

Application for Accident and Health insurance

Insurance advisor _____

Insurance number _____

Instructions

THIS APPLICATION IS TO BE FILLED OUT BY THE PERSON TO BE INSURED. It is important that all questions are answered and as accurately as possible. If you are in doubt as to whether specific details are significant, you should nonetheless include them in the application or on an accompanying sheet of paper. If you make mistake in filling out the form, cross out the error, correct it and confirm the correction with your initials. CORRECTION FLUID (TIPP-EX, etc.) MAY NOT BE USED.

All agreements between me and my consultant will be stated in this application. All information are treated as confidential.

I. General information.

Name of the insured _____ Id.no _____

Address _____ Postal Code _____ City/Town _____

Phone Number _____ Mobile Phone _____ Fax _____

E-mail _____

Policy Holder (if other than insured) _____

Id.no _____ Address _____

II. Occupation and special risks – All changes in occupation shall be reported to the company.

1. Occupation _____ other occupation _____ No Yes
 If yes, what _____ wish to have insured _____ No Yes

2. Special risk due to occupation, hobbies or sports such as mountain climbing, private aviation, gliding, hang gliding, sky-diving, diving, motorsport or something else you wish to have insured ? _____ No Yes

If yes, please fill out appropriate form.

3. Do you plan to travel to a country where acts of War and Terrorism is going on? _____ No Yes

If yes, please name the country/region and how long you plan to stay there

III. Insurance and benefits requested. Effective date.

1. Accident insurance

Accidental benefits at 100% disability _____

Weekly benefits (max. 75% of income) _____

Payment waiting period

2 4 8 12 26 weeks

Benefit period

1 2 3 years (waiting period deducted).

2. Health insurance

Medical benefits at 100% disability _____

Weekly benefits (max. 75% of income) _____

Payment waiting period 4 8 12 26 weeks

Benefit period 1 2 3 years (waiting period deducted).

3. Accidental death benefit ISK. _____

Beneficiary; Death benefits will be paid to the spouse of the insured person. If there is no spouse present the payment will go to your legal heir. The word spouse means by law a partner in marriage or validated cohabitation but not in domestic partnership.

If other nomination is requested than please state here;

Registration of the designated beneficiaries;

Name _____ Id.no _____

4. Do you have a medical- and/or accidental insurance valid by another company? No Yes

If yes, state the amount and company _____

Do you want that insurance to be invalidated? No Yes

If yes, you need to fill out a resignation.

Insurance will come into effect; As soon as application has been approved.
 Later- effective date _____

5. Has your application for a personal insurance ever been denied, postponed or premium been raised by an insurance company ? No Yes

If yes, please give details ? _____

IV. Personal health information.

1. Name and address of family doctor? _____

2. Height _____ Weight _____ (if pregnant state your weight before pregnancy)

3. Do you smoke, or have you ever smoked? No Yes

If yes, how many daily _____ Smoked since _____ Stopped smoking _____

4. Do you have or have you had the following diseases or symptoms ?

- a) cardiovascular diseases, high blood pressure or other symptoms from the heart or vascular system .. No Yes
- b) allergy or skin diseases No Yes
- c) metabolic, thyroid or glandular diseases or diabetes No Yes
- d) stomach or colon diseases No Yes
- e) symptoms from bones, joints, muscles or pain in the musculoskeletal system No Yes
- f) discus prolaps, lumbago, neck pain, back pain or other back symptoms No Yes
- g) abnormal results from researches, e.g. blood or urine tests or radiogram No Yes
- h) lung, bronchial or respiratory diseases No Yes
- i) diseases or symptoms from kidneys, urinary system, liver or gall bladder No Yes
- j) tumor, cancer or changes of the cell growth No Yes
- k) depression, anxiety or other mental symptoms No Yes
- l) diseases in sense organs (e.g. eyes or ears) No Yes
- m) diseases in the nervous system and/or dizziness/tremor No Yes
- n) diagnosis of AIDS or do you have any reason to suspect you might be HIV infected No Yes
- o) had an operation/surgery No Yes
- p) any hereditary diseases No Yes

For women;

q) any gynecological disorders, breast symptoms or gestational problems No Yes

If any of the above answers is positive, please specify;

- i. Name of disease/symptom _____
 - ii. When you became aware of the disease/symptom _____
 - iii. How long the disease/symptom lasted _____
 - iv. Whether there was a partial or full recovery _____
 - v. When medical care began and when it was concluded _____
 - vi. What medical institution/physician treated you(name and address) _____
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5. Have you had diseases or physical injury, symptoms, accident or poisoning that have required or may require medical test, operation or treatment? No Yes

If yes, give details about what, when and the name of the doctor that treated you _____

6. Have you been classified as a disabled person due to accident or disease? No Yes

If yes, please provide full details _____ % disability _____

7. Are you currently healthy and have you been perfectly healthy and able to work during the previous three years? No Yes

If no, give details? _____

8. Have you visited a doctor or had a medical check-up during the past three years for anything apart from temporary flu or viruses (e.g. therapy, test or radiogram)? No Yes

If yes, please state why, when and give the physician's name and address _____

9. Do you use or have you used medication continually? No Yes

If yes, which medication, for what reason and when/period? _____

10. Do you drink alcohol? No Yes

11. Do you use or have you ever used narcotics? No Yes

12. Has alcohol consumption or other use of narcotics caused you health damage or interrupted your work or personal life? No Yes

13. Have you ever needed a doctors treatment because of alcohol or narcotics consumption? No Yes

If yes to any of the questions 11-13, please fill out appropriate form.

V. Premiums payment

Credit transfer

Payment slip

Credit card

VISA

EURO

Number of payments _____

Credit card no. _____ Valid thru _____

Cardholder authorization signature _____ id.no. _____

If the payer is other than the insured, please sign;

Name _____ id.no. _____

VI. Declaration and signature of the applicant.

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 physician, 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, as being provided to reinsurers. 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 risk being expect from the insurance or 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.

Statement.

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 with my own hand and realize that false or insufficient information about my health may cause a loss of compensation rights, in parts 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 Vörður tryggingar hf. It is clear to me that this insurance does not cover previous illness or accidents or their effects. I the undersigned, hereby grant the company, Vörður tryggingar hf., permission to provide Vörður líftryggingar hf., access to the information about me which is necessary for performing the agreed services.

I consent to information processing being conducted in the manner described above, and realize the purpose of such processing. In addition, **I grant my permission to physicians, medical institutions and others possessing information in my health to provide the company and its consulting physician with any such information as may be necessary for decision 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.

I have noted the company terms that are in effect regarding the insurance for which I am herewith applying.

Signature of the insured _____ Date _____

Attested by the consultant _____ Date _____

To be filled out by the Company

