SJÓVÁ

Sjóvá-Almennar tryggingar hf. | Sjóvá-Almennar líftryggingar hf.
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| Skírteini nr. | |
|---|---|
| Söluaðili | Ábending |

# Group life insurance

The insured must always fill out the insurance application himself or herself. Fill out the insurance application as accurately as possible. If you are in any doubt as to whether certain facts are relevant to our assessment of your application, please include them on the form.

If you make a mistake when filling out the application, please cross it out, make corrections and put your initials next to the corrections. Do not use correction fluids such as Tipp-Ex.

**The company's purpose in obtaining information on risks**

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 physicians, 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 well 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 risks being excepted from the insurance or to 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.

## I. Basic Information

| | | | |
|---|---|---|---|
| The Insured | | | ID No. |
| Address | | Postcode | Town |
| Telephone/Home | Telephone/Work | Telephone/Mobile | Fax |
| Email | | | |
| Payer: | | | ID No. |

## II. Type of Insurance, Sums and Effective Dates

1. a) ) Do you presently have other life and/or health insurance?. . . . . ☐ No ☐ Yes

If yes,

| Type of insurance: | Sum insured: ISK | With what insurance company? | Should the old policy be cancelled? |
|---|---|---|---|
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |

**Life Insurance**

1. Proposed sum insured: ISK

2. Life insurance effective date
   - ☐ Immediately—when application has been approved
   - ☐ Later—effective date

**Critical Illness Insurance**

1. Proposed sum insured: ISK

2. Critical illness effective date
   - ☐ Immediately—when application has been approved
   - ☐ Later—effective date

## III. Personal Health Information

1. Name of your family doctor Address

2. Your height cm Your weight kg

3. Do you currently suffer or have you ever suffered from serious diseases or had symptoms of diseases, e.g. heart and vascular diseases, cancer or other malignant diseases, kidney diseases, colon diseases, diabetes, positive HIV test or symptoms from the nerve system (vertigo, numbness or tremor) or mental disease.. . . . . ☐ No ☐ Yes

If yes, please explain:

4. Have you been unable to work for three consecutive weeks or more for the past 3 years?. . . . . ☐ No ☐ Yes

If yes, please explain why?

5. Are you currently waiting for any results of medical examinations or have you undergone medical examination, blood tests or been under doctor's supervision, operated on or had prescribed medication to take on regular basis for the past 3 years?. . . . . ☐ No ☐ Yes

If yes, please explain why?

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

7. Have your parents or siblings suffered from heart or vascular diseases, stroke, high blood pressure, diabetes, kidney disease, cancer, MS, MND, Parkinson's disease or Alzheimer's disease before they reached the age of 60?. . . . . ☐ No ☐ Yes

If yes, give details of exact diagnosis, type of cancer and age at diagnosis.

8. Do you smoke, or have you ever smoked?. . . . . ☐ No ☐ Yes

If yes,
what is/was your daily consumption? | Started smoking month/year | Quit month/year

## IV. Designation of a Beneficiary of the Sum Insured

☐ **Lawful holder not nominated**
This designation means that the spouse of the insured is the beneficiary of the insurance sum. If the spouse is not alive, the children of the insured are the beneficiaries; if the children are not alive, then the insured's legal heirs will be considered the beneficiaries. (Please note that the term "spouse" means that the individual is in a formal marriage and is not cohabiting.)

☐ **Legal heirs**
This designation means that if the insured leaves a spouseand children, one-third of the sum will go to the spouse and two-thirds of the sum will go to the children. (Please note that the term "spouse" means that the individual is in a formal marriage and is not cohabiting.)

☐ **Registration of the designated beneficiaries**

| Name | ID No. |
|---|---|
| Name | ID No. |
| Name | ID No. |
| Name | ID No. |

## V. Declaration and Signature of Applicant

**Statement by the applicant, and her/his consent to medical data being acquired from others**

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 in my own hand and realise that false or insufficient information about my health may cause a loss of compensation rights, in part 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 Sjóvá-Almennar líftryggingar hf. It is clear to me that this insurance does not cover previous illnesses or accidents, or their effects. At its offices throughout Iceland, Sjóvá-Almennar tryggingar hf. provides the full range of services for the customers of its subsidiary, Sjóvá-Almennar líftryggingar hf., according to a special agreement on services. I, the undersigned, hereby grant the latter company, Sjóvá-Almennar líftryggingar hf., permission to provide Sjóvá-Almennar tryggingar hf. access to the information about me which is necessary for performing the agreed services. I hereby confirm that information I have provided on diseases of parents or siblings are given with their consent in the cases where it is reasonable to expect that is could be obtained. I CONSENT TO INFORMATION PROCESSING BEING CONDUCTED IN THE MANNER DESCRIBED ABOVE, AND REALISE THE PURPOSE OF SUCH PROCESSING. IN ADDITION, I GRANT MY PERMISSION TO PHYSICIANS, MEDICAL INSTITUTIONS AND OTHERS POSSESSING INFORMATION ON MY HEALTH TO PROVIDE THE COMPANY AND ITS CONSULTING PHYSICIAN WITH ANY SUCH INFORMATION AS MAY BE NECESSARY FOR DECISIONS 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.

Any pledges and arrangements between the advisor and me are to appear on this application form.

I have noted the company terms that are in effect regarding the insurance for which I am herewith applying.

Date | Place

Signature of the insured

Attested by the consultant

**To be filled out by the company**

☐ Smoker status ☐ Non-smoker ☐ Special terms ☐ Extra premium