Application form

Medical cost insurance - Domestic

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

For those not covered by medical insurance under Art. 10 of the State Social Security Act No. 112/2008.

Your application contains questions relating to your health. The information that you provide, due to your insurance policy application, is necessary for VÍS to assess the company's risk and, as appropriate, establish a contract, cf. the provisions of Chapter XIII of Act No. 30/2004 on Insurance Contracts. In some cases, it may be necessary, before an insurance application is processed, to collect further information on your earlier health history from physicians, medical centers or from others holding such information. The purpose of collecting such information is to determine whether the insurance should be granted with a special surcharge, whether particular risks are exempted from compensation or whether the company rejects the application for insurance. The processing of personal information at VÍS as regards customers and other individuals is in accordance with Act No. 90/2018 on the Protection of Privacy as Regards the Processing of Personal Data. VÍS is the controller of the processing and is, therefore, regarded as the guarantor according to personal privacy laws.

When filling in the application, please make sure that you respond to all questions conscientiously and according to the best of your knowledge. If you are unsure whether some information is relevant, please indicate that this is the case rather than skipping the question.

1.0 - General information

Insured _____ National ID/Date of birth _____

Nationality/Country of origin _____

Current domicile _____

Postal code _____ City/town _____ Country _____

Telephone _____ Email _____

Address in Iceland _____ Postal code _____ City/town _____

Planned length of stay in Iceland _____

Gender ☐ Male ☐ Female ☐ Other

Occupation _____

It is only necessary to fill in the fields below if the policyholder or payer is other than the insured.

Policy holder name _____ National ID _____

Address _____ Postal code _____ City/town _____

Telephone _____ Email _____

2.0 - Insurance amount and duration

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: _____

3.0 - Special risk

Do you wish to insure specially for competitive sports that are excluded in the insurance terms?

☐ No ☐ Yes, which? _____

_____

Applicant's initials for confirmation of completion _____

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4.0 - Insurances with other insurance companies

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 - Health information

5.1

Height(cm) _____ Weight(kg) _____

5.2 - Do you smoke? (Vape and electric cigarettes counts as smoking)

☐ Yes. How much daily? _____

☐ No. Have you smoked? ☐ No ☐ Yes When did you stop? _____ Month _____ Year.

5.3

Are you, and have you for the last three years been perfectly healthy and able to work? ☐ No ☐ Yes

If no,why? _____

Have you been advised and/or are you planning to undergo any medical treatments and/ or researches? ☐ No ☐ Yes

If yes, why? _____

5.4

Do you routinely take any medication? ☐ No ☐ Yes

If yes, what medication and how much daily for how long? _____

5.5

Do you use, or have you used, any narcotic or stimulating drugs? ☐ No ☐ Yes

If yes, please give details _____

5.6

Do you have history of alcohol abuse and/ or drug abuse? ☐ No ☐ Yes

If yes, specify all types abused _____

How long did consumption last (years)? _____

Have you been treated for this? ☐ No ☐ Yes

If yes, specify all treatments ie. where and when (year) _____

_____

Have you consumed any of the substances mentioned above and/or any other after the last treatment? ☐ No ☐ Yes

If yes, please give details _____

_____

Have you suffered any damage related to the abuse, e.g. hepatitis, psychiatric problems? ☐ No ☐ Yes

If yes, please give details _____

Other things you want to mention: _____

_____

Have you now, or previously had, the diseases or the symptoms listed below and/ or sought medical treatment for those diseases or symptoms?

a. Cardiovascular disease? ☐ Yes ☐ No
b. High blood pressure, blood clot or stroke? ☐ Yes ☐ No
c. Gastrointestinal diseases? ☐ Yes ☐ No
d. Thoracic or pulmonary diseases? ☐ Yes ☐ No
e. Allergies and / or skin problems? ☐ Yes ☐ No
f. Diseases of the kidneys or urinary tract? ☐ Yes ☐ No
g. Diabetes, thyroid or metabolic disorder? ☐ Yes ☐ No
h. Cancer, cell transformations, benign tumours or blood disorders? ☐ Yes ☐ No
i. Depression or mental diseases? ☐ Yes ☐ No
j. In the nervous system, such as paralysis, MS, MND, epilepsy, migraine or spinal cord? ☐ Yes ☐ No
k. Sought medical attention because of dizziness, tremors, numbness or visual disturbance? ☐ Yes ☐ No
l. Diseases of bones, joints or muscles? ☐ Yes ☐ No
m. Diseases of the sense organs? ☐ Yes ☐ No
n. AIDS, or do you have reason to think you are infected with HIV? ☐ Yes ☐ No
o. Blood test results been abnormal f. ex. blood sugar or lipid levels ☐ Yes ☐ No
p. Other health problems, symptoms or illnesses? ☐ Yes ☐ No
r. Diseases of the breasts or uterus (For women)? ☐ Yes ☐ No

If the answer to all items in 6.0 are negative, please fill out question 6.2. If the answer to some items in 6.0 is yes, please fill out question 6.1. If more than one question is answered with yes then a supplementary form needs to be filled out.

6.1

Name of disease / symptoms: _____

Short description of symptoms: _____

When did you first notice the symptoms (year)? _____

When did you last notice the symptoms (month and year)? _____

What did/does the treatment entail? _____

Have you recovered?

☐ Completely according to doctors ☐ Partly according to doctors, please give details _____

_____

☐ Other, please give details _____

_____

Have you been treated in a hospital and/ or had outpatient treatment for the disease and/ or symptoms? ☐ Yes ☐ No

If yes specify where, when and for how long _____

Do you take any medication for the disease/ symptoms?

☐ Yes, specify name/names of medication and dosage _____

☐ No. Have you ever taken medication for the disease or symptoms? ☐ Yes ☐ No

If yes, specify name/names of medication _____

When did the medication intake stop (month and year)? _____

Did the medication intake stop according to doctors advise? ☐ Yes ☐ No

Please provide name and workplace for the doctor that treats you for the disease/ symptoms.

_____

Is regular monitoring needed for the disease/ symptoms? ☐ Yes ☐ No

Have you attended all scheduled monitoring?

☐ Yes

☐ No. Please explain why _____

How often in a year is monitoring scheduled? _____ When did you last attend monitoring? _____

When is the next scheduled monitoring? _____ Something other you want to add? _____

_____

6.2

Have you had a surgery? ☐ Yes ☐ No

If yes, when was the surgery done (year)? _____

If yes, please specify the cause and type of surgery _____

Have you recovered?

☐ Completely according to doctors ☐ Partly according to doctors, please give details _____

_____

☐ Other, please give details _____

_____

Are there more surgeries planed related to the previous one? ☐ Yes ☐ No

If yes, pleas specify when and why _____

_____

Are you under monitoring because of the previous surgery? ☐ Yes ☐ No

Please provide name and workplace for the doctor that can provide information about the surgery

_____

6.3

Have you been assessed for disability or are you awaiting disability assessment? ☐ Yes ☐ No

If yes, pleas specify what the disability is and when the assessment took place _____

_____

What is your disability rate according to disability assessment? _____ %

6.4 - Please *do not* specify connections, names or ID numbers

Have your parents and/ or siblings been diagnosed with the following diseases?

Cardiovascular and / or vascular disease, stroke? ☐ Yes ☐ No

If yes, please specify the type and age of the diagnosis _____

Muscle degeneration, connective tissue disease, MS, MND, Parkinson's, Huntington's or other neurological disorders? ☐ Yes ☐ No

If yes, please specify the type and age of the diagnosis _____

Cancer? ☐ Yes ☐ No

If yes, please specify the type and age of the diagnosis _____

Alzheimer's, diabetes 1 or 2 or kidney disease? ☐ Yes ☐ No

If yes, please specify the type and age of the diagnosis _____

7.0 – Upplýsingar er varða persónuvernd

Processing personal information
Under Act No. 90/2018 on the processing of personal information, the personal information of individuals is granted extensive protection. The Act ensures, for example, your right to obtain information on the processing of personal information by the guarantor and more. In accordance with the requirements of the Act, VÍS would like to inform you of specific aspects of the processing of personal information and your rights.

By delivering this application to the company, you are authorising the company to process personal information relating to you. As stated previously, this collection of information is important for the company's assessment of your application for insurance coverage. The information will only be used for the purpose of establishing or maintaining a medical cost insurance according to this application or to assess whether the insurance policy entitles you to compensation. In addition, you grant permission to the doctors and medical facilities that hold information about your heath to allow the experts of the company and/or re-insurers access to all such information if further information is required for the insurance or in the event of having to assess a claim for compensation.

All information will be treated as confidential and is subject to obligations of confidentiality. Personal information is preserved for the duration of the business relationship, and if/when it ends, the information is preserved in accordance with the rules on time limits for claims, cf. Chapter XVIII of Act No. 30/2004 on Insurance Contracts.

Your rights
You are entitled to revoke your consent for the processing of personal data. As the processing of the above information is a prerequisite for the establishment of the insurance contract, revocation of consent means that you no longer wish to maintain the insurance contract.

You are entitled to the return of the data you have provided the company according to a written request thereto. In addition, you may also request that the company send the above data to another guarantor.

The company's policy on the processing of personal data may be seen here.

If you are dissatisfied with the company's processing of your personal information, you can send a complaint to the Icelandic Data Protection Authority (personuvernd.is).

Comments/questions may be directed to the personal protection representative of VÍS by sending an e-mail to personuvernd@vis.is.

I agree to the processing of personal information as described above and to understand the purpose of the processing.

_____

Signature of applicant

I, the undersigned, hereby declare that I have personally answered all the questions contained in this application and confirm hereby that my responses are according to my best knowledge and correct and true and that I have left nothing out that may be of significance to the risk assessment of the company as relates to the insurance. I understand that incorrect or inadequate information about my health can result in the loss of compensation entitlement in part or in full.

VÍS' risk acceptance as regards the work and leisure activities of the insured is based on the information provided in this application.

In the event of loss or damage, compensation will be paid in accordance with such information. It is important to notify VÍS of any changes that occur during the insurance period.

I have been informed of the terms and conditions of the insurance and agree to them.

VÍS reserves the right to decline the application without any further reasoning.

Attention:
This insurance dose not cover cost related to pregnancy, childbirth or miscarriage including diseases or hospital stays.

If an insurance has not been issued for some reason and the application form is older than 3 months the company reserves the right to ask for a new application.

The premium for this insurance is not refundable after the insurance has been issued. This dose not apply if the insured never enters the country because the insured visa is denied, in those cases the premium is refunded excluding the base premium.

_____ _____

Signature of applicant | Place and date

_____ _____

Signature of policy holder (if other than applicant) | Place and date

Filled in by the company: | Risk assessment and comments

_____

Salesman

Applicant's initials for confirmation of completion _____

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