**HEALTH CERTIFICATE FOR APPROVAL OF AN APPLICATION FOR HEALTH INSURANCE EXPAT RESIDENT**
**EXAMINATION COSTS WILL BE BORNE BY THE APPLICANT! TO SUBMIT WITH AGE OF 60 AND ABOVE**

# HEALTH CERTIFICATE TOWARDS WÜRZBURGER VERSICHERUNGS-AG (INSURER)

**APPLICANT / PARTY ENTITLED TO INSURANCE:**

| Surname: | First name(s): | Date of birth: |
|---|---|---|
| Address: | | |

**1. DECLARATION TO THE DOCTOR:**

| | | ANSWER | IF YES: WHICH, TREATED WHERE (DOCTOR), DIAGNOSIS | WHEN? |
|---|---|---|---|---|
| **1.a** | Are you currently suffering from complaints, illnesses or the results of accidents? | ☐Yes ☐No | | |
| **1.b** | Do you or have you suffered from a chronic or repetitious illness? | ☐Yes ☐No | | |
| **1.c** | Have you been examined, advised or treated by medical staff (e.g. doctors, consultants, medical practitioners, psychologists, masseurs..) in the last three years or have you been unable to work - even temporarily? | ☐Yes ☐No | | |
| **1.d** | Have operations or treatment been performed, planned or advised? | ☐Yes ☐No | | |
| **1.e** | Has hospital treatment (including clinics, sanatoriums etc.) taken place in the last 5 years? | ☐Yes ☐No | | |
| **1.f** | Have blood examinations been performed? With which results? | ☐Yes ☐No | | |
| **1.g** | Has an HIV infection been determined, e.g. by an AIDS test? | ☐Yes ☐No | | |
| **1.h** | Have you had or are you engaged in cytostatic treatment? | ☐Yes ☐No | | |
| **1.i** | Do you or have you regularly imbibed medicines, alcohol or drugs? | ☐Yes ☐No | | |
| **1.j** | Do you have impaired sight or do you require an aid to vision (e.g. spectacles, contact lenses)? Dioptre? | ☐Yes ☐No | | |
| **1.k** | Which doctor do you usually consult? (Regular GP) | | | |
| **1.l** | Is dental treatment necessary, particularly with regard to dentures, dental surgery or parodontosis? | ☐Yes ☐No | | |
| **1.m** | Are you pregnant? | ☐Yes ☐No | | |

I hereby confirm with my handwritten signature that the above declaration is a part of my application for health insurance and that the I have answered the above questions dictated to me individually by the doctor personally and truthfully.

Place / Date:

Signature of the applicant:

Anamnesis performed (Stamp / Signature of the doctor):

Stand: 01.07.2014

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| EXAMINATION DIAGNOSIS FOR: | | | |
|---|---|---|---|
| Surname: | | First name(s): | |
| **2.** | **GENERAL:** | | |
| | | **ANSWER** | **DIAGNOSIS / DEVIATIONS / EXPLANATION** |
| **2.a** | Have you examined, advised or treated the person in the past? | ☐Yes ☐No | |
| **2.b** | Height:<br>Weight: | cm<br>kg | |
| **2.c** | Do you consider the skeleton and locomotion to be healthy? | ☐Yes ☐No | |
| **2.d** | Do you consider the skin, mucous membranes and lymph glands to be healthy? | ☐Yes ☐No | |
| **2.e** | Do you consider the sensory organs to be healthy? | ☐Yes ☐No | |
| **2.f** | Do you consider the nervous system and psyche to be healthy? | ☐Yes ☐No | |
| **2.g** | Are the reflexes normal? | ☐Yes ☐No | |
| **2.h** | Do you consider the hormonal system to be healthy? | ☐Yes ☐No | |
| **2.i** | Is the thyroid gland normally shaped? | ☐Yes ☐No | |
| **2.j** | Are you suspicious of an organic disorder? | ☐Yes ☐No | |
| **3.** | **CARDIOVASCULAR SYSTEM:** | | |
| **3.a** | Pulse at rest<br>After 10 knee bends<br>Return to normal in | <br><br> | <br><br>minutes |
| **3.b** | Blood pressure at rest<br>After 10 knee bends | /<br>/ | mm Hg<br>mm Hg |
| **3.c** | Can unhealthy hear sounds be heard? | ☐Yes ☐No | |
| **3.d** | Is the heart arrhythmic? | ☐Yes ☐No | |
| **3.e** | Is the heart enlarged or displaced? | ☐Yes ☐No | |
| **3.f** | Are there any signs of insufficiency? | ☐Yes ☐No | |
| **3.g** | Does the patient have dyspnoea? | ☐Yes ☐No | |
| **4.** | **BLOOD VESSELS:** | | |
| **4.a** | Is the patient oedemic? | ☐Yes ☐No | |
| **4.b** | Does the patient have haemorrhoids, varicose veins? (type? / extent?) | ☐Yes ☐No | |
| **4.c** | Does the patient have scars, ulcers? (type? / extent?) | ☐Yes ☐No | |
| **5.** | **RESPIRATORY ORGANS:** | | |
| **5.a** | Does the patient suffer from hoarseness, coughs, bronchitis? (since when? extent?) | ☐Yes ☐No | |
| **5.b** | Is the rib cage deformed? | ☐Yes ☐No | |
| **5.c** | Are the results of the percussion and auscultation examinations normal? | ☐Yes ☐No | |
| **5.d** | Do you consider die respiratory organs to be healthy? | ☐Yes ☐No | |
| **6.** | **DIGESTIVE AND ABDOMINAL ORGANS:** | | |
| **6.a** | Signs of illness on the tongue, tonsils, throat? | ☐Yes ☐No | |
| **6.b** | Are the examination results of the abdomen normal? | ☐Yes ☐No | |
| **6.c** | Is the liver enlarged? | ☐Yes ☐No | |
| **6.d** | Is the pancreas enlarged? | ☐Yes ☐No | |
| **6.e** | Does the patient suffer from a rupture? | ☐Yes ☐No | |

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| EXAMINATION DIAGNOSIS FOR: | | | |
|---|---|---|---|
| Surname: | | First name(s): | |
| | | **ANSWER** | **DIAGNOSIS / DEVIATIONS / EXPLANATION** |
| **6.f** | Unhealthy diagnosis of the digestive organs? | ☐ Yes ☐ No | |
| **7.** | **URINAL AND SEXUAL ORGANS:** | | |
| **7.a** | Is the condition of the renal capsule normal? | ☐ Yes ☐ No | |
| **7.b** | urine examination: | protein ☐ Yes ☐ No<br>sugar ☐ Yes ☐ No<br>bile pigment high ☐ Yes ☐ No | sediment: |
| | exterior condition:<br>pathological components: | | |
| **7.c** | Regarding woman: Pregnancy? | ☐ Yes ☐ No | in _____ month |
| **8.** | **MISCELLANEOUS:** | | |
| **8.a** | What other disorders and still unnamed diagnoses were found? | ☐ Yes ☐ No | |
| **8.b** | Are there signs of an immune disorder? | ☐ Yes ☐ No | |

**OTHER ASPECTS THAN THE EXAMINATION RESULTS ARE SOMETIMES DECISIVE IN THE EVALUATION OF THE RISK.**
**PLEASE DO NOT DISCLOSE ANY INFORMATION OF THE INSURANCE RISK.**

Place / Date

Stamp / Signature of the doctor

**DETAILS OF THE DENTAL STATUS**

# DENTAL STATUS

**DIAGNOSIS OF ALL TEETH**

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DIAGNOSIS** | | | | | | | | | | | | | | | | | **DIAGNOSIS** |
| | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | |
| | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | |
| **DIAGNOSIS** | | | | | | | | | | | | | | | | | **DIAGNOSIS** |

| **DIAGNOSIS / LEGEND:** | | | | | |
|---|---|---|---|---|---|
| **f** missing teeth | **e** replaced teeth | **K** crowned teeth | **b** bridged teeth | **s** teeth in need of rehabilitation | **)(** space closure |

| **9.** | **DENTAL:** | **ANSWER** | **IF YES: WHICH, TREATED WHERE (DOCTOR), DIAGNOSIS** | **WHEN?** |
|---|---|---|---|---|
| **9.a** | Are there gum diseases? | ☐ Yes ☐ No | | |

Stand: 01.07.2014

Place / Date

Stamp / Signature of the dentist