Hallesche
ALH Gruppe

Additional questionnaire

as a supplement to the application resp. demand for an offer from: ________________

(does not replace answering the health questions in the application resp. demand for an offer)

surname	policy no.
first name	date of birth

Eye diseases

Incorrect or incomplete information may entitle us - depending on fault - to withdraw from the contract, to terminate it or to adjust it, which can lead to the insurer being released from performance - even for insured events that have already occurred. Please also note the "Information of the Consequences of the Violation of the Disclosure Obligation" in the application.

We ask you not to send us any results or data of genetic examinations or analysis!
You only have to inform us of already existing complaints, pre-existing conditions, no matter by which examination methods you have acquired this information.

What was the medical doctor's diagnosis for the disease?

- ☐ conjunctivitis
- ☐ myopia (short-sightedness)
- ☐ hyperopia (farsightedness)
- ☐ glaucoma
- ☐ hordeolum, sty(e)
- ☐ astigmatism
- ☐ others, which ones?
- ☐ cataract
- ☐ keratoconus
- ☐ retinal degeneration (tears, holes, detachment)
- ☐ macular degeneration
- ☐ iritis
- ☐ squint, strabismus

____

Do you wear glasses or contact lenses? ☐ yes ☐ no

If "yes", please indicate diopter values? right eye: ________ dpt left eye: ________ dpt

Are both eyes diseased? ☐ yes ☐ no,
☐ right eye only ☐ left eye only

Which treatment did you receive? (e.g. for eye drops: name, dosage; laser treatment, surgery)

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☐ eye drops name: ____

dosage: ☐ daily (_______ per day) ☐ weekly (_______ per month)

☐ approx. _______ per year

☐ medications (drugs) name: ____

dosage: ☐ daily (_______ per day) ☐ weekly (_______ per month)

☐ approx. _______ per year

What therapeutic measures were carried out?

☐ prescription lenses
☐ laser treatment when? __________________ which eye? ____________________
☐ operation, surgery when? __________________ which eye? ____________________
☐ other, which ones?

____

What diagnostic measures were carried out?

☐ eye examination
☐ eye pressure measurement (ophthalmotonometry)
☐ eye test
☐ other, which ones?
☐ slit lamp inspection
☐ optical coherence tomography
☐ HRT-examination

____

Findings, examination results?

____

Please provide us with a copy of the treatment and findings reports!

Is there a cause or underlying disease? ☐ yes ☐ no

If “yes”, which ones? (e.g. high blood pressure, circulatory disorders, diabetes mellitus, rheumatism)

____

Are control examinations necessary? ☐ yes ☐ no

If “yes”, how often? ___________ per year

Have you already had a surgery? ☐ yes ☐ no

If “yes”, on both eyes? ☐ yes ☐ no, only ☐ right only ☐ left

Type of surgery? (e.g. artificial lens, laser treatment)

____

Was the surgery successful? ☐ yes ☐ no

Are you now completely free of complaints? ☐ yes ☐ no

If “no”, which complaints do you still have?

____

If a laser treatment has been carried out, please indicate diopter values before and after the laser treatment:

Diopter values **before** the laser treatment? right eye: _________ dpt left eye: _________ dpt

Diopter values **after** the laser treatment? right eye: _________ dpt left eye: _________ dpt

Are further diagnostic and/or therapeutic measures necessary, intended or recommended? ☐ yes ☐ no

If “yes”, which ones?

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Which doctor can provide information? (Please provide name and address.)

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Additional comments from the applicant or interested party:

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Notice: Please let us have the discharge, examination, treatment and findings reports available to you for a short time (if possible, a copy).

Declaration

The information provided on the questions has been answered correctly and completely to the best of our knowledge. I am solely responsible for the correctness of the information, even if I did not fill out the declaration myself. I have observed the information on the “Consequences of the Violation of the Disclosure Obligation” in the application.

Place/date	Signature of the applicant resp. interested party