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ERGO

Insured person's health questionnaire (A2)

Name and surname of the insured person

Personal identity number

Date of birth

Citizenship(s) of

☐ Latvia ☐ Other (country)

Sex

☐ Male ☐ Female

Occupation / position

Phone number

Email

Name and surname (or company name) of the policyholder

Please read the questions carefully, because in case of false or incomplete information related to the insured event, the insurer has the right to reduce or not to pay the insurance indemnity.

If there is not enough space in the field for an answer, please use a separate page with the question number, but indicate the attachment in the health declaration. You may submit personal data that you do not wish to disclose to the representative of the insurer's distributor directly to us in writing within 5 working days after completing the application. Indicate this in this declaration. Please note that the insurer may ask to submit additional information necessary for the assessment of the insurance risk.

1. Does your work involve hazard to health or life (e.g., work with explosives, radioactive or toxic substances; work in a gas or oil industry, special forces, security service, aviation; you have been issued a service weapon; you work at a height of more than 15 m; you work with construction equipment, moving machinery; you are a sailor, diver, firefighter)? ☐ Yes ☐ No

Please describe the potential risk in more detail.

2. Are you engaged in extreme sports (e.g., flying vehicles, auto-motor sports, combat sports, BMX/HD and similar bicycles, rollerblading on ramps, diving to depths of more than 40 metres, sailing, mountaineering, caving, hang gliding and motorised/non-motorised flying, kitesurfing, parachuting, bungee jumping, cross-country skiing, skiing and snowboarding off-piste or in the use of paragliding/helicopters, equestrian sports, etc.). ☐ Yes, in my free time ☐ Yes, professionally ☐ No

Name the sports you are engaged in.

3. Are you engaged in any type of sport professionally: are you preparing for/participating in national or international competitions organised by a federation or union in the sport concerned, playing sport as an individual or as part of a team that receives sponsorship or remuneration for its activities? ☐ Yes ☐ No

Name the sports you are engaged in.

4. What is your height and weight? Height, cm Weight, kg

5. Do you have any illnesses, health complaints about:

5.1. Respiratory diseases (e.g., bronchial asthma, chronic bronchitis, chronic obstructive pulmonary disease, pneumonia, laryngeal diseases, frequent sinusitis, or other diseases)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.2. Cardiovascular diseases (e.g., high blood pressure, myocardial infarction, ischaemic heart disease, atherosclerosis of the coronary arteries, heart rhythm disturbances, cardiac rheumatic fever, cardiac insufficiency, heart failure, cardiac malformation, stroke, cerebral circulation disorders, vascular anomalies, venous inflammation, or other conditions)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

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5.3. Digestive system diseases (e.g., ulcers, oesophagus, stomach, liver, gallbladder, pancreas, intestinal or other diseases)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.4. Diseases of the kidneys, urinary tract, genital tract (e.g., kidney inflammation, insufficiency, urolithiasis, inflammation of the bladder, prostatitis or other conditions)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.5. Have there been/are there abnormalities in the urine (e.g., blood, protein, glucose, leukocytes)? ☐ Yes ☐ No

What abnormalities?

5.6. For women only:

5.6.1. Gynaecological or breast diseases? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.6.2. Are you pregnant? ☐ Yes ☐ No

If you are pregnant, please provide a copy of your pregnancy care card.

5.7. Metabolic diseases (e.g., diabetes mellitus, elevated cholesterol level, thyroid dysfunction, gout, other endocrine diseases)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

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

What is/was the diagnosed illness? When? Where were you treated?

5.9. Musculoskeletal system, connective tissue diseases (e.g., bone, joint, vertebral, intervertebral disc, ankylosing spondylitis, muscle diseases, tendonitis, rheumatoid arthritis, systemic lupus erythematosus, polymyositis, osteoporosis, or other diseases)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.10. Nervous or mental diseases (e.g., epilepsy, paralysis, myopathy, muscular dystrophy, neuropathy, dizziness, Parkinson's disease, multiple sclerosis, encephalitis, encephalopathy, cerebral circulation disorder, neurosis, mental or behavioural disorder, depression, anxiety disorder, schizophrenia, or other diseases)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.11. Have you attempted suicide? ☐ Yes, once ☐ Yes, more than once ☐ No

5.12. Have you been diagnosed with a tumour (benign/malignant)? ☐ Yes ☐ No

What type of tumour (or which organ)? When? Where was it treated?

5.13. Eye diseases (e.g., retinal pathology, glaucoma, keratoconus, inflammation of the optic nerve or other)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

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5.14. Do you have a visual impairment (myopia/ hyperopia)? If yes, please indicate your visual acuity in diopters. ☐ Yes ☐ No

Left eye | Right eye

5.15. Ear diseases, hearing loss? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.16. Allergies (e.g., hay fever, urticaria, anaphylaxis) or skin conditions (e.g., psoriasis, systemic lupus erythematosus, scleroderma, ichthyosis, bleeding, painful, discoloured or abnormally sized moles or lesions on the skin or other)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.17. Infectious diseases (e.g., tuberculosis, polio, viral hepatitis, sexually transmitted diseases, blood infections, tropical diseases, fungal, parasitic or other)? ☐ Yes ☐ No

What is/was the diagnosed illness? When? Where were you treated?

5.18. Have you been diagnosed with HIV infection (positive HIV test)? ☐ Yes ☐ No

When? Where were you treated?

5.19. Have you had any accidents, injuries, poisonings, injuries with residual complications? ☐ Yes ☐ No

When? What?

5.20. Treatment:

5.20.1. Are you scheduled for surgery or inpatient treatment? ☐ Yes ☐ No

With regard to what illness? When?

5.20.2. Have you had any consultations, inpatient treatment, surgery in the last 10 years? ☐ Yes ☐ No

With regard to what illness? When?

5.20.3. Are you currently undergoing/recommended for any diagnostic tests, are you being treated, monitored for diseases? ☐ Yes ☐ No

What? With regard to what illness?

5.20.4. Are you taking regular medicines (e.g., sleeping pills, sedatives, painkillers, lowering blood pressure or other)? ☐ Yes ☐ No

What kind of medicine? When? With regard to what illness?

5.20.5. Have you been treated / prescribed treatment for an oncological disease? ☐ Yes ☐ No

When? What?

5.20.6. Have you sought medical advice, been examined/ tested, consulted, treated preventively in the last 5 years? ☐ Yes ☐ No

Were there any abnormalities or disease? What were they? When?

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5.21. Harmful habits:

5.21.1. Do you drink alcohol? ☐ Yes ☐ No

What kind? Amount per week?

5.21.2. Do you smoke (including electronic cigarettes, combustible tobacco)? ☐ Yes ☐ No

How many cigarettes per day?

5.21.3. Have you used/ are you using narcotic or intoxicating substances? ☐ Yes ☐ No

What kind?

5.22. Have you been diagnosed with a reduced level of work capacity, a disability, special needs? ☐ Yes ☐ No
Please provide a copy of a certificate on the level of your work capacity.

What is the reason? When?

6. Which physician is best informed about your health condition or healthcare establishment in which your personal health record is held (name, surname of physician and/or name of medical institution)?

7. Is sum insured for total and permanent disability higher than four (4) times your current annual gross salary? ☐ Yes ☐ No
(Please answer if you are taking out insurance against total and permanent disability for sum insured above 20 000 EUR).

Additional information (provide, if you have additional comments)

I agree that:

- With my signature I confirm the information provided in this application is true and complete and certify that I am informed that ERGO Life Insurance SE, on whose behalf the Latvian branch of ERGO Life Insurance SE acts in Latvia (hereinafter - the Insurer) will process personal data in accordance with the Privacy Policy which is available on the website www.ergo.lv, in the Privacy Policy section, as well as I have get acquainted with the mentioned policy.
- I agree that the Insurer will process my health data, including the Insurer may check, evaluate, request and receive my health data from medical personnel, medical institutions and other institutions and persons, to get acquainted with my health data, medical documentation, to transfer my health data to the reinsurer in order to perform a risk assessment, to check the information necessary for the fulfilment of the insurance contract obligations and to fulfil the insurance and reinsurance contract obligations.

☐ Agree

* I am informed that in case of disagreement with the mentioned processing of personal data, the Insurer may not be able to provide the chosen insurance service.

Date Name and surname of the insured person Signature