Application for Medical Cost Insurance

THIS APPLICATION IS TO BE FILLED OUT BY THE PERSON TO BE INSURED. It is important that all questions are answered. 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 there is not enough space on the application form for all your information, you may write your answers on a sheet of paper and attach it to the application, making sure to mark your answer with the number of the question in each case. If you make a mistake in filling out the form, cross out the error, correct it and confirm the correction with your initials. CORRECTION FLUID (TIPP-EX, et cetera) MAY NOT BE USED.

Insurance amount: (minimum ISK. 2.000.000) _____ **Insurance period: from** _____ **to** _____

I. GENERAL INFORMATION

Name of the insured person: _____ Date of birth: _____

Address: _____ Postal code: _____ Municipality: _____

Telephone home: _____ Telephone work: _____ Mobile phone: _____ e-mail address: _____

Sex _____ Marital status? _____ Present domicile: _____ Since what date: _____

Nationality: _____ Place (Country) of birth: _____

Policy Holder (if other than insured person): _____ Id. No: _____

Address: _____ Postal code: _____ Municipality: _____

Telephone home: _____ Telephone work: _____ Mobile phone: _____ e-mail address: _____

II. OCCUPATION AND SPECIAL RISKS

What is your occupation? _____

Do you pursue any activities which involve special risks? ☐ **Yes** ☐ **No**

If yes, please give details _____

_____

III. HEALTH INFORMATION

1. Name and address of family doctor: _____

2. What is your height and weight? _____ cm. _____ kilograms.

3. Are you or have you ever been a smoker? ☐ **Yes** ☐ **No**

If yes, for how long and how many a day? _____ If you used to smoke, when did you stop? _____

4. Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes, how many units per month? _____ Beer _____ (1 unit = 0,5l) Wine _____(1 unit = 130 ml) Spirits _____(1 unit = 30 ml)

5. Do you use, or have you used, prescription drugs? (Mention tranquilisers or stimulants especially.) ☐ **Yes** ☐ **No**

If yes, what drugs? _____ For what ailment? _____ Amount _____

6. Have you needed to seek medical help because of alcohol or drug consumption? ☐ **Yes** ☐ **No**

If yes, please give details _____

HEALTH INFORMATION

7. Are you suffering from or have you suffered from the following diseases or symptoms?

a) Heart or circulatory disease (incl stroke) ☐ **Yes** ☐ **No**

b) High blood pressure? ☐ **Yes** ☐ **No**

c) Gastric, intestinal or liver illness? ☐ **Yes** ☐ **No**

d) Lung, bronchial or respiratory disease? ☐ **Yes** ☐ **No**

e) Disease of the kidneys or urinary tract? ☐ **Yes** ☐ **No**

f) Gynaecological disorders? ☐ **Yes** ☐ **No**

g) Ailments of bones, joints or muscles, or skin complaints? ☐ **Yes** ☐ **No**

h) Slipped disc, lumbago, neck or back pain? ☐ **Yes** ☐ **No**

i) Illness in nervous system e.g.Paralysis, MS, MND, epilepsy and headache (migraine)? ☐ **Yes** ☐ **No**

j) Illness or problems with eyes or ears? ☐ **Yes** ☐ **No**

k) An irregular result from a blood test, exempli gratia abnormally high cholesterol or blood sugar? ☐ **Yes** ☐ **No**

l) Cancer, blood or lymphatic ailment or benign brain tumours? ☐ **Yes** ☐ **No**

m) Metabolic, thyroid or glandular illnesses or diabetes? ☐ **Yes** ☐ **No**

n) AIDS, or do you have any reason to suspect you might be HIV infected? ☐ **Yes** ☐ **No**

o) Have you had an accident, been poisoned or had an illness which has demanded investigation and medical treatment? ☐ **Yes** ☐ **No**

p) Have you been assessed with a handicapped or are you awaiting assessment? If yes, give the percentage of your assessment _____% ☐ **Yes** ☐ **No**

q) Depression, anxiety or mental ailment? ☐ **Yes** ☐ **No**

r) Other illnesses or problems? ☐ **Yes** ☐ **No**

If any answer to questions a-r is positive specify:

Name of the illness or type of accident: _____

When the illness appeared or the accident occurred? _____

Whether there was a partial or full recovery? _____

When care began and when it was concluded? _____

What medical institution/physician treated you? (location) _____

8. Are you, or have you been, undergoing treatment by a physician or on a special diet? ☐ **Yes** ☐ **No**

If yes, explain why, when, by whom, for how long time and result of therapy. _____

9. Have you sought the advice of a doctor during the past three years for anything apart from temporary flu or viruses? ☐ **Yes** ☐ **No**

If yes, explain in detail and give the physician's name and address. _____

10. Are you in perfect health and working condition? ☐ **Yes** ☐ **No**

If no, give details. _____

IV. OWN STATEMENT AND SIGNATURE

I hereby declare that I have personally answered all of the questions in this application and confirm that all the answers have been provided in accordance with my best knowledge, as I have not concealed any items which could make a difference to the company's risk assessment. I am aware that incorrect or incomplete information on my health condition could result in the limitation or loss of right to compensation and that the premiums paid will be non-refund able. My responses in this application, together with the terms and conditions of the insurance, form the basis of my insurance contract with Tryggingamiðstöðin hf. I HEREBY AUTHORISE PHYSICIANS, HOSPITALS AND OTHER PARTIES IN POSSESSION OF INFORMATION ON MY HEALTH CONDITION AND MEDICAL HISTORY TO PROVIDE THE COMPANY AND ITS CONTRACTED PHYSICIAN ANY INFORMATION NECESSARY FOR A DECISION ON PROVIDING ME WITH INSURANCE.

_____ **Place**

_____ **Date**

_____ **Signature of the person to be insured**

_____ **Signature of policy holder**