

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

# HEALTH CERTIFICATE

**APPLICANT / PARTY ENTITLED TO INSURANCE:**

Surname:	First name(s):	Date of birth:
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.b	Do you or have you suffered from a chronic or repetitious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.d	Have operations or treatment been performed, planned or advised?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.e	Has hospital treatment (including clinics, sanatoriums etc.) taken place in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.f	Have blood examinations been performed? With which results?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.g	Has an HIV infection been determined, e.g. by an AIDS test?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.h	Have you had or are you engaged in cytostatic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.i	Do you or have you regularly imbibed medicines, alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.j	Do you have impaired sight or do you require an aid to vision (e.g. spectacles, contact lenses)? Dioptré?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.k	Which doctor do you usually consult? (Regular GP)			
1.l	How many natural teeth (excluding wisdom teeth) have you lost without final replacement?			
1.m	Is dental treatment necessary, particularly with regard to dentures, dental surgery or parodontosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.n	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> 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):

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.b	Height:	cm	
	Weight:	kg	
2.c	Do you consider the skeleton and locomotion to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.d	Do you consider the skin, mucous membranes and lymph glands to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.e	Do you consider the sensory organs to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.f	Do you consider the nervous system and psyche to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.g	Are the reflexes normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.h	Do you consider the hormonal system to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.i	Is the thyroid gland normally shaped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**3. CARDIOVASCULAR SYSTEM:**

3.a	Pulse at rest		
	After 10 knee bends		
	Return to normal in		minutes
3.b	Blood pressure at rest	/	mm Hg
	After 10 knee bends	/	mm Hg
3.c	Can unhealthy heart sounds be heard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.d	Is the heart arrhythmic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.e	Is the heart enlarged or displaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.f	Are there any signs of insufficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.g	Does the patient have dyspnoea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**4. BLOOD VESSELS:**

4.a	Is the patient oedemic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.b	Does the patient have haemorrhoids, varicose veins? (type? / extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.c	Does the patient have scars, ulcers? (type? / extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**5. RESPIRATORY ORGANS:**

5.a	Does the patient suffer from hoarseness, coughs, bronchitis? (since when? extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.b	Is the rib cage deformed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.c	Are the results of the percussion and auscultation examinations normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.d	Do you consider the respiratory organs to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**6. DIGESTIVE AND ABDOMINAL ORGANS:**

6.a	Signs of illness on the tongue, tonsils, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.b	Are the examination results of the abdomen normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.c	Is the liver enlarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.d	Is the pancreas enlarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.e	Does the patient suffer from a rupture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.f	Unhealthy diagnosis of the digestive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

EXAMINATION DIAGNOSIS FOR:			
Surname:		First name(s):	
<b>7. URINAL AND SEXUAL ORGANS:</b>			
		<b>ANSWER</b>	<b>DIAGNOSIS / DEVIATIONS / EXPLANATION</b>
<b>7.a</b>	Is the condition of the renal capsule normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7.b</b>	urine examination:	protein <input type="checkbox"/> Yes <input type="checkbox"/> No	sediment:
		sugar <input type="checkbox"/> Yes <input type="checkbox"/> No	
		bile pigment high <input type="checkbox"/> Yes <input type="checkbox"/> No	
	exterior condition:		
	pathological components:		
<b>7.1 REGARDING WOMAN:</b>			
<b>7.1a</b>	Are you suspicious of an organic disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7.1b</b>	Pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	in _____ month
<b>8. MISCELLANEOUS:</b>			
<b>8.a</b>	What other disorders and still unnamed diagnoses were found?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>8.b</b>	Are there signs of an immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 ONLY NECESSARY IF APPLICATION INCLUDES MODULE EXPAT®R-DENT**

## DENTAL STATUS

### DIAGNOSIS OF ALL TEETH

<b>DIAGNOSIS</b>																<b>DIAGNOSIS</b>	
	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	
<b>DIAGNOSIS</b>																	<b>DIAGNOSIS</b>

### DIAGNOSIS / LEGEND:

<b>f</b> missing teeth	<b>e</b> replaced teeth	<b>K</b> crowned teeth	<b>b</b> bridged teeth
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Place / Date

Stamp / Signature of the dentist