SJÓVÁ

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Skírteini nr.	
Söluaðili	Ábending

Application for Sickness Cost Insurance

This application is to be filled out by the person to be insured.

It is important to answer all questions in the application with yes, no or in another explicit way. If a question is left unanswered then it is interpreted as the risk factor in question is not present, and it can thus affect the right of the insured, if it is later revealed that the answer was insufficient to estimate the risk in the right way

The company's purpose in obtaining information on risks.

The information provided by the applicant in this application will be used for company risk assessment. Company employees will evaluate this information, assessing whether additional information on the applicant's previous health is needed from physicians, medical institutions, or others possessing such information, or whether a medical examination is required to allow for the possibility of arriving at a final decision on granting the policy to the applicant. Such information is provided to the company and its consulting physician. If additional information is needed on health, no position will be taken on the application until that information is available. The information may lead to the insurance being issued with a special surcharge on the premium or with a specified latency period before the insurance takes effect or to specified risks being excepted from the insurance or to the insurance being denied.

The provisions of Act No. 77/2000, on the Protection of Privacy as Regards the Processing of Personal Data, are observed during any processing of personal information. The consulting physician and company staff dealing with the information are bound to secrecy and lifelong confidentiality on anything contained in the information.

Deductible: ISK 50.000 - See insurance terms.

A. Please choose an insurance amount:

☐ 2.000.000 ISK. ☐ 3.000.000 ISK. ☐ 4.000.000 ISK. ☐ 5.000.000 ISK. ☐ 6.000.000 ISK.

Name of the insured		Date of Birth
Id No	Id No (Icelandic)	
Address in home country		
Postal Code	City/Town	Country
Address in Iceland		
Phone number at home	Mobile	E-mail
Nationality	Place of birth, country	
Sex	Marital status	

Reliable party/Payer (if other than the insured)		
Id.No	Address	Postal Code.
Phone number	Mobile	E-mail

Please state estimated time of arrival to Iceland/ The date of introduction of the insurance

Attention is brought to the fact that the insurance period begins when the insured arrives in Iceland and is valid for six months or until the insured has gained access to the SSI or departs Iceland.

Notes of representative/salesperson

Notes of the insurance company

Handling Decision on premium

I. Health condition and other risk factors. Must be filled out by the person to be insured.

1. Employment:

2. Special risks due to employment, hobbies or sports:

3. Height cm Weight kg.

4. Do you smoke, **or have you ever smoked?** . . . ☐ No ☐ Yes

If yes, what is your daily consumption? Started smoking month/year Quit month/year

5. Has alcohol consumption caused you health damage or interrupted your work or personal life? . . . ☐ No ☐ Yes

If yes, explain further:

6. Do you use or have you used prescription medication? . . . ☐ No ☐ Yes

If yes, which and why?

7. Have you been assessed with an invalidity degree? . . . ☐ No ☐ Yes

If yes, explain further:

8. Has any insurance company denied you sickness, life insurance or other health insurance coverage, demanded higher premium, special terms, medical certificate or terminated your insurance? ☐ No ☐ Yes

If yes, explain further:

9. Have your parents or siblings suffered from heart or vascular diseases, stroke, high blood pressure, diabetes, kidney disease, cancer, MS, MND, Parkinson's disease or Alzheimer's disease before they reached the age of 60? ☐ No ☐ Yes

If yes, explain further:

10. Do you have or have you had the following diseases or disease symptoms?

a) Cardiovascular diseases or high blood pressure? ☐ No ☐ Yes
b) Stomach or colon diseases? ☐ No ☐ Yes
c) Diseases in lungs or respiratory organs? ☐ No ☐ Yes
d) Diseases in kidneys or urinary system? ☐ No ☐ Yes
e) Diseases in bones, joint or muscles? ☐ No ☐ Yes
f) Diseases in the nervous system or mental diseases? ☐ No ☐ Yes
g) Disease related to the body metabolism, glands and/or diabetes? ☐ No ☐ Yes
h) Diseases in eyes or ears? ☐ No ☐ Yes
i) Allergy or skin diseases? ☐ No ☐ Yes
j) Tumour, cancer or cell changes or growth? ☐ No ☐ Yes
k) Have you been operated on? ☐ No ☐ Yes
l) Have you had accidents or been poisoned? ☐ No ☐ Yes
m) Diseases in breasts or uterus (women)? ☐ No ☐ Yes
n) Do you have AIDS or do you have any reason to believe that you are HIV positive? ☐ No ☐ Yes
o) Other diseases than mentioned above? ☐ No ☐ Yes

If you answer any of the questions above with yes then specify the name of the disease, when it started and how long it lasted, whether recovery was complete or partial, what where the consequences of the disease and what doctor treated you. If you have had an accident then specify which accident and its sequelae.

11. Are you currently healthy and have you been perfectly healthy and able to work during the two previous years? ☐ No ☐ Yes

If No, explain further:

12. Have you been to a doctor or had a medical check-up during the past twelve months? ☐ No ☐ Yes

If yes, clarify:

13. Name and address of general practitioner:

14. If pregnant, give date of expected delivery: (Answer does not give right to payment of cost)

Attention is brought to the limitations of liability. The company does not pay cost due to pregnancy ,delivery or diseases which may be related to pregnancy or miscarriage.

II. Statement and Signature of Applicant

Statement by the applicant, and her/his consent to medical data being acquired from others

I, the undersigned, hereby declare that I have myself answered all of the questions in this application, and I hereby confirm that my answers are, in accordance with the best of my knowledge, correct and in correspondence with the truth, and that no items have been left out which might matter for the company's risk assessment regarding this insurance. I have filled out this application in my own hand and realise that false or insufficient information about my health may cause a loss of compensation rights, in part or in whole, and that paid premiums will be unrecoverable. Moreover, the purpose of providing the information in this application or from others is clear to me, so that together with the insurance terms it becomes the basis of agreement between me and Sjóvá-Almennar líftryggingar hf. It is clear to me that this insurance does not cover previous illnesses or accidents, or their effects. At its offices throughout Iceland, Sjóvá-Almennar tryggingar hf. provides the full range of services for the customers of its subsidiary, Sjóvá-Almennar líftryggingar hf., according to a special agreement on services. I, the undersigned, hereby grant the latter company, Sjóvá-Almennar líftryggingar hf., permission to provide Sjóvá-Almennar tryggingar hf. access to the information about me which is necessary for performing the agreed services. I hereby confirm that information I have provided on diseases of parents or siblings are given with their consent in the cases where it is reasonable to expect that is could be obtained. I CONSENT TO INFORMATION PROCESSING BEING CONDUCTED IN THE MANNER DESCRIBED ABOVE, AND REALISE THE PURPOSE OF SUCH PROCESSING. IN ADDITION, I GRANT MY PERMISSION TO PHYSICIANS, MEDICAL INSTITUTIONS AND OTHERS POSSESSING INFORMATION ON MY HEALTH TO PROVIDE THE COMPANY AND ITS CONSULTING PHYSICIAN WITH ANY SUCH INFORMATION AS MAY BE NECESSARY FOR DECISIONS ABOUT ISSUING THIS INSURANCE AND FOR THE NECESSARY ASSESSMENT OF COMPENSATION CLAIMS. I have been informed of how privacy protection is guaranteed by the company and that I am allowed to revoke my consent to the processing of this information, if I do so in writing.

Any pledges and arrangements between the advisor and me are to appear on this application form.
I have noted the company terms that are in effect regarding the insurance for which I am herewith applying.

Date Place

Signature of the one to be insured

Signature of reliable party/payer

I hereby declare that I have assisted

Name Id. no

with filling out this application form for sickness cost insurance and explained the questions and the declaration on the application in the applicant's native language (name the language)

Place Date

Signature of the interpreter Id. no

Print Form