsy, encephalitis or meningitis	\bigcirc
8) Muscle or skeletal problems e.g. arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, fractures, osteoporosis, gout or inflammatory conditions	\bigcirc
9a) Female urinary or reproductive system problems e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, incontinence, ovarian cysts, polycystic ovaries, pelvic inflammation, cervical disease, endometriosis, dysmenorrhoea, irregular menstruation, fibroids, breast disease or infertility	Y N
9b) Male urinary or reproductive system problems e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, benign prostate hypertrophy or enlarged prostate or infertility	YN
10) Blood/infective/immune disorders e.g. abnormal blood tests, anaemia, hepatitis, HIV, malaria or any autoimmune disorder	\bigcirc
11) Eye, ear, nose and throat problems e.g. cataracts, glaucoma, visual impairment, detached retina, macular degeneration, deafness, ear infections, glue ear, deviated nasal septum, tonsillitis or gingivitis	Y N
12) Mental health disorders e.g. schizophrenia, bipolar, compulsive or eating disorders, depression, stress, anxiety or drug/alcohol dependency, panic attacks, paranoia or ADHD	\bigcirc
13) Congenital/Hereditary conditions e.g. Downs syndrome, spina bifida, cystic fibrosis, cerebral palsy, cleft lip or cleft palate, sickle cell anemia, Huntington's disease, thalassemias or hemochromatosis	Y N
Please also answer the following questions:	
14) Are you taking any medication, prescribed or otherwise?	$\bigcirc \bigcirc \bigcirc$
15) Do you currently have, or ever had:	
o Cancer	(V) (N)
Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	(YN)
o Stroke	(V) (N)
o Prosthetic implants and appliances in his/her body e.g. shunts, pacemakers, joint replacements	(YN)
16) Are you 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?	\bigcirc
17) In the last 3 months have you experienced any signs or symptoms of any medical problem, illness, or injury not yet diagnosed	\bigcirc

Family name	Date of	birth	D M M Y Y Y
Further details (for over 16s only):			
How tall are you?	feet/inches metres/centimetres		
How much do you weigh?	stones/pounds kilograms		
D) Additional Information			
This section applies if you have indicated "Yes" If you are unsure whether any details are relevan			
Please enter the question number (Questions 1-17 Medical Information Questionnaire)	that you have answered YES to on the		
Please specify as accurately as possible the name Where applicable, please state the area of the bo			
When did the symptoms start and when was trea	tment completed?		
What treatment did you receive and when (pleas	e include dates, names and details of medications)?		
What was the outcome of the treatment (e.g. ong	going, complete recovery, recurrent or likely to recur)?		
Please enter the question number (Questions 1-17 Medical Information Questionnaire)) that you have answered YES to on the		
Please specify as accurately as possible the name Where applicable, please state the area of the bo			
When did the symptoms start and when was trea	tment completed?		
What treatment did you receive and when (pleas	e include dates, names and details of medications)?		
What was the outcome of the treatment (e.g. ong	going, complete recovery, recurrent or likely to recur)?		
Additional information: Do you have additional r	nedical information?	Yes	○ No
All relevant up-to-date medical reports should be	enclosed in the event of any pre-existing medical condition	ons.	
If you experience any additional symptoms othe Failure to do so may affect your cover.	r than the above described before you receive your insur	ance documents, pl	ease notify us immediately.
If there is insufficient space, please use the notes	sheet at the end of this form and indicate that you have d	one so by ticking he	ere 🔘

Family name																			Date of birth	D	D	М	М	Υ	Υ	Υ	Υ	
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E) Privacy notice

Last updated: March 2022

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. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice available at: www.bupaglobal.com/privacypolicy. If you do not have access to the internet and would like a paper copy of the full privacy notice, or if you have any questions about how we handle your information, please contact the Bupa Global service team on +44 (0) 1273 323 563. Alternatively you can email or write to the team via info@bupaglobal.com or Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

Information about Bupa Global

In this privacy notice, "we" "us" and "our" mean the Bupa companies trading as Bupa Global. For details of these companies, visit www.bupaglobal.com/legal-notices

The Bupa companies that process your information will depend on which of our products and services you ask us about, buy or use. For our insurance policies, your information will be processed by the insurer and the lead administrator of your policy who may share it with other Bupa companies as set out in the 'Sharing your information section'. Please refer to your policy documentation for confirmation of the insurer and lead administrator.

1. What this privacy notice covers

This privacy notice applies to anyone who interacts with us about our products and services ("you", "your"), in any way (for example email, website, phone, app and so on).

2. How we collect personal information

We collect personal information from you and from other organisations (for example those acting on your behalf, like brokers, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

3. Categories of personal information

We process the following categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example information we use to contact you, identify you or manage our relationship with you), special categories of information (for example health information, information about race, ethnic origin and religion that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks or other background screening activity).

4. What we use personal information for and our legal reasons for doing so

We process your personal information for the purposes set out in our full privacy notice, including to deal with 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 to protect our rights, property, or safety , or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary so we can perform a contract, for our or others' legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

5. 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 interest you (including discounts on our products and services). This may involve evaluating information about you and, in limited 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.

6. Sharing your information

We share your information within the Bupa group of companies, with relevant policyholders (including your employer if you are covered under a group scheme), with funders who arrange services on your behalf, those acting on your behalf (for example brokers and other intermediaries) and with others who help us provide services to you (for example healthcare providers) or who we need information from to handle or check claims or entitlements (for example professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

7. International transfers

We work with companies that we partner with, or that provide services to us (such as healthcare providers, other Bupa companies and IT providers) that are located in, or run their services from, countries across the world. As a result, we transfer your personal information to different countries including transfers from within the UK to outside the UK, and from within the EEA (the EU member states plus Norway, Liechtenstein and Iceland) to outside the EEA, for the purposes set out in this privacy notice. We take steps to make sure that when we transfer your personal information to another country, appropriate protection is in place, in line with global data protection laws.

8. How long we keep your personal information

We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice.

9. Your rights

You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used, to ask us to transfer information you have made available to us, to withdraw your permission for us to use your information and to ask us not to make automated decisions which produce legal effects concerning you or significantly affect you. Please contact us if you would like to exercise any of your rights.

10. Data protection contacts

If you have any questions, comments, complaints or suggestions about this notice, or any other concerns about the way in which we process information about you, please contact us at info@bupaglobal.com. You can also use this address to contact our Data Protection Officer.

You also have the right to make a complaint to your local privacy supervisory authority. We are regulated by the Data Protection Commissioner (www.dataprotection.ie) who can be contacted at, 21 Fitzwilliam Square South, Dublin 2, D02 RD28, Ireland. Tel +353 (0)761 104 800 or +353 (0)57 868 4800.

Family name																			Date of birth	D	D	М	М	Υ	Υ	Υ	Υ
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F) Your Application Declaration

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 terms and conditions and this Medical Questionnaire, and accept that the terms and conditions together with the insurance certificate (and the application forms) will represent the insurance contract with Bupa Global. I agree that Danish law will apply to the policy.

I also declare that I and my dependants are not permanently resident in the U.S. 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 U.S. (or in the case of an additional person becoming a permanent resident of the U.S., 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 U.S., 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 U.S. who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in the U.S., and 'U.S. shall include the Commonwealth of Puerto Rico for this purpose.

I understand that my personal information and that of any other person to be covered by this policy will be processed by Bupa Global for the purposes set out in Bupa Global's privacy notice. I confirm that I have brought Bupa Global's privacy notice to the attention of these covered.

I understand and accept that some policy documentation will be provided in my preferred language and all other written communications associated with this application may be provided in English. I acknowledge that Bupa will endeavour to facilitate verbal communication in an alternative language insofar as is possible however I understand and accept that some verbal communications may also be in English.

Signatory		

Date	:						
D	D	М	М	Υ	Υ	Y	Y

I hereby authorise (full name ar	nd re	latio	n)																
Name of Person (in full):																			
Relation to insured person:																			
Date of birth:	D	D	М	М	Υ	Υ	Υ	Υ											
Address:																			
Email:																			
Phone number (including count	try c	ode)):																

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.

Signatory	Date							
	D	D	М	М	Y	Y	Y	Y

Bupa Global Customer Service, Victory House, Trafalgar Place, Brighton, BN1 4FY, United Kingdom Tel: +44 (0) 1273 323563 Fax: +44 (0) 1273 820517 Email: info@bupaglobal.com www.bupaglobal.com

Bupa Global Designated Activity Company (Bupa Global DAC), trading as Bupa Global, is a designated activity company limited by shares registered in Ireland under company number 623889 and having its registered office at Second Floor, 10 Pembroke Place, Ballsbridge, Dublin 4, DO4 VIW6.

Authorised Person