INSURANCE CONTRACT CHANGE REQUEST
NOVIS

Insurance Contract No.

Agent Name

Social Security No. of the Agent

DATA OF THE POLICYHOLDER REQUESTING THE CHANGE

Name

Social Security No.

DATA OF THE PERSON CONCERNING THE CHANGE

Name

Social Security No.

PERSONAL DATA MODIFICATION REQUEST

New name

New ID/passport No.*

New address

New contact details Email / Mobile No.*

Other:

*cross out if not applicable

NEW INSURANCE COVERAGE

In case of increase of insurance premiums or addition of new insurance risks, it is necessary to fill in the Health Questionnaire on the 2nd page of this request.

Insurance sum for death 0 0 0 €

Insurance sum for critical illnesses 0 0 0 €

Insurance sum for permanent disability 0 0 0 €

New regular premium
Minimum 60 €/month (under 39 years old)
100 €/month (above 40 years old) €

NEW DESIRED INVESTMENT ALLOCATION RATIO

Please fill in the desired allocation of insurance funds. If this section is not filled we will apply the even allocation into all insurance funds. None of the insurance funds can have higher allocation than 60%.

Balanced allocation of the insurance funds ○ Yes ○ No

NOVIS Fixed Income Insurance Fund %

NOVIS Global Select Insurance Fund %

NOVIS Sustainability Insurance Fund %

TOTAL 1 0 0 %

NEW BENEFICIARIES

Name	Relationship to the policyholder	Social Security No.	Share %
			%
			%
			%

TOTAL: 100 %

SIMPLIFIED MEDICAL EXAMINATION

Simplified medical examination is available in case following conditions are met: maximum insured sum for death insurance 20 000 €, maximum age at entry is 64 years no additional insured risks.

Can you truthfully make the following declaration?

I hereby declare that at the moment I am fully able to work and I do not receive and have not applied for any benefits because of reduction in earning capacity, occupational disability or invalidity or long-term care.

In addition, **I confirm** that I was not in inpatient treatment in the last five years and that I did not have treatment or that I was not on medication longer than three weeks uniterrupted because of the same diseases, appeals or health problems.

I declare that following diseases did not occur or do not occur: Malignant tumor diseases, diseases of the nervous system, mental diseases, HIV infection, heart attack or stroke.

◯ Yes ◯ No

Date, signature of the policyholder

IF THE DECLARATIONS WAS ANSWERED "NO" A COMPLETE ANSWERING OF THE MEDICAL QUESTIONS ON THIS PAGE IS REQUIRED.

HEALTH QUESTIONS

Current occupation:

Are you a mother or a father? ◯ Yes ◯ No **Height and weight:** cm kg

Do you smoke? ◯ Yes (number of cigarettes/cigars per day): ◯ No (I have not smoked in the last 12 months)

Sport: Leisure sport Semi professional sport Professional sport

	Yes	No
1. Do you have any contract for life, accident or health insurance in other insurance company? If yes, please specify the type and scope of the contract as well as the name of the company.	◯	◯
2. Have any insurance company declined, postponed or accepted with a risk loading your application for life, accident or health insurance in the last five years? Did you have any exclusion of some part of the insurance? If yes, please specify the type, scope of the contract as well as the name of the company and reason.	◯	◯
3. Are you exposed at work or in your spare time to any special risks? (e.g. dangerous and flammable substances, hazardous sports such as parachuting, paragliding, private motor airplane or glider flying, diving, mountain sports, martial arts, moto-sports, etc.). Do you practise other sport disciplines regularly? Are you planning a longer stay in countries out of Europe for more than 6 months? If yes, please specify (if necessary, additional questionnaire will be provided).	◯	◯
4. Did you have any surgeries, were you hospitalized or treated during the last 5 years? Are any surgeries, hospitalisation or treatment planned or recommended? If yes, please specify when and for what reason.	◯	◯
5. Are you suffering of chronic illness or physical / mental disability, birth defects, results of surgery, infections or injury? If yes, please specify from when, treatment and complications.	◯	◯
6. Did you take medication regularly or for a longer period during the last five years because of health problems, pain, illness or injury? In this content „longer „means a period of more than two weeks. If yes, provide the name, dosage and the length of taking the medication.	◯	◯
7. Have you been suggested a treatment or were you treated due to alcohol, drugs or other addiction (e. g. gambling and others)? If yes, please specify when, how long, the reason and type of addiction.	◯	◯
8. Do you or did you receive annuity due to disability or invalidity or did you apply for such annuity? If yes, please specify the reason and the length.	◯	◯
9. Have you been unable to work for more than 21 days in the last 5 years or are you actually unable to work? If yes, please specify when, for how long and the reason.	◯	◯
10. Illnesses and diseases listed in parentheses are not final and serve as examples of possible diseases of specific organs. Are you or have you ever been treated or hospitalized in the last 5 years for the following diseases, health disorders or do you have symptoms of these diseases?		
a) Hearth, vascular system and blood circulation (e.g. high or fluctuating blood pressure, heart rhythm disorders, palpitation, heart murmur, coronary heart disease, chest pain, myocardial infarction, angina pectoris, varicose veins, thrombosis etc.)	◯	◯
b) Nervous system and mental disorders (e.g. common headache, migraine, vertigo, seizure disorders, epilepsy, multiple sclerosis, paralysis, Parkinson's, Alzheimer's, psychiatric disorders, anxiety, depression, psychosis, eating disorders, etc.)	◯	◯
c) Blood, lymphatic system and spleen (e.g. anaemia, blood coagulation disorders, haemophilia, leukaemia, changes in the blood, spleen disease, etc.)	◯	◯
d) Respiratory system (e.g. dyspnoea, embolism, asthma, tuberculosis, hay fever, chronic bronchitis etc.)	◯	◯
e) Eye and ear (e.g. blurred vision, vision impairment, cataracts, blindness, tinnitus, hearing loss, deafness etc.). If you wear glasses or contact lenses, please provide the dioptre of lenses for each eye separately.	◯	◯
f) Musculoskeletal system (e.g. spinal disorders, spinal discs, joints, muscles, tendons and ligaments, arthrosis, shortening of the leg, the absence of the limbs. Orthopaedic defects limiting normal movements and requiring continuous use of orthopaedic appliances (e.g. wheelchair, crutches, orthosis, spinal fixator etc.).	◯	◯
g) Gastrointestinal tract: oesophagus – e.g. reflux disease, varicose veins and other, stomach - e.g. peptic ulcer disease, gastritis and other, bowel disease – e.g. Crohn's disease, ulcerative colitis, ulcer disease and other.	◯	◯
h) Kidney, genitourinary system and prostate (e.g. inflammation, stones, cysts, prostate disease etc.)	◯	◯
i) Gynaecological disorders or breast disease (eg. cysts, fibroids, adenomas, polyps, dysplasia, menstrual disorders, infertility treatment, caesarean section, risk pregnancy, ectopic pregnancy, etc.)	◯	◯
j) Skin (e.g. eczema, itching, redness, allergy etc.)	◯	◯
k) Liver, glands or metabolism (e.g. diabetes, higher values of cholesterol, higher values of liver enzymes, gout, thyroid gland or other diseases of endocrine glands) or rheumatoid illnesses.	◯	◯
l) Immune system, chronic infectious or viral diseases (e.g. inherited immunity disorder, hepatitis, tropical diseases, fever of unknown cause, etc.)	◯	◯
11. Do you have or did you have oncological diseases or other cancer diseases (e.g. benign and malignant, cysts, myomas, etc.)	◯	◯
12. Have you been or are you undergoing a HIV / AIDS screening? If yes, please explain, since when, the results or treatment.	◯	◯
13. Have you undergone radiotherapy, chemotherapy, or you were found abnormal results of specialized tests (e.g. CT, MRI, X-ray, ultrasound, EKG, EEG, measuring blood pressure, laboratory values etc.)? If yes, please provide details the following illnesses before the age of 60: diabetes, malignant tumors in the large intestine, rectum, chest or ovaries, cardiovascular diseases, polycystic kidney illnesses, multiple sclerosis, Alzheimer's, Parkinson's, Huntington's disease, hypertrophic cardiomyopathy)?	◯	◯

For detailed information on health questions answered with YES:

Question	Type of disease, complaint, change	When? How long?	Name and address of the physician / hospital

OTHER CHANGE REQUESTED

SIGNATURES

By signing, I confirm that I have stated all the information truthfully and completely.

Date

Signature of policyholder
(necessary for every
change request)

Signature of insured person

IDENTIFICATION OF THE POLICYHOLDER AND SIGNATURE OF AGENT

Identification of the policyholder according to Anti Money Laundering legislation

Identification No.

The applicant has provided identity with: ◯ Personal ID ◯ Passport

Issuing Location

Issuing Authority:

Valid until ☐☐.☐☐.☐☐☐☐

Issuing Country:

I, the agent, confirm the information of the applicant required for the determination of identification has been provided with this person present. I have examined the correctness of the data and signature(s) on the basis of the identification document submitted to me. The information obtained is confirmed by me as applicable. Furthermore, there are no other risk-increasing circumstances known, if such are not attached in a separate report.

Place, Date

Agent Signature

IS-1019