Europ Assistance India
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INSURED'S MEDICAL QUESTIONNAIRE
To be completed by Insured

Date: **Case #:**
Insured Name: **E-mail:**

Please complete the requested information below and return this form via fax or e-mail to Europ Assistance India. If you have any questions regarding the Insured, please contact the hospital and/or treating physician directly.

1. Indicate if you have had any of the below diagnostic tests performed before <<policy inception date>>

Yes	No	Diagnostic Test	Treatment Date(s)
		EKG/ECG/Cardiogram	
		Stress test (exercise, Thallium, MIBI)	
		Echocardiogram	
		Heart Catheterization	
		X-rays	
		Laboratory	
		Surgery	
		Biopsy	
		Endoscopy/Broncoscopy	
		Other (specify)	

2. Have you been medically diagnosed or received medical treatment for Acquired Immune Deficiency Syndrome or AIDS-Related Complex?

	Yes
	No

3. List all medications that you are currently taking?

	None

Name of Medication	Dosage

4. Indicate below if you have been diagnosed or treated before <<~info_pol_inception>> for any ailment or injury of the following organs or disease or sickness listed.

Yes	No	Condition	Prior Treatment Date(s)
		Brain/nervous system	
		Headaches, migraines	
		Strokes, paralysis, epilepsy	
		Convulsions, fainting	
		Lung disease, asthma, emphysema	
		Tuberculosis, spitting blood, pneumonia	
		Heart disease, chest pains, angina	
		Heart murmur, irregularity or heart failure	
		Arteriosclerosis, varicose veins, blood clots	
		High blood pressure	
		Liver, gall bladder disease, jaundice	
		Stomach ulcers, indigestion	
		Rectal or hernia	
		Chronic diarrhea	
		Kidney, bladder, prostate	
		Alcoholism, drug addiction	
		Pain management	
		Kidney stone	
		Blood, pus, albumin in urine	
		Sugar or casts in urine	
		Cancer, tumor, goiter	
		Anemia, diabetes, gout	
		Arthritis, neuritis	
		Rheumatism	

		Bone or joint disorder	
		Osteoporosis	
		Back problem, back surgery	
		Mental or psychological	
		Depression, anxiety	
		Weight loss, eating disorder	
		Overdose	
		Pregnant or reproductive	
		Disease of eyes or ears	
		Other (specify):	

5. Following, list all names, addresses, and contact information for all medical providers (physician or specialist) who have examined, evaluated and/or treated you before <<~info_pol_inception>> your current treatment and the name and address of all treatment facilities.

Indicate none if applicable:

	None

Family Physician In India (Mandatory)

Name:	
Street Address:	
City:	Country:
State:	Phone:

Medical Provider (Treating Physician or Facility)

Name:	
Street Address:	
Specialty:	
City:	Country:
State:	Phone:

Medical Provider (Treating Physician or Facility)

Name:	
Street Address:	
Specialty:	
City:	Country:

State:	Phone:

Medical Provider (Treating Physician or Facility)

Name:	
Street Address:	
Specialty:	
City:	Country:
State:	Phone:

6. I authorize EAI to disclose my health information to the party or parties listed below (i.e. family, friend or employer).

Designee name:		Relationship:	
Designee contact #:		e-mail:	

Organization Name:		Relationship:	
Organization Contact#:		e-mail:	

7. My signature below attests that the information that I have provided is complete and accurate.

Signature:		Date:	

If Completed by someone other than the insured:

Name (Print):		Relationship to insured:	
Phone#:		e-mail:	
Signature:			