Application form

Medical cost insurance

Vátryggingafélag Íslands hf
Ármúla 3, 108 Reykjavík, 560 5000
kt. 690689-2009, www.vis.is

For those not covered by medical insurance under Art. 32 of the State Social Security Act No. 117/1993.

It is important to answer all questions on the application with Yes, No or in another clear way. A blank will be interpreted as a statement that the relevant risk item does not exist. A blank can therefore affect the insured's right to compensation if it is discovered later that the answer was unsatisfactory for risk assessment.

Policy number: _____

1.0

Please choose the insurance amount:

☐ Amount ISK: 2.000.000 ☐ Amount ISK: 4.000.000 ☐ Amount ISK: 6.000.000

Duration of insurance from: _____ To: _____

2.0

Policy holder name _____ National ID _____

Address _____ Postal code _____ City/town _____

Telephone(Home) _____ Telephone(Work) _____ Mobile _____

Email _____

3.0

Insured _____ National ID _____

Previous domicile _____ Nationality/Country of origin _____

Postal code _____ City/town _____ Country _____

Email _____ Date of birth _____

Address (Icelandic) _____ Postal code _____ City/town _____

Telephone(Home) _____ Telephone(Work) _____ Mobile _____

Planned length of stay in Iceland _____

Gender ☐ Male ☐ Female Marital status ☐ Single ☐ Co-habitation ☐ Married

Occupation _____

4.0

Do you wish to be insured in any of the risk exclusions mentioned in 4.15 and 4.16 in the terms of medical cost insurance?

☐ No ☐ Yes, which? _____

_____

09.2012

4.0 (frh.)

Has any insurance company denied you of medical or life insurance coverage, demanded a higher premium, special policy terms, medical certificate or terminated your insurance?

☐ No ☐ Yes, which one? _____

_____

5.0

Who is your family doctor? _____

6.0

Are you, and have you for the last two years been perfectly healthy and able to work?

☐ Yes ☐ No, why? _____

Have you visited a doctor or had a physical examination in the last 12 months?

☐ Yes ☐ No, why? _____

7.0

Height(cm) _____ Weight(kg) _____

8.0

Have you now, or previously had, the diseases or the symptoms listed below?

a. Cardiovascular disease?	☐ Yes	☐ No
b. High blood pressure?	☐ Yes	☐ No
c. Gastrointestinal diseases?	☐ Yes	☐ No
d. Thoracic or pulmonary diseases?	☐ Yes	☐ No
e. Diseases of the kidneys or urinary tract?	☐ Yes	☐ No
f. Cancer, tumor or diseases of the thyroid?	☐ Yes	☐ No
g. Diseases of bones, joints or muscles?	☐ Yes	☐ No
h. Depression or mental diseases?	☐ Yes	☐ No
i. Other diseases of the nervous system?	☐ Yes	☐ No
j. Diseases of the sense organs?	☐ Yes	☐ No
k. AIDS, or do you have reason to think you are infected with HIV?	☐ Yes	☐ No
l. Allergies, skin diseases, glandular diseases?	☐ Yes	☐ No
m. Any known congenital diseases?	☐ Yes	☐ No
n. Other diseases?	☐ Yes	☐ No
o. Have you had an operation?	☐ Yes	☐ No
p. Have you been in a serious accident?	☐ Yes	☐ No
q. Have you been classified as disabled due to an accident or disease?	☐ Yes	☐ No
If yes, when? _____ Disability rate (%) _____		
r. Have you stayed in a hospital?	☐ Yes	☐ No
s. Diseases of the breasts or uterus (women)?	☐ Yes	☐ No
t. Felt weakness, fever, lack of appetite, frequent urination or diarrhea in the last three months?	☐ Yes	☐ No

09.2012

9.0

If you answer any of the above with Yes then specify the disease, when it started and how long it lasted.
What is the name of the doctor (hospital) that treated you? What where the consequences of the disease?
If you have been in an accident then specify which accident and its consequences:

10.0

Do you know of any hereditary diseases in your family? If you do, please explain

Do you smoke, or have you smoked? ☐ No ☐ Yes, when and for how long?

Do you routinely take any medication? ☐ No ☐ Yes, what medication?

How much daily?

11.0

Do you consume alcohol? ☐ Never ☐ Seldom ☐ Weekly ☐ More often

Do you use, or have you used, any narcotic or stimulating drugs?

☐ No ☐ Yes, how much daily?

Do you use any other drugs? ☐ No ☐ Yes

Have you visited a doctor because of the use of alcohol or drugs?

☐ No ☐ Yes, please give details

12.0

Women's attention is drawn to provisions of the policy terms on pregnancy, birthing assistance and diseases traceable to pregnancy and embryo death.

Are you pregnant? ☐ No ☐ Yes, estimated date of birth?

Applicant's comments

I hereby confirm that the answers to the questions above are to my best knowledge correct and true. To my best knowledge I do not exclude 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 which 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.

Place and date

Signature of applicant

Signature of policy holder (if other than applicant)

Filled in by the company:

Agency

Salesman

Number

Application approved by