Application

for Life and Critical Illness Insurance

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

vís

1.0 The Insured

The insured ______________________ ID no. ______________

Address ______________________ Postal code ________ City/town ______________

Tel./Mobile ______________ Email ______________________

2.0 Policyholder

Policyholder ______________________ ID no. ______________

Address ______________________ Postal code ________ City/town ______________

Tel./Mobile ______________ Email ______________________

3.0 Employment and special risks

3.1

Principal occupation ______________________

Other occupation ______________________

3.2

Do you engage in activities that carry particular risk? (Particular risk includes e.g. mountain/cliff climbing requiring special equipment, cliff rappelling, wrestling and martial arts, driving sports, hang-gliding, gliding, parachuting, bungee jumping, scuba diving and other comparable activities). ☐ Yes ☐ No

If yes, what activities? ______________________

Please fill in the appropriate form – Form for special risks

3.3

Over the next three years, do you intend to travel to countries where there are conflicts? ☐ Yes ☐ No

If yes, specify country/countries ______________________

4.0 Policyholder

Please indicate the insurance you are requesting.

☐ Life insurance - Insurance amount ____________ ISK

☐ Critical illness insurance - Insurance amount ____________ ISK

5.0 Life insurance compensation

If applying for life insurance (Item 4.0), please complete this Item (5.0).

Appointment of the beneficiary of the insurance amount – Select one option only.

☐ No beneficiary appointed - When the policyholder appoints the beneficiary, the rules of Article 100 (2–6) of Act No. 30/2004 shall apply. According to these, the general rule is that the amount is payable to the spouse of the deceased and thereafter to the heirs according to law or will if there is no surviving spouse. Co-habiting partners are not considered spouses.

☐ Legal heirs - In such case, 1/3 of the insurance amount is payable to the spouse of the insured and 2/3 to the children of the insured. Co-habiting partners are not considered spouses.

☐ Registration of beneficiaries

Full name ______________________ ID no. ______________ ______ %

Full name ______________________ ID no. ______________ ______ %

Full name ______________________ ID no. ______________ ______ %

☐ Irrevocable appointment of beneficiary

Full name ______________________ ID no. ______________

Signature of irrevocable beneficiary ______________________

The spouse of the insured and/or the irrevocable beneficiary specifically requests notification if the insurance is cancelled due to payment defaults.

Full name ______________________ ID no. ______________

6.0 Life insurance compensation

6.1

Are you or have you been life insured? ☐ Yes ☐ No

If yes, what insurance company? ______________________

Is the older policy to be cancelled? ☐ Yes ☐ No

If yes, please fill in the appropriate form.

6.2

Do you have or have you had critical illness insurance? ☐ Yes ☐ No

If yes, what insurance company? ______________________

Is the older policy to be cancelled? ☐ Yes ☐ No

If yes, please fill in the appropriate form.

6.3

Has any insurance company denied you life insurance, critical illness insurance or accident insurance; demanded higher premium payment; required special terms or a medical certificate; or cancelled an insurance? ☐ Yes ☐ No

If yes, why? ______________________

7.0 Health information

7.1

Height (cm) __________ Weight (kg) __________ If pregnant, weight before pregnancy __________

7.2

Name and adress of general practitioner ______________________ ______________________

7.3

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

If no, why? ______________________

7.4

Have you had and/or do you intend to undergo surgery, medical treatment and/or medical investigation? ☐ Yes ☐ No

If yes, specify ______________________

7.5

Do you use or have you used depressants and/or stimulants? ☐ Yes ☐ No

If yes, explain further and provide the name of the drug/s ______________________

7.6

Do you smoke or have you smoked? ☐ Yes ☐ No

If yes, how many per day? __________ Smoked from __________ Quit year __________

7.7

Do you drink alcohol? ☐ Yes ☐ No

If yes, does your consumption disrupt your work and/or private life? ☐ Yes ☐ No

7.8

Do you have a history of substance abuse or excessive use of alcohol or other addictive drugs? ☐ Yes ☐ No

If yes, what was used (specify all types)? ______________________

7.8 (cont.)

What was the extent of the use on average (per week)? I.e. the volume of alcohol and/or each type of drug. ______________

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How long did the use persist (years)? ______________ Have you undergone treatment(s) in this respect? ☐ Yes ☐ No

If yes, specify all treatments, i.e. where and when (year) ______________

Have you consumed the above substances or other related substances since your most recent treatment? ☐ Yes ☐ No

If yes, explain further ______________

Anything else you wish to include? ______________

____

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7.9

Do you presently or have you previously suffered from the following illnesses or symptoms and/or sought the advice of a doctor as a result?

a) Cardiac or vascular system? ☐ Yes ☐ No
b) High blood pressure, blood clots or stroke? ☐ Yes ☐ No
c) Digestive system, such as in the oesophagus, stomach or intestines? ☐ Yes ☐ No
d) Lungs or chest, e.g. asthma? ☐ Yes ☐ No
e) Hypersensitivity, skin diseases, gland diseases? ☐ Yes ☐ No
f) Kidneys and urinary tract? ☐ Yes ☐ No
g) Diabetes, thyroid or metabolic diseases? ☐ Yes ☐ No
h) Cancer, cell transformations, benign tumours or blood disorders? ☐ Yes ☐ No
i) Depression/anxiety, ADHD or other mental illnesses? ☐ Yes ☐ No
j) Nervous system, e.g. paralysis, MS, MND, epilepsy, migraine or Duchenne's disease? ☐ Yes ☐ No
k) Sought medical attention due to dizziness, tremors, numbness or visual disturbances? ☐ Yes ☐ No
l) Bones, joints or muscles, e.g. rheumatism? ☐ Yes ☐ No
m) Senses, e.g. as regards sight or hearing? ☐ Yes ☐ No
n) AIDS, or do you have reason to believe that you are infected with the disease? ☐ Yes ☐ No
o) Results of blood tests have been abnormal, e.g. blood sugars and cholesterol. ☐ Yes ☐ No
p) Other health problems, symptoms or illnesses? ☐ Yes ☐ No
q) (For women) In breasts, uterus or illness during pregnancy? ☐ Yes ☐ No

If the response to any of the items in 7.9 is positive, please complete question 8.0.

If the applicant responds positively to more than one item in question 7.9, a separate form will be needed to answer question 8.0 for each positive response.

8.0 Questions relating to the illness/condition

Name of illness / type of problem ______________ When diagnosed (year)? ______________

Briefly describe the symptoms ______________

When did they first appear? ______________ Most recently? ______________

What treatment was administered? ______________

Is your recovery ☐ Complete according to a doctor ☐ Partial according to a doctor, provide further description

____

Have you been admitted to hospital, used the outpatients' / day ward as a result of the illness? ☐ Yes ☐ No

If yes, where and how long? ______________

Specify the names and the location of doctors who have treated you ______________

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Does the same doctor treat you today? ☐ Yes ☐ No If no, name of doctor and location ____________________

When did he/she take over your treatment? ____________ Have you ever taken medication for the illness? ☐ Yes ☐ No

If yes, name/s of medication ____________________

Doctor who prescribed the medication ____________________

Do you take any medication today for the illness? ☐ Yes, name of medication ____________________ ☐ No

Is there a need for medication according to a doctor? ☐ Yes ☐ No

Doctor who prescribed the medication ____________________

Is regular observation required as a result of the illness? ☐ Yes ☐ No

Have you attended the scheduled observation appointments? ☐ Yes ☐ No

How often per year are the observation appointments scheduled? __________ When did you last attend? __________

When is the next appointment? ____________________ Anything else you wish to include? ____________________

____

9.0 Questions relating to surgery

Have you undergone surgery? ☐ Yes ☐ No

If yes, what type of surgery, and why was it performed? ____________________

When (year) and where was the surgery carried out? ____________________

Is recovery full or partial after the surgery? Describe in greater detail. ____________________

____

Specify the name and location of the doctor who performed the surgery ____________________

Is any further surgery planned that relates to the earlier surgery? ☐ Yes ☐ No

If yes, when? ____________ What is to be corrected? ____________________

Are you under observation due to an earlier operation? ☐ Yes ☐ No

If yes, what does this involve? ____________________

10.0 Questions relating to disability

Have you been assessed for disability? ☐ Yes ☐ No

If yes, what does the disability involve? ____________________

What is your disability percentage according to the disability assessment? ______ %

11.0. Questions relating to parents and/or siblings

Do your parents and/or siblings have or have they had any of the following diseases?
Please specify all parties / parents and siblings as appropriate.

Cardio and/or vascular disease? ☐ Yes ☐ No

If yes, what type of heart disease, and at what age was the disease diagnosed? ____________________

Muscular atrophy, connective tissue disease, MS, MND, Parkinson's, Huntington's or other neurological disease? ☐ Yes ☐ No

If yes, what disease/name is involved? ____________________

Cancer? ☐ Yes ☐ No

If yes, where was the cancer located, and at what age was it diagnosed? ____________________

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

If yes, what type of disease/condition, and at what age was the disease diagnosed? ____________________

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12.0. Information for the policyholder

Experts from VÍS will assess whether additional information relating to health or further information from a doctor or a medical facility that has treated the applicant will be required or whether a medical examination will be required. In such cases, the application will await further processing until the information has been obtained.

When processing personal information, the provisions of the Act on the Protection of Privacy as Regards the Processing of Personal Data No. 77/2000 are upheld at all times. Employees who process personal insurance are bound by confidentiality and irreversible duty of non-disclosure as regards the information.

13.0. Declaration and consent (applies when 11.0. is completed)

Declaration and consent – Confirmation of the consent of parents/siblings.

I hereby confirm, with my signature, that the information about parents and/or siblings is provided with their consent.

Full name ______________________________ ID no. ______________________

VÍS' risk acceptance at work and during leisure time 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, 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 nothing is left 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.

I agree to the processing of my information in the manner described previously and understand the purpose of such processing. In addition, I grant permission to the doctors and medical facilities that hold information about my 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 having to assess a claim for compensation.

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.

The issuer of the life and critical illness insurance is Líftryggingafélag Íslands, Ármúla 3, 108 Reykjavík.

______________________________ ______________________________

Signature of the insured | Place and date

______________________________ ______________________________

Signature of the policyholder | Place and date

______________________________ ______________________________

To be completed by Vátryggingafélag Íslands hf. | Risk assessment and comments

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Salesman