ERGO Life Insurance SE
Geležinio Vilko str. 6A, LT-03507 Vilnius
Company code 110707135

ERGO

Request

to receive offer for personal health insurance

(The application shall be valid for one month as of the date of signature thereof if during such period no insurance policy is issued. The start of the insurance specified in the application shall be preliminary and may be changed by the insurer subject to receipt of all data necessary for the issue of the insurance policy. The start of the insurance shall be specified in the insurance policy. Any changes in the data on the insurance condition or other data provided in the application which took place as of the date of completion of the application to the date of issue of the insurance policy must be immediately notified to the insurer in writing.)

1. Policyholder

☐ Male ☐ Female ☐ Company

Name, surname or name of the company

Address

Phone

E-mail

Citizenship

Identification number

Date of birth

2. Insured

☐ Male ☐ Female

Name, surname

Address

Phone

E-mail

Citizenship

Identification number

Date of birth

Relationship with the policyholder

Workplace and position held

3. Are you insured with Compulsory health insurance? ☐ Yes ☐ No

4. Insurance options

☐ Minimal ☐ I ☐ II ☐ III

5. Primary insurance data

Payment frequency ☐ annually ☐ half-yearly ☐ quarterly

Start of insurance

Start of insurance coverage: 10 days as of the date of completion of the application. The insurance premium must be paid within 10 days as of the date of the present application for conclusion of insurance contract.

Please answer to the questions by crossing the appropriate box

1. Your weight ____ **kg** **2. Your height** ____ **cm** **Body mass index** ____

3. Do you smoke more than 10 cigarettes per day? ☐ Yes ☐ No

If yes, please indicate since when

I quit smoking since

4. Do you take more than 6 units of alcohol per week (50 ml of vodka – 1 unit; 200 ml of wine – 1 unit; 250 ml of beer – 1 unit)? ☐ Yes ☐ No

If yes, please indicate the number of units

5. Do you take or use any narcotic substances? ☐ Yes ☐ No

If yes, please indicate what substances

Please answer to the questions in detail. In case the answer to a question is yes, please describe it in detail at the end of the questionnaire. If the space for the answer to a question is insufficient, please use a separate sheet as an annex to the present questionnaire. In case you do not want to provide your personal data to the broker, you are entitled to notify us in writing within 3 days as of the date of completion of the present questionnaire. Please indicate it in the present questionnaire.

1. Is your work dangerous to your health or life (e.g. explosive or radioactive substances, poisons, chemicals, assigned service gun, work at height or other dangers to health)? ☐ Yes ☐ No

2. Are you engaged in mountaineering, mountain sports, avia sports, parachuting, gliding, moto sports, auto sports, sailing, fighting sports, diving, shooting, hang-gliding, paragliding or other extreme sports **during your leisure time?** ☐ Yes ☐ No

3. Have you ever suffered from any accidents, injuries, intoxications? ☐ Yes ☐ No

4. Did you suffer from the below diseases during the last 10 years, do you suffer from the below diseases today?

(a) respiratory diseases, e.g. bronchial asthma, bronchitis, pneumonia, repeated sinusitis, angina or other diseases? ☐ Yes ☐ No

(b) cardiovascular diseases, e.g. hypertension, myocardial infarction, cardiac ischemia, atherosclerosis, heart rhythm disorder, heart rheumatics, heart failure, heart disease, stroke, cerebrovascular disorder, phlebitis or other diseases? ☐ Yes ☐ No

(c) digestive system diseases, e.g. peptic ulcer disease, stomach, liver, gall-bladder, pancreas, intestine or other diseases? ☐ Yes ☐ No

(d) renal, urinary track, genital diseases, e.g. nephritis, renal failure, stone, cystitis, prostate inflammation or other diseases? ☐ Yes ☐ No

(e) Metabolic diseases, e.g. diabetes mellitus, high cholesterol of blood, thyroid disorder, podagra, other endocrine diseases? ☐ Yes ☐ No

(f) Bone-muscle system diseases, e.g. bone, joint, spinal disc, intervertebral disc, muscle, tendon or other diseases? ☐ Yes ☐ No

(g) Blood diseases, e.g. anaemia, leukaemia, blood coagulation disorders, other blood diseases? ☐ Yes ☐ No

(h) Nervous or mental diseases, e.g. paralysis, myopathy, muscle dystrophy, neuropathy, vertigo, multiple sclerosis, encephalitis, mental or behavioural disorder, depression, anxiety disorder, other diseases? ☐ Yes ☐ No

(j) Infectious diseases, e.g. tuberculosis, infectious hepatitis, sexually transmitted diseases, septicaemia, fungous diseases, parasitic diseases or other diseases? ☐ Yes ☐ No

(i) Other not mentioned diseases, e.g. tumours, congenital diseases? ☐ Yes ☐ No

5. Were you treated in hospital, day in-patient department, rehabilitation centre, sanatorium, had a surgery during the last 5 years? ☐ Yes ☐ No

If yes, then when?

6. Did you apply to any doctor / Were you examined, consulted, treated during the last 3 years? ☐ Yes ☐ No

☐ on a preventive basis ☐ due to a disease

7. Are you planning to have a surgery? When? ☐ Yes ☐ No

8. Are any diagnostic tests being carried out or planned in the future? ☐ Yes ☐ No

9. Did you take any pharmaceuticals, e.g. soporific, sedative, analgesic, blood pressure lowering medicines or other medicines, **for the period longer than four weeks during the last three years?** ☐ Yes ☐ No

10. Only for women: Did you suffer / do you suffer from any gynaecological, breast diseases? Are you pregnant? ☐ Yes ☐ No

11. Has any disability or loss of working capacity been established for you (established special need for nursery, need for care assistance)? ☐ Yes ☐ No
(If yes, indicate the reason, e.g. due to occupational, congenital or acquired disease or accident)

12. Did your father, mother, brothers, sisters suffered (currently suffers) from any of the following diseases: cardiovascular diseases, e.g. hypertension, myocardial infarction, cardiac ischemia, atherosclerosis, ischemic stroke), diabetes mellitus, tumours (e.g., breast, ovarian, intestine), intestinal polyposis, renal polycystosis, multiple sclerosis, Parkinson's disease, hereditary diseases? ☐ Yes ☐ No

a) if yes, since what age?

b) if deceased, at what age
(please specify the reason of death)?

If you answered yes to any of the above questions, please specify your answer.

Question No	Please specify the danger; disease	When you were ill?	Medical institution, physician

Note: if there is not enough space for your answers, please answer to the questions on a separate sheet indicating the number of the question.

Extra page is attached: ☐ Yes ☐ No

By signing the present application I do certify that I have familiarised and agree with the terms and conditions of the insurance option chosen by me, the insurance regulations, the amounts of insurance premiums and insurance amounts and the contents of the present application. I have fully and correctly answered to the questions set out in the application to ERGO Life Insurance SE without concealing anything.

Date | Signature of the policyholder | Signature of the insured

Note! If the insured is a minor, his/her parents or guardian (carer) shall sign instead of him/her.

Data protection

By signing the present application I do certify that:

1. I agree that ERGO Life Insurance SE the information provided herein by me in conclusion, of the insurance contract, when investigating the insured events and to this end interview the physicians, hospitals and other medical care and wellness service establishments in which I was or shall be treated and/or nursed and/or I was provided with wellness services as well as other provided wellness services and all other personal information about me as a patient. I confirm that I have been informed that this consent is valid until it is canceled by contacting the insurance company's customer service department or by e-mail info@ergo.lt
2. I am aware that I am entitled to disagree with the processing of my personal data, to familiarize myself with my personal data, to request to correct, delete or restrict the processing of my personal data; into data portability; submit a complaint to the State Data Protection Inspectorate.

Date | Signature of the policyholder | Signature of the insured