pkrück

HEALTH DECLARATION

To be completed by the insured person.

CONTACT INFORMATION

First name	_____	Surname	_____
Street	_____	Postal code, city	_____
Telephone	_____	E-Mail	_____
Date of birth	_____	OASI number	_____
Employer	_____	Occupation	_____
Pension institution	_____		

HEALTH INFORMATION

1. Are you fully capable for work? ☐ Yes ☐ No
   If not, what is the extent of your incapacity to work? _____ %
   What is the reason for your incapacity to work? _____
2. If your answer to one of the following questions is **YES**, please complete page 3:
   2.1 Have you been fully or partially incapable for work for an uninterrupted period of more than 3 weeks during the last 5 years? ☐ Yes ☐ No
   2.2 Over the past 24 months, have you had more than 4 consultations or undergone treatment with a physician or psychologist / psychiatrist (**not** including vaccinations, influenza, visits to the dentist and routine gynaecological check-ups)? ☐ Yes ☐ No
   2.3 Are you currently undergoing treatment with a physician or psychologist/psychiatrist which has not yet been definitively completed? ☐ Yes ☐ No
   2.4 Over the past 24 months, have you taken prescription drugs (apart from contraception) for longer than 4 weeks or have such drugs been prescribed for you? ☐ Yes ☐ No
   2.5 Have you consumed illegal drugs over the past 24 months? ☐ Yes ☐ No
   2.6 Have you ever received a pension and/or daily benefits for more than 6 weeks due to illnes or an accident? ☐ Yes ☐ No
3. Has an HIV test ever produced the result of HIV positive for you? ☐ Yes ☐ No
4. Please specify your height (_____ cm) and your weight (_____ kg).
5. Does or has your pension fund ever applied a restriction for health reasons or charged an additional premium? ☐ Yes ☐ No
   If yes, for what reason? _____

   If yes, please enclose a copy of the restriction / additional premium.

AUTHORISATION AND CONSENT

Disclosure of data for the purpose of risk assessment and authorisation to obtain health data

The provision of insurance cover in accordance with the plan may be rendered conditional upon a current risk assessment. The pension institution has instructed its reinsurer PKRück AG (**www.pkrueck.com**) to carry out this risk assessment. In order to do so, the pension institution or respectively PKRück needs to be granted full rights to examine the information provided by you in the health questionnaire and also to obtain further health-related information from third parties. The pension institution or respectively PKRück will process information relating to your health for the purpose of risk assessment and in order to justify any restrictions.

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HEALTH DECLARATION

To be filled by the insured person.

Data processing by the providers of occupational benefits insurance and reinsurance for the purpose of risk assessment
The pension institution has obtained insurance from PKRück against the risks of death and disability. In some cases, PKRück for its part avails itself of further reinsurers. In order for the providers of occupational benefits insurance and reinsurance to be able to assess and monitor the risk, the pension institution or respectively PKRück will disclose your health data to them. Your personal data will be used by the providers of occupational benefits insurance and reinsurance only for the above-mentioned purposes.

Authorisation to obtain health data and consent to the disclosure of data

☐ I hereby authorise any physicians, psychologists, physiotherapists, psychotherapists and other medically trained personnel providing treatment in relation to the health-related information reported by me to disclose all information and documentation pertaining to my health and any treatment to the pension institution or respectively PKRück for the purpose of risk assessment. I release the above-mentioned persons and any employees of the above-mentioned institutions from their duty of confidentiality in respect of the pension institution or respectively PKRück. I further agree that the pension institution or respectively PKRück may pass on my health data to these bodies for the above-mentioned purposes and expressly release the employees of these institutions from their duty of confidentiality.

☐ I hereby consent to the transmission of my health data – to the extent necessary – to PKRück and, as the case may be, to any further reinsurers and to its use by them for the purposes specified in this document. This authorisation expressly also covers the right of PKRück to pass on my health data to further reinsurers for the same purposes.

This authorisation may be revoked at any time by written notice to the pension institution and to PKRück. The undersigned is aware that it may not be possible to guarantee the provision of insurance cover in accordance with the plan if the necessary authorisation is refused or an authorisation granted is revoked.

I hereby confirm that I have answered the above questions truthfully and completely.

Place, date: _____ Signature: _____

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QUESTIONS 2.1 TO 2.4

What is / was the diagnosis, or which complaints do/did you have?	Since when?	Has the treatment been completed?	Are there any consequences or are relapses / complications tob e expected?	Name and address of the physician/ hospital providing treatment:
1 _____	_____	☐ Yes, since _____ ☐ No	_____	_____
2 _____	_____	☐ Yes, since _____ ☐ No	_____	_____
3 _____	_____	☐ Yes, since _____ ☐ No	_____	_____

QUESTION 2.4

Name of the prescription drug:	Dosage:	Since when?	Has the treatment been completed?	Name and address of the physician/ hospital providing treatment:	
1 _____	_____	_____	☐ Yes, since _____ ☐ No	_____	_____
2 _____	_____	_____	☐ Yes, since _____ ☐ No	_____	_____
3 _____	_____	_____	☐ Yes, since _____ ☐ No	_____	_____

QUESTION 2.5

Which illegal drugs have you consumed/ do you consume?	How much and how often?	Please specify the duration:
1 _____	_____	_____
2 _____	_____	_____

QUESTION 2.6

For what reason did you receive a pension and / or daily benefits?

_____ from _____ to _____

Name and address of the physician who is best informed about your state of health:

_____

Place, date: _____

Signature: _____