Your health declaration form

Please complete this health declaration for yourself and any dependent (spouse or child) that you have named in your Application Form and tick the box corresponding to your answer.

		Main Insurance	Spouse	Child 1	Child 2	Child 3
1	Name					
2	Last name					
3	E-mail					
4	N.I.F.					
5	Date of Birth					
6	Weight (kg)					
7	Height (cm)					
8	Gender	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐
9	Have you smoked over the past seven years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, kindly indicate the average number of cigarettes smoked per day and when you ceased smoking if relevant.					
10	Over the past 10 years, have you undergone:					
	a. A surgery?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b. A laser treatment, chemotherapy, radiation therapy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
11	Over the past 5 years, have you been afflicted by an, illness or involved in an accident that resulted in:					
	a. Sick leave for over 3 consecutive weeks?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b. Having to undergo medical treatment for over a month?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12	Have you suffered from or ever been diagnosed for:					
	a. Nervous disorders (chronic fatigue, anxiety, depression, migraine, epilepsy)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b. Spinal cord disorders (lower back pain, sciatica, herniated disc, stiff neck)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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		Main Insurance	Spouse	Child 1	Child 2	Child 3
12	c. Arthritis and / or rheumatism (e.g. hip, knee, shoulder, hands)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	d. Heart disease and / or vascular disorders (e.g. hypertension, angina / chest pain, heart attack, heart rhythm abnormalities, aneurysm)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	e. Diseases of the esophagus, stomach, intestines, liver, pancreas (e.g., stomach ulcers, Crohn's disease, ulcerative colitis)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	f. Urinary problems (ex: renal colic, testicular or prostate disorders, bladder or kidney problems, Polyp)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	g. A trauma, disease or illness requiring regular medical care and / or regular medical treatment.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
13	Have you ever performed a serological screening test as follows: If yes, kindly specify the result in the table below	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	a. ¿Hepatitis B virus (HBV)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b. ¿Hepatitis C (HCV)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	c. ¿HIV (AIDS)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
14	Have you ever had addiction problems related to alcohol and / or drugs?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
15	Within the next 6 months following the effective date of your contract, do you think you may:					
	a. Go to see a doctor or require any medical test (e.g. laboratory, imaging, endoscopy) and / or see a specialist and / or seek medical or surgical treatment?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b. Receive hospital treatment? (e.g. removal oftonsils, removal of a cyst, removal of a mole)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Dental and ophthalmal health (top modality only)

		Main Insurance	Spouse	Child 1	Child 2	Child 3
16	Are missing teeth that have not been replaced? (Except for teeth or judgment teeth)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, specify, how, when, and when:					
17	Do you have fixed dentures (crowns, implants, bridges, etc.)? If yes, specify, how, what and when:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, specify, how, what and when:					

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		Main Insurance	Spouse	Child 1	Child 2	Child 3
18	Do you plan to undergo, or do you need to undergo, any dental treatment, paradontosis or oral surgery?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, please specify the treatment:					
19	Do you suffer from paradontosis?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
20	Have you undergone a dental examination in the past 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, please indicate date (DD/MM/YYYY):					
	And result:					
21	Has undergone some type of ophthalmologic treatment, tests or analysis in the last 5 years; Such as decreased visual acuity or refractive capacity (With or without glasses), diseases of the retina or other diseases?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Your accident insurance declaration form (top modality only)

Please complete this health declaration for yourself and any dependant (spouse or child) that you have named in vour Application Form and tick the box corresponding to your answer.

		Main Insurance
22	Do you suffer from a handicap, disability or chronic illness?	Yes ☐ No ☐
23	In the 12 months preceding the effective date of your contract, have you taken sick leave more than 3 times?	Yes ☐ No ☐
24	Do you or anyone in your family have a history of the following diseases? Heart disease, vascular, neurological, psychiatric, cancer, diabetes?	Yes ☐ No ☐
25	Are you currently on sick leave?	Yes ☐ No ☐
26	Have you been declared disabled?	Yes ☐ No ☐
	Are you in the process of being declared disabled?	Yes ☐ No ☐
27	Are you currently insured for health or life insurance?	Yes ☐ No ☐
	Have you ever been refused, restricted or received a premium loading for a previous insurance policy?	Yes ☐ No ☐
28	Do you fly in a private or aviation club aircraft as a passenger or pilot (excluding regular commercial aircrafts)?	Yes ☐ No ☐
29	Have you suffered any medical condition other than those mentioned above?	Yes ☐ No ☐
30	Please add any other information regarding your health status that we should know.	Yes ☐ No ☐

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Health declaration

If you answered “yes” to any of the above questions, kindly clarify the details in the table below.

	Question number	Date of declaration of the first symptoms	Date of the last symptoms	Treatments, tests and results	Complementary precisions
Main Insurance					
Spouse					
Child 1					
Child 2					
Child 3					

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Declaration and authorization

1. To ensure medical confidentiality, you must submit this questionnaire and any medical documents sealed andmarked confidential, addressed to the attention of the medical board of Henner:
   Medical board (Care & Health Application)
   Henner Medical Department
   14 Boulevard du Général Leclerc,
   CS 20058,
   92527 Neuily-sur-Seine Cedex- FRANCE
   Medical.questionnaire@henner.com
2. Please provide your answer on a separate piece of paper and attach it to this Declaration when sending if youneed more space to provide your response. If you are applying with more than 3 children, please complete a secondform for the additional children.
3. Certify that the statements above are complete, accurate and truthful and agree to provide the medical board ofHenner all the medical information that they need. Any misrepresentation or omission shall render the policy nulland void and the premiums paid will be retained by the insurer as damages. The Insured and his dependents willhave to refund the benefits they have received.

Please tick the box if you want your intermediary (if any) to be your official representative for medical questions:

☐ I, the undersigned, authorize the Medical Advisory Board or the insurer to provide and request to myintermediary any medical information that is required.

Your email (compulsory):

Signed in (City, Country): Date (dd/mm/yyyy)):

Signature(s) of the Insured and all dependants who have reached majoritywith the mention “read and approved”.

Pre-contractual information

In accordance with the provisions of Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies, the Insurer from whom cover has been requested declares:

1. That this insurance contract is entered into under the right of establishment with MARKEL INSURANCE SE, Branch in Spain, with registered office at Paseo de la Castellana 259C, Floor 34, Torre de Cristal, 28046 Madrid (Spain), registered in the Register of Insurance Entities of the Directorate General of Insurance and Pension Funds under authorisation code No. E 0235.
2. The Member State responsible for supervising the activities of the Insurer is Germany, and the Supervisory Authority is BaFin (Bundesanstalt für Finanzdienstleistungsaufsicht), with registered office at Graurheindorfer Str. 108l, 53117 Bonn, Germany.
3. The legislation applicable to this contract shall be Law 50/1980 of 8 October on Insurance Contracts and Law 20/2015 of 14 July on the Regulation and Supervision of Private Insurance, Supervision and Solvency of Insurance and Reinsurance Companies and other Spanish regulations implementing it.
4. The provisions relating to complaints are the following:

   a. Internal complaint contacts:

   If you have any complaints, you may write to the broker who intermediated the policy, if applicable, or to the relevant department or area of Markel Insurance SE, Branch in Spain.

If you are not satisfied, and you wish to submit a complaint relating to your legally recognized interests and rights, you may write to our Customer Service Department:

Responsible person: Ms Sandra Santos Matarranz
C/ Serrano 76, 6 D
28006 – Madrid
Telephone: 91 556 19 78
Email: atencioncliente@markel.com

b. External complaint bodies:

If your complaint has not been accepted, or your request has been rejected in whole or in part, or if two months have elapsed since the date of submission to Customer Service without a resolution, you may contact the Complaints Service of the Directorate General of Insurance and Pension Funds.

In the event of a dispute, you may file a claim, pursuant to Article 24 of the Insurance Contract Act, before the Court of First Instance corresponding to your place of residence.

Likewise, you may voluntarily submit your differences to arbitration under the terms provided for in Article 31 of the General Law for the Defence of Consumer and User Rights and its implementing regulations, without prejudice to the provisions of the Arbitration Law, in the event that the parties submit their differences to the decision of one or more arbitrators.

CLIENT DATA PROTECTION INFORMATION

DATA CONTROLLER: Markel Insurance SE Branch in Spain, Paseo de la Castellana, 259C, Floor 34, 28046 Madrid. Contact details: markel@delegado-datos.com. Registration number: W2764898I. **PURPOSES:** Assessing the risk of the requested coverage through health declarations, as well as studying, accepting and calculating insurance premiums. **LEGITIMACY:** Consent of the interested party. **TRANSFERS:** As established by law. **RETENTION PERIOD:** For the duration of the insurance request and insurance contract, if applicable. **RIGHTS:** You have the right to request access to, rectification of, erasure of, objection to, restriction of and portability of your data by contacting the data controller. If you find any discrepancies, you can submit a complaint to the Spanish Data Protection Agency (www.aepd.es). No customer documentation will be disclosed to unauthorised third parties.

Declaration: I/we declare that:

(a) this form has been completed following appropriate investigation;

(b) the information provided is true and accurate;

(c) all facts and matters relevant to the insurance proposal have been disclosed. I/we also agree that this form and all information provided will be incorporated into the insurance contract and will form part of it.

Signature:

Full name:

Job title:

Date (DD/MM/YYYY):