Entiero na Kuota
seguro di entiero

New ☐
Renewal ☐ incl. arrears ☐ excl. arrears
Policy #:_____
Application #:_____

Insurance Contract Application

Last Name, Given Names:_____
Gender: ☐ male ☐ female
Date of Birth:___-___-_____ I.D#___-_____-_____
Place of Birth:_____-_____
Address:_____-_____
Neighborhood:_____

Phone/cell:_____
E-mail:_____
Employer:_____
Occupation:_____
Employment: ☐ Temporary ☐ Fixed

Insured Amount: ANG._____
Monthly Payment Amount: ANG._____-_____
Fecha di pago promé kuota:_____-___-20___
Period:___Month(s) @ ANG. _____ 1 Month @ ANG. _____
Due Date of Last Payment: _____-___-20___

1st Benificiary

Last Name, Given Names:_____
Date of Birth:___-___-_____ / I.D#___-_____

2nd Benificiary

Last Name, Given Names:_____
Date of Birth:_____-___-_____ / I.D#___-_____

Children under the age of 18:

Last Name, Given Names	**Date of Birth**	**I.D#**
1._____	_____-_____-_____	_____-_____
2._____	_____-_____-_____	_____-_____
3._____	_____-_____-_____	_____-_____
4._____	_____-_____-_____	_____-_____
5._____	_____-_____-_____	_____-_____
6._____	_____-_____-_____	_____-_____
7._____	_____-_____-_____	_____-_____
8._____	_____-_____-_____	_____-_____

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Fam, Nòmbernan:_____

Health Questionnaire

Fecha di nasimentu:_____

I hereby declare that, to the best of my knowledge, at the time of signing this questionnaire, I am in good health and that I have truthfully answered the following questions, by marking 'yes' or 'no' if I am presently suffering or have suffered within the past five years from:

Asthma	yes / no	Paralysis	yes / no
Difficulty Breathing	yes / no	Epilepsy	yes / no
Chest Pains	yes / no	Diabetes	yes / no
Coughing up blood	yes / no	(chronic) Kidney Disease	yes / no
High Blood Pressure	yes / no	(chronic) Liver DiseaseMalu	yes / no
Heart Attack	yes / no	(chronic) Intestinal Disease	yes / no
Palpitations	yes / no	Anemia	yes / no
Other type of Heart Disease	yes / no	Cancer	yes / no
Stroke	yes / no	HIV / AIDS	yes / no
		Hepatitis	yes / no

I have truthfully answered with 'yes' or 'no', if I have received within the past five years:

Radiation Treatment	yes / no	Kidney Dialysis	yes / no
Chemotherapy	yes / no	**Transplant of:**	
Amputation of a limb	yes / no	Kidneys, Heart or Liver	yes / no

In the past two years I have been hospitalized _____times. The longest period I have been hospitalized for (in one continued hospitalization) was _____weeks and_____days.
This was due to the following condition: _____ From (date) _____until (date)_____

Height / Weight: _____m. / _____kilograms.
I have had the following operation(s): _____
Date of Operation(s): _____
Name of Surgeon: _____
Name of my current Doctor: _____
I am currently receiving medical treatment for:_____
I have suffered from / Date: _____ / _____-_____-_____
I am currently using the following medication: _____
Since: _____-,_____-,_____

I hereby authorize any and all physicians who have treated me in the past or who will treat me in the future, to provide all information concerning my state of health or the cause of my death, when FUNDASHON ENTIERO NA KUOTA so requests. By signing this document, I declare that I have filled out this entire questionnaire truthfully and to the best of my knowledge. I am also aware that any false information given on this questionnaire - either purposely or accidentally - that may lead to the rejection of this application, will make the corresponding rules and regulations invalid and cancellation of the contract (art. 320 WvK).
This application is subject to acceptance, and after acceptance will form an integral and inseparable part of the corresponding rules and regulations.

Curaçao,_____-,_____-,_____ Applicants Signature:_____

Accepted / Rejected:_____

Observation:_____

Signature / Date:_____