

HEALTH DECLARATION

You have been sent a health declaration.

The producer of a project that you will take part in has informed Amstel Lloyd Assuradeuren B.V. ('**ALA**') that it wishes to take out insurance against personal incapacity. That is why you receive this health declaration.

Recommendation: read the explanatory notes before completing the health statement.

Submission of the fully completed and signed health declaration

This health declaration must be sent **directly** (preferably by email, scanned or not scanned) to the medical adviser.

*Geneeskundig Advies Schaderegelingen B.V. ('**GENAS b.v.**')*

www.genas.nl

ala@genas.nl

Medical adviser

The medical adviser will assess the content of the health declaration and inform ALA directly. Based on this advice, ALA will take stock of the risk of incapacity for the production(s) and inform the producer with regard to your acceptance under this policy.

Completion of health declaration

You must answer the following questions correctly and as **fully** as possible. This is important! This is how you prevent the following:

- that your acceptance as insured person under the producer's policy is delayed;
- that ALA might fail to pay the producer if you become incapacitated;
- that ALA might demand a refund of a payment made to the producer;
- that you might become registered in the events record and the internal incident register of ALA and the External Reference register (EVR) of the insurers that are members of the Dutch Central Information System (Stichting CIS).

Your answers must provide an insight into your general state of health, as well as your state of health in the light of the production(s) for which this health declaration is requested (for example, the demands placed on your health due to the nature of the location, work, climatological circumstances, etc.).

Please insert a cross as applicable when completing this health declaration. If you place a cross next to 'yes', please provide an additional explanation for follow-up questions 4 and 5 (annexes) to this form.

If your health changes

It is possible that your health will change. What if it happens after you completed the health declaration but before the insurance policy comes into effect? If that is the case, you must report it directly to the medical adviser.

Processing of personal data

In order to accept you as insured person under the producer's policy, we ask you to provide us with (special) personal data, including your health information, in this health declaration. Without processing these details, including your health information, it is impossible for the medical adviser to give independent, expert advice to ALA on your health condition, and ALA will be unable to assess whether it can accept you as an insured person under the producer's policy or to implement the policy cover entered into.

ALA is committed to protecting your privacy. Your personal data, including your health information, will therefore be handled with care. ALA processes these with due observance of the provisions of the General Data Protection Regulation (GDPR), the General Data Protection Regulation implementation act and other regulations, such as the Code of Conduct covering Personal Data Processing by the Insurance Industry. In order to protect your privacy and to comply with the Code of Conduct for Personal Data Processing by the Insurance Industry, we ask you to send this health declaration directly to the medical adviser. The controller of the data processing is Amstel Lloyd Assuradeuren B.V., 's-Gravelandseweg 69, 1217 EJ Hilversum, the Netherlands. If you have questions about the processing of your personal data, please contact our data protection officer by email to compliance@dsv-insurance.nl.

Surname and initials:	_____ <input type="checkbox"/> male <input type="checkbox"/> female
First name:	_____
Address:	_____
Postcode/town:	_____
Date of birth:	_____
Place of birth:	_____

Insurer:	Amstel Lloyd Assuradeuren B.V. acting on behalf of HDI Global GdWU mSE, the Netherlands in its capacity as MGA.
Insurance broker:	DSV Mediapolis
Name/description of production:	_____
Name of producer:	_____
Production start date:	_____
Production end date:	_____

1. GENERAL	
a. In what capacity do you take part in the production?	_____
b. Do you plan to take part in dangerous activities in the period preceding the production? (if so, go to question 4 b)	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Do you know of any circumstances that may force you to postpone your work for this production, to temporarily interrupt it, cancel it or terminate it early? (if so, go to question 4 c)	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Do you know of any family circumstances that may force you to postpone your work for this production, to temporarily interrupt it, cancel it or terminate it early? (if so, also go to question 4 d)	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Name of your family doctor Address Town Phone number	_____ _____ _____ _____
f. Name(s) of your medical specialist(s) Address Town Phone number	_____ _____ _____ _____

2. PERSONAL DATA			
a. What is your height?	_____ cm	b. What is your weight?	_____ kg
b. Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What do you smoke? _____ How old were you when you started smoking? _____ On average, how much do you smoke per day? _____	
c. Have you ever smoked?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What did you smoke? _____ How old were you when you started smoking? _____ On average, how much did you smoke per day? _____ Until what age did you smoke? _____	
d. Do you drink alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	On average, how many glasses do you drink per week? _____ Which drink(s)? _____	
e. Have you ever drunk alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Which drink(s)? _____ What age were you when you started to drink? _____ How many glasses did you drink on average per week? _____ Until what age did you use to drink? _____	
f. Do you use drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, you must complete the questionnaire on drug use (see annex 5.)		
g. Have you ever used drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, you must complete the questionnaire on drug use (see annex 5.)		

3. YOUR HEALTH STATUS	
<p>Do you currently have, or have you ever had, one or more of the following conditions, illnesses and/or symptoms. Please place a cross next to 'Yes' if you:</p> <ul style="list-style-type: none"> - consulted a family doctor, specialist or health assistant; - have been admitted to hospital, a psychiatric institution or other care home; - have undergone surgery; - are still using medication or have used it in the past; - are still being monitored. <p>What is a symptom? By symptom, we mean physical or mental discomfort or pain. With a symptom, it is not always clear what causes it. Back pain is an example of a symptom.</p> <p>What is a condition? A condition is a deviation from a healthy physical or mental status. A broken leg is an example of a condition.</p> <p>What is an illness? An illness is also a condition. With an illness, we often envisage a physical defect, but a mental disorder is also called an illness. An illness can restrict someone now or later in the way they function. Or it can cause them to die earlier. Diabetes is an example of an illness.</p>	
a. Muscular disorders, limb and/or joint disorders, including neck, shoulder, hand, back, hip and knee problems, rheumatic disorders or paralysis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. Brain or nervous disorders, TIA (transient ischaemic attack), CVA (cerebrovascular accident), seizures, epilepsy, muscle diseases, optic nerve	<input type="checkbox"/> No <input type="checkbox"/> Yes

inflammation, headaches or dizziness?	
c. Disorders or symptoms of a mental nature, including depression, schizophrenia, psychosis, ADHD, a stress disorder, a disorder related to overworking, anxiety disorder, insomnia, hyperventilation or burn-out?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Increased blood pressure, cardiovascular disease, including heart attack, tightness or pain in the chest, increased blood pressure, palpitations, narrowing or inflammation in the blood vessels or an embolism?	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Diabetes or other metabolic or storage diseases or hormonal imbalance disorders, including elevated cholesterol, gout, thyroid and hormonal abnormalities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
f. Disorders, diseases or problems affecting the lungs or respiratory tract, including asthma, COPD, shortness of breath, pleurisy, bronchitis, prolonged coughing or a pulmonary embolism?	<input type="checkbox"/> No <input type="checkbox"/> Yes
g. Disorders of the oesophagus, stomach, bowels, liver, gallbladder, pancreas?	<input type="checkbox"/> No <input type="checkbox"/> Yes
h. Disorders relating to the kidney, bladder, urinary tract or genitals?	<input type="checkbox"/> No <input type="checkbox"/> Yes
i. Skin diseases or allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
j. Disorders, diseases or problems with regard to the eyes, venous leg ulcers, fistulas and thrombosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
k. Throat, nose or ear diseases, including hearing problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
l. Problems with exhaustion, sleep apnoea, STIs (Sexually Transmitted Infections), an HIV infection or other infectious diseases?	<input type="checkbox"/> No <input type="checkbox"/> Yes
m. Benign or malignant swelling or tumour, malignant diseases, cancer, blood disease or anaemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes
n. Illnesses, afflictions and/or deficiencies (also including complaints or symptoms) that cannot be assigned to any of the aforementioned categories?	<input type="checkbox"/> No <input type="checkbox"/> Yes
o. Have you been forced in the last five years to cancel or interrupt your participation in productions due to health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
p. Are you partly or fully unable to work?	<input type="checkbox"/> No <input type="checkbox"/> Yes
q. Have you used or are you still using medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you placed at least one cross next to 'yes' above?	<input type="checkbox"/> No <input type="checkbox"/> Yes, if so, please also complete annex 4

The replies you give may lead to a request for further information. In order to gain access to this information, you must authorise the doctor or specialist to provide the information. In that respect, you are asked to complete and sign the enclosed **medical authorisation** (page 10).

You have the right to be the first person to be informed of the medical adviser's opinion. In some circumstances, the medical adviser might issue an opinion proposing inclusion of a restriction (a reservation, limitation or exclusion provision) in the cover for the policyholder (the producer).

If you wish to exercise the right to be the first person to be informed directly by the medical adviser of his opinion, you must tick the option in this health declaration that you wish to exercise the right to be informed, and indicate the phone number on which you can be contacted **privately and directly, by mobile phone**. You can then ask the medical adviser not to disclose his opinion to ALA. When you exercise this right, ALA will discontinue the acceptance process and it will be impossible to accept you as an insured person under the producer's insurance policy.

Do you wish to exercise this right to be informed?

No Yes, on (private) mobile phone number

(Private) mobile phone number _____

The undersigned is aware that this declaration is issued in the context of a production insurance policy for 'personal incapacity'.

The undersigned declares:

- that he or she has read the Explanatory Notes to the Health Declaration;
- that he or she has personally answered all the questions in this health declaration and annex(es);
- that he or she has reported any doubts to ALA and/or the medical adviser;
- that the answers to the above questions are correct and complete, and to be aware that any subsequently apparent inaccuracies in this declaration can result in the rights accruing from the insurance policy concerned being forfeited or amended, which may have significant (financial) consequences for the producer;
- that he or she knows that ALA will assess whether the undersigned can be accepted under the producer's policy and agrees with this. And that, in doing this ALA will also base its assessment on the medical adviser's opinion. You agree to this;
- that you know and that the medical adviser will retain your health declaration for as long as legally allowed and agree to this.

Agreed and signed (in block letters):

Name: _____

Date: _____

Signature: _____

or _____

Signature of parent/guardian,
if the insured person is a minor: _____

4. ANNEX: ADDITIONAL INFORMATION WITH THE HEALTH DECLARATION

Please give additional information for every question answered with 'yes'.

a. Name of insured person _____

Annex to question 1 (General information) Additional information for questions answered with 'yes':

b. In which dangerous activities will you take part? _____

c. Which circumstances could result in a delay, interruption, cancellation or early termination? _____

d. Which family-related circumstances could result in a delay, interruption, cancellation or early termination? _____

Annex to questions 3 a to n (Your state of health) Additional explanation for the questions answered with 'yes':

e. The letter of the category that you answered 'Yes' to, in reply to question 3 _____

f. Which condition, illness, or defect, including any symptoms, do you suffer from or have you suffered from? _____

g. In which period(s) do you have or did you have the condition(s), illness(es) or disorders (including symptoms) concerned?	<p>_____ to _____</p> <p>_____ to _____</p>
h. Which of the following doctors or care providers/services did you use in connection with it? (family doctor, medical specialist, physiotherapist, psychologist, psychotherapist, counselling service, practitioner of an alternative therapy (e.g. homoeopath, acupuncturist, chiropractor, etc.)	<p>Name: _____</p> <p>Speciality _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
i. When did you visit this doctor/care provider/service:	<p>_____</p> <p>_____</p>
j. Are you still being monitored?	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
k. Do you still experience symptoms?	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
Additional information for question 3 o	
l. What has forced you to cancel or interrupt your participation in productions in the last five years and in which period?	<p>_____</p> <p>_____</p> <p>_____ to _____</p>
Additional information for question 3 p	
m. What is causing you to be unfit for work and to what extent?	<p>_____</p> <p>_____</p>
Additional information for question 3 q (medicine)	
n. What medicine has been prescribed for you?	<p>_____</p> <p>_____</p>
o. During which period did you use these medicines?	<p>_____ to _____</p> <p>_____ to _____</p>
p. Are you still using them?	<p><input type="checkbox"/> No, when did you stop taking them? _____</p> <p><input type="checkbox"/> Yes, what was the dosage? _____</p>

The undersigned declares:

- that he or she has personally answered all the questions in this annex;
- that the answers to the above questions are accurate and complete;
- that he or she has reported any doubts to ALA and/or to the medical adviser;
- that he or she is aware that the producer of a project that the undersigned will take part in wishes to take out personal incapacity insurance, and consent to this;
- that the undersigned knows that this form will form part of the acceptance process for acceptance of the undersigned as an insured person under the producer's policy and that the undersigned is aware that anything in this declaration that later appears to be inaccurate might result in the rights arising from the insurance policy concerned being forfeited or changed, which might have significant (financial) consequences for the producer.

Agreed and signed (in block letters):

Name: _____

Date: _____

Signature: _____

or _____

Signature of parent/guardian:
(if insured person is a minor) _____

5. ANNEX: QUESTIONNAIRE ON DRUG USE (continued from question 2 f and/or g)	
Are you currently using any of the following substances, or have you ever used them?	
a. Amphetamines e.g. 'ecstasy', 'ice', MDMA, 'speed', 'uppers', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. Barbiturates e.g. 'downers', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Cannabis, e.g. 'hashish', marijuana, 'pot', 'weed', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Cocaine, e.g. 'coke', 'crack', 'snow', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Hallucinogens, e.g. 'acid', 'angel dust', 'haze', LSD, 'microdots', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
f. Opiates, e.g. codeine, heroin, methadone, morphine, opium, 'smack', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
g. Sedatives, e.g. diazepam, nitrous oxide, 'downers', nitrazepam, 'tranqs', etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
h. Solvents, e.g. aerosols, glue, etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes
i. Miscellaneous (please provide additional explanation)	_____ _____
If you answered any of the above questions with YES, please provide further explanation, including the name of the substance and date when the use started and when it ended.	_____ _____ _____
j. Are you currently still using drugs?	<input type="checkbox"/> No, when did you _____ stop it? _____ <input type="checkbox"/> Yes, which drugs? _____ How often? _____ _____
k. Have you ever received medical treatment for drug use or withdrawal?	<input type="checkbox"/> No <input type="checkbox"/> If so, from which doctor(s) and what are the details? _____
l. Did you ever use drugs intravenously?	<input type="checkbox"/> No <input type="checkbox"/> Yes, please explain, including information on where the syringes came from and/or whether they were shared. _____
m. Did you ever, or do you still suffer from a condition related to the drug use, such as hepatitis B, HIV infection, mental condition, etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes, please explain _____

The undersigned declares:

- that he or she has personally answered all the questions in this annex;
- that the answers to the above questions are accurate and complete;
- that he or she has reported any doubts to ALA and/or to the medical adviser;
- that he or she is aware that the producer of a project that the undersigned will take part in wishes to take out personal incapacity insurance, and that he or she consents to this;
- that the undersigned knows that this form will form part of the acceptance process to accept the undersigned as insured person under the producer's policy and that the undersigned is aware that anything in this declaration that later appears to be inaccurate might result in the rights arising from the insurance policy concerned being forfeited or changed, which might have significant (financial) consequences for the producer.

Agreed and signed (in block letters):

Name: _____

Date: _____

Signature: _____

or _____

Signature of parent/guardian:
(if insured person is a minor) _____

6. AUTHORISATION

You hereby authorise your doctor or specialist to provide details to the medical adviser at the request of the producer's insurer. This information may be requested in the context of a 'personal incapacity insurance' for a production.

You hereby authorise the doctor/specialist who treats/has treated you:

Name of doctor / specialist: _____
 Speciality _____
 Address: _____
 Postcode/town: _____
 Hospital: _____
 Illness, condition, defect, symptom: _____
 Known since: _____

to provide all relevant details, i.e. the medical history with the precise start date, the examinations performed and resulting findings, any diagnosis, treatment(s) and developments to date with regard to the aforementioned condition, disorder, deficiencies or symptoms, at the request of Amstel Lloyd Assuradeuren B.V, to the medical adviser GENAS b.v. in Arnhem.

Signed for approval by the person to be insured under the producer's policy:

Name: _____
 Address: _____
 Postcode/town: _____
 Date: _____
 Signature: _____
 or _____
 Signature of parent/guardian:
 (if the insured person is a minor) _____

Geneeskundig Advies Schaderegelingen B.V. ('**GENAS b.v.**')
(Medical adviser at the request of Amstel Lloyd Assuradeuren B.V. namens HDI Global Specialty SE, the Netherlands)

PO Box 4025
 6803 EA Arnhem
 Tel. (+31)85-0067900
ala@genas.nl
www.genas.nl