# Application for Medical Cost Insurance

Ráðgjafi _____

Skírteinisnúmer _____

## I. General Information

Name of the insured _____ ID no. (Icelandic) _____

Nationality _____ Date of birth _____ Sex: ☐ Male ☐ Female

Address _____ City/Town _____ Country _____

Address in Iceland _____ Postal Code _____ City/Town _____

Phone number _____ Mobile Phone _____ E-mail _____

Arrival date in Iceland: _____ How long is the planned stay in Iceland? _____

Policy Holder (if other than insured) _____ ID no. (Icelandic) _____

Address _____ Postal Code _____ City/Town _____

Phone number _____ Mobile Phone _____ E-mail _____

## II. 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, etc.) MAY NOT BE USED.

All agreements between me and my consultant will be stated in this application. All information is in confidence.

## III. Insurance amount and duration

Insurance amount is 2.000.000 ISK.

Insurance will come into effect at date: _____ The insurance duration is 6 months

## IV. Occupation and special risks

1. Occupation _____

2. Special risks due to occupation, hobbies or sports? ☐ Yes ☐ No

If yes, please give details _____

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 Initials _____

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## V. Health information

1. Name and address of family doctor _____

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

3. Are you pregnant? ☐ Yes ☐ No

If yes, when do you expect to give birth _____ (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**

4. Do you smoke, or use any other type og tobacco/nikotin? ☐ Yes ☐ No

If yes, what kind of tobacco an how much daily _____ Used since _____

If no, have you smoked or used another kind of tobacco/nikotin? ☐ Yes ☐ No

If yes, when did you quit using it? Quit month/year _____

5. Do you drink alcohol? ☐ Yes ☐ No

If yes, what quantity per week _____

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

If yes, please explain _____

_____

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

8. Do you use or have you used medication regularly? ☐ Yes ☐ No

If yes, which medication, why and when _____

_____

9. 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? ☐ Yes ☐ No

b) stomach or colon disease? ☐ Yes ☐ No

c) disease of the kidney or urinary system? ☐ Yes ☐ No

d) lung, bronchial or respiratory disease? ☐ Yes ☐ No

e) allergy or skin diseases? ☐ Yes ☐ No

f) discus prolaps, lumbago, neck pain, back pain or other back problems or pain in the musculoskeletal system? ☐ Yes ☐ No

g) a disease in the nervous system, e.g. dizziness, tremor, MS, MND, epilepsy, headaches or migraines? ☐ Yes ☐ No

h) a disease, symptoms of or medical problems with the sense organs e.g. eyes or ears? ☐ Yes ☐ No

i) abnormal results from researches, e.g. blood or urine tests or radiogram? ☐ Yes ☐ No



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j) tumor, cancer or changes of the cells growth? ☐ Yes ☐ No

k) metabolic, thyroid or glandular disease and/or diabetes? ☐ Yes ☐ No

l) diagnosis of AIDS or are you awaiting the result of an HIV test or do you have any reason to suspect you might be HIV infected? ☐ Yes ☐ No

m) disease or physical injury, any symptoms, accidents or poisoning that have required or may require a medical test, operation or treatment? ☐ Yes ☐ No

n) have you been classified as a disabled person due to accident or disease? ☐ Yes ☐ No

If yes, please provide full details _____ % disability _____

o) depression, anxiety or other mental symptoms? ☐ Yes ☐ No

p) other diseases, symptoms or medical problems? ☐ Yes ☐ No

For women:

q) any gynaecological disorders, breast symptoms or gestational problems? ☐ Yes ☐ No

If any of the above answer A-Q is positive, please specify:

a) Name of disease, description of symptom or type of accident _____

_____

b) when you became aware of the disease, symptom or when the accident occurred _____

c) whether there was a partial or full recovery _____

d) when medical care began and when it was concluded _____

e) what medical institution/physician treated you (please state location) _____

_____

10. Have you sought 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) ☐ Yes ☐ No

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

_____

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

If no, explain further _____

_____

## VI. Additional Information

_____

_____

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## VII. Statement and signature of applicant

I hereby confirm that the answers to the questions above are to my best knowledge correct and true. To my best knowledge I have not excluded anything that could affect the Company's assessment of the risk. I am aware of the fact that this insurance does not cover consequences of prior diseases or any prior condition.

I also give my full permission to physicians, hospitals, and others that hold information about prior diseases to provide the Company or the Company physician with all such information.

Furthermore I give the Company my consent to gain information concerning myself from Statistics Iceland/Hagstofa Íslands and the Directorate of Immigration/Útlendingastofnun. If needed, the Company may ask the insured to get a physical examination undertaken by the Company physician.

I do understand that the Company's liability initiates upon the receipt and approval of this application.

☐ The undersigned has read the above statement

**Place and date**

**Signature of the person to be insured**

**Please sign your initials on page 1-3**

**Signature of the policy holder**

## VIII. If an interpreter has assisted the insured with filling out the application, please sign here

I hereby declare that I have assisted

Name _____ Date of birth _____

filling out this application for Medical Cost Insurance and have explained the questions and the statement for the applicant

in his/her native language.

**Place and date**

**Interpreter's name**

**ID no. (Icelandic)**

**Undirskrift starfsmanns / vátryggingamiðlara**

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