

# DENTAL QUESTIONNAIRE FOR RUSSIA

Please complete this form in BLOCK CAPITALS.

First name

Surname

Date of birth  /  /

1. Are dental measures (bridges, crowns, inlays, onlays, implants, etc.) currently being performed or recommended? Yes  No

If Yes, please provide details

Expected cost (incl. currency)

Please attach a treatment/cost plan.

2. Do you suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)? Yes  No

If Yes, please provide details

Details of ongoing treatment

Details of planned treatment

Expected cost (incl. currency)

Please attach a treatment/cost plan.

Please fill in the dental chart below using the abbreviations provided. For your information, the first front tooth on your upper left jaw is referred to as number 21; number 22 is the tooth located to the left of this.

### Abbreviations

#### Currently existing:

- m = missing tooth
- g = gap closure
- c = crown
- f = filling
- b = bridge
- i = implant
- in = inlay
- on = onlay

#### Planned treatment/procedure:

- I = Implant
- C = Crown
- T = Telescope crown
- ON = Onlay
- B = Bridge
- S = Support element
- IN = Inlay
- M = Metal-ceramic crown

Dental chart																		
Right									Left									
Treatment date (MM/YY)																		Treatment date (MM/YY)
Planned treatment																		Planned treatment
Existing																		Existing
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw	
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw	
Existing																	Existing	
Planned treatment																	Planned treatment	
Treatment date (MM/YY)																	Treatment date (MM/YY)	

### Example

If you already have an existing crown, the letter "c" must be entered into the "Existing" row (located above or below the number) and in the box that relates to this tooth. Similarly, if an implant is planned, an "I" must be entered into the relevant box on the "Planned treatment" row.



## DATA PROTECTION ACTS – COLLECTION AND USE OF PERSONAL INFORMATION

We are entitled to process the personal data of an insured person once he/she has been included in the insurance agreement. According to the Federal Law "On personal data" dated July 27th, 2006 No152-FZ data can be processed for the following purposes: compliance with laws and other regulations related to personal data; performance of obligations under the insurance agreement, control of the quality of services rendered and/or protecting the insurer's interests.

The insurer guarantees that the transfer of the insured persons' personal data to the insurer is performed only upon receipt of the Insured person's written consent in line with provisions of this article. Such consent will be effective within the whole period of insurance coverage and 5 years after its expiration or termination. Such consent may be withdrawn by an Insured person by giving the Insurer a written notice.

Processing of the Insured persons' personal data includes all activities listed in article 3 of the Federal Law dated July 27th, 2006 No152-FZ «On personal data» (including all activities (operations) with personal data performed with or without use of automation facilities such as collecting, recording, systematization, accumulation, storage, specification (update, amendment), extraction, use, transfer (circulation, provision of access to) depersonalization, blocking, deletion of data). Along with this, the Insurer is entitled to transfer personal data to Allianz Group companies including cross-border transfer of personal data to AWP Health & Life Services Limited, a limited liability company registered in Ireland. Registered no.: 509216. Registered office 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Partners is a registered business name of AWP Health & Life Services Limited.

## DECLARATION

Please read the following declarations carefully and only sign below if you understand and accept them.

- (a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between the insurer and myself, and that any false, incorrect or misleading statement or non disclosure of material medical information may render the contract null and void.
- (b) I undertake to inform the insurer immediately in writing of any changes in my or my dependants' state of health occurring between completing the Dental Questionnaire and the start date of the contract.
- (c) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that the insurer, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare providers, all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to provide relevant medical information relating to me, if requested by the insurer, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

**This declaration and form must be signed and dated by the applicant presenting the dental condition(s). If the applicant is a minor, a parent or guardian should sign this section.**

Signature		Date	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">D</td><td style="width: 10px; height: 20px;">/</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td><td style="width: 10px; height: 20px;">/</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td></tr></table>	D	D	/	M	M	/	Y	Y	Y	Y
D	D	/	M	M	/	Y	Y	Y	Y				
Printed name													

## PLEASE RETURN YOUR FULLY COMPLETED QUESTIONNAIRE BY:

**Email to:** AzCareApplication@allianz.ru  
**Post to:** LLC IC Allianz Life, 30 Ozerkovskaya nab, 115184 Moscow, Russia