

<input type="checkbox"/> Home <input type="checkbox"/> On a health centre <input type="checkbox"/> On a hospital <input type="checkbox"/> Elsewher, where ? _____		
12. Name and addresse of the treatment clinic _____ _____ _____	Treatment began ____/____/____ ____/____/____ ____/____/____	Treatment complete ____/____/____ ____/____/____ ____/____/____
13. If you are disabled after the accident than state how mutch ; <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% ?		
14. If disabled that state the influence it has on your income;		
15. Did you have any injury before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the name of the doctor that treated you and describe the injury;		
16. Did you suffer from any illness before the accident ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state the name of the doctor that treated you and describe the illness ;		
17. Have you been hospitalized because of these illness ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Have you been assessed as invalid? If yes than state when the disability rating took place, describe the trauma, who did the valutation and what is the precentage of the invalidism. <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Other:		
20. Compensation shall be deposit into account nr. _____ - _____ - _____		

Informed consent for the processing of sensitive personal information

I, the undersigned, hereby certify that my responses to the above questions are, to the best of my knowledge, correct and truthful and that no attempt is made to conceal anything that may be of importance in the company's determination of liability and compensation amount

I, the undersigned, herby grant Vördur tryggingar hf. unequivocal permission to collect information from physicians, hospitals, healthcare centres and other medical institutions/treatment entities about my current health. This permission, moreover,



applies to the collection of information about previous illnesses and/or accidents as deemed necessary for the processing of this case.

Furthermore, I authorise the company to collect information from the State Social Security Institute, pension funds, unions, tax authorities and other insurance companies as deemed necessary for the processing of this case and determining the amount of compensation.

I am aware that Vöður tryggingar hf. will use this information for the sole purpose of processing my case with the company and that access to this information within the company is solely in the hands of those parties who are responsible for processing personal claims.

This declaration includes my consent for processing personal information in accordance with Act No. 77/2000. This consent may be recalled at any time by written notification thereto to the company.

Place/date

Signature