

# Health Questionnaire

# Adeslas

DO NOT  
WRITE IN  
SHADED  
BOXES

## APPLICANT'S PERSONAL DETAILS

Surnames \_\_\_\_\_ First name \_\_\_\_\_ ID No/NIF \_\_\_\_\_

## DETAILS OF THE PERSON TO BE INSURED (In the case of a handicapped person, this questionnaire may be filled in by the legal representative)

Surnames \_\_\_\_\_ First name \_\_\_\_\_ ID No/NIF \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Relationship to applicant \_\_\_\_\_ Order Number \_\_\_\_\_

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Surnames \_\_\_\_\_ First name \_\_\_\_\_ ID No/NIF \_\_\_\_\_

## INFORMATION RELEVANT TO HEALTH

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SegurCaixa Adeslas, S.A. de Seguros y Reaseguros, with registered address at Paseo de la Castellana, 259 C (Torre de Cristal), 28046 Madrid, with Tax No./ NIF A28011864, and registered in the Madrid Companies Registry, volume 36733, folio 213, page M-658265.

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