

# 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 \_\_\_\_\_ Postal Code \_\_\_\_\_ City/Town \_\_\_\_\_

in Iceland

Phone number \_\_\_\_\_ Mobile Phone \_\_\_\_\_ E-mail \_\_\_\_\_

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

Policy Holder \_\_\_\_\_ ID no. (Icelandic) \_\_\_\_\_

(if other than insured)

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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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 of tobacco/nikotin? .....  Yes  No

If yes, what kind of tobacco and 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) disc 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

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**

\_\_\_\_\_  
\_\_\_\_\_

## 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

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Place and date

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Signature of the person to be insured

Please sign your initials on page 1-3

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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.

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Place and date

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Interpreter's name

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ID no. (Icelandic)

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Undirskrift starfsmanns / váttryggingamiðlara

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