

Application form for insurance - Life and Critical illness 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

The insured _____ Id.no _____

Address _____ Postcode _____ City/Town _____

Telephone _____ Mobile phone _____ Fax _____

Email _____

Married Unmarried Spouse's id.no _____

II. Type of insurance. Insurance sum. Effective days.

Life insurance

Insurance sum being applied for ISK _____

Do you presently have life insurance No Yes

If yes, please state insurance sum and with what insurance company _____

Should the old policy be cancelled No Yes

If yes, please fill out a cancellation form

Effective date; Immediately - when application has been approved
 Later - date _____

Critical illness insurance

Insurance sum being applied for ISK _____

Do you presently have critical illness insurance No Yes

If yes, please state insurance sum and with what insurance company _____

Should the old policy be cancelled No Yes

If yes, please fill out a cancellation form

Effective date; Immediately - when application has been approved
 Later - date _____

Have you ever applied for life and/or critical illness insurance but your application was postponed or declined or premium been raised

No Yes

If yes, please explain at what company and why _____

III Occupation. Special risk.

1. Main occupation _____ other occupation _____

Full time employee

Self employed

2. Do you engage in any activities that involve special risk such as mountain climbing, private aviation, glider flight, hang gliding, sky diving, diving, motor sports or other such activities? No Yes

If yes, please fill out a special form.

3. Do you intend to reside abroad for a period longer than six months during the next three years? No Yes

If yes, specify the country and length of stay _____

IV . Personal health information.

1. Name and address of your family doctor _____

2. Height _____ Weight _____ (If pregnant, please state weight before pregnancy)

If with child please state estimated date of birth _____

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

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

What do you smoke/smoked? _____

4. Do you currently suffer or have you ever suffered from any of the following;

a) heart disease, symptoms or a heart condition, a disease of or medical problems relating to the vascular system, blood vessels of the brain (e.g. stroke) or high blood pressure? No Yes

b) disease, symptoms of or medical problems with the stomach, liver, gall bladder, duodenum, pancreas, small intestine, colon, rectum , kidneys or the urinary system? No Yes

c) disease of the lungs, asthma, bronchitis, allergies, shortness of breath or any other symptoms in the respiratory organs? No Yes

d) disease of the skin, symptoms of or medical problems with the bones, joints or muscles? No Yes

e) discus prolapsus (slipped disk), lumbago, neck pain, back pain or other back problems or pain in the musculoskeletal system? No Yes

f) disease, symptoms of or medical problems with the nervous systems, e.g. paralysis, multiple sclerosis (MS), motor neuron disease (MND), epilepsy, dizziness, tremors, headache or migraines? No Yes

g) disease, symptoms of or medical problems with the eyes or ears? No Yes

h) abnormal results from researches, e.g. increased level of cholesterol or blood sugar? No Yes

i) cancer or other malignant diseases or related medical problems, changes of the cells, or growths, tumor, blood disease, lymph disease or benign brain tumor? No Yes

j) disease related to the body's metabolism, thyroid gland or other glands and/or diabetes? No Yes

k) diagnosis of AIDS following tests, or are you awaiting the results of such tests or do you have reason to believe that you are HIV positive? No Yes

- l) Depression, anxiety or other mental illness? No Yes
- m) other diseases/medical problems or symptoms? No Yes

If you have answered "yes" to any of the above questions from a-m than please specify;

- I. name of disease, description of symptoms/description of accident? _____

- II. when you became aware of the disease, symptoms / when did the accident occur? _____

- III. how long did the disease, symptom last / what were the consequences of the accident? _____

- IV. was your recovery total or partial? _____

- V. when did medical care begin and end? _____

- VI. what medical institution and what doctor attended you? Give the address of the doctor _____

5. Have you had any disease, symptoms or physical injury, accident or poisoning that result in you to receive treatment and / or undergo tests or roentgenography by a medical doctor/specialist? No Yes

If yes, explain why and when and give the name and address of the doctor? _____

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

If yes, provide full details _____ % disability _____

7. Are you currently and have you been for the last three years in perfectly good health and able to work? No Yes

If no, please clarify? _____

8. Have you visited a medical doctor or a medical facility during the last three years for reasons other than a brief illness ? (f.eks. treatment, investigation or roentgenography)? No Yes

If yes, please explain why and when and give the name and address of the doctor. _____

9. Are you currently taking or have you taken prescription medicine? No Yes

If yes please clarify what medicine, dosage and why? _____

10. Do you use alcohol? No Yes

11. Do you use or have you used tranquilizing or stimulating drugs? No Yes

12. Has the use of alcohol and / or other intoxicants ever been a problem for you? No Yes

13. Have you ever sought medical advice because of your use of alcohol or other drugs/narcotics? No Yes

If yes is the answer to any of the questions 11-13 than please fill out a special form.

14. Are your parents or siblings deceased? No Yes

If yes please state the age at death and the cause of death. _____

15. Have your parents or siblings suffered from heart or vascular disease, stroke, Huntington's Chorea, diabetes, kidney disease, cancer, MS, MND, Parkinson's or Alzheimer's disease before they reached the age of 60 years? No Yes
If yes, please state the age at diagnosis and the name of the disease _____

V. Designation of a Beneficiary of the Sum Insured.

Spouse, If the spouse is not alive, than the insured's legal heir's according to the law or will. The term "spouse" means that the individual is in a formal marriage and not just cohabiting. The right to payment is according to Act. No. 30/2004 on Insurance Contracts, clause no.100.

Registration of the designated beneficiaries

Name _____ id.no _____ % _____

Name _____ id.no _____ % _____

Name _____ id.no _____ % _____

Name _____ id.no _____ % _____

Irrevocable designation of a beneficiary of the sum insured.

Name _____ id.no _____

This nomination involves a promise to the beneficiary and requires his signature or a statement where this promise is stated.

This nomination will not be changed without written statement from the beneficiary.

Signature of the beneficiary _____ id.no. _____

Statement dated _____ see enclosed statement.

VI. Premiums payment.

Credit transfer

Payment slip

Credit card no.

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. _____

VII. 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 expected 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 líftryggingar 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 líftryggingar hf., permission to provide Vörður tryggingar 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

