Health declaration 5 years / Consent form

The completed form must be sent to Euro Accident via the contact form on Euro Accident's website www.euroaccident.dk, under Contact information.

Your full name	Civil reg. no.
Address	Postal code/city
Tel./mobile	E-mail
Position	Employer
Provider's name/company	

Health information

Please complete this declaration as establishment of your insurance cover depends on your health. It is important that you answer all questions in detail yourself and return the form to Euro Accident. For your own sake, you must mention all matters that you can think of – even if you do not think that they are important for us. Otherwise, there is a risk that there will be no cover under your insurance if you need it one day. If you are unsure of, for example, diagnoses and dates, you may contact your physician before completing the declaration. If there is not enough space on the form, you may write on a blank piece of paper and submit it with the declaration. It is also important that you let us know if there are any changes in your health in the period when we are assessing the terms on which your insurance policies can be taken out.

In the event that the insurance cannot be arranged on standard terms, you will receive a letter informing you of the fact, and your policy will also reflect this. It is thus important that you read these and get in touch with Euro Accident as soon as possible, if you do not wish to accept the terms and conditions.

1.	Have you applied for, been recommended for, have you received or do you receive public disability pension or disability benefits?	No ☐ Yes ☐	If Yes, state the following: Since when? _____ Month/year
2.	Have you applied for, been recommended for, have you participated in or are you participating in a work ability test, job clarification programme, flexjob, sheltered job, resource-building employability programme or employment rehabilitation?	No ☐ Yes ☐	If Yes, state the following: Since when? _____ Month/year
3.	Have you within the last 5 years received insurance benefits due to loss of earning capacity/disability?	No ☐ Yes ☐	If Yes, state the following: Reason? _____ When? _____ Month/year
4.	Are you working reduced hours for health reasons or has a special agreement been concluded with your employer such as an agreement under section 56 of the Danish Sickness Benefits Act?	No ☐ Yes ☐	If Yes, state the following: Reason? _____
5.	Have you within the last 5 years been absent from work due to any other illness than the common cold or flu?	No ☐ Yes ☐	If Yes, state the following: Reason? _____ Number of sick days? _____ Which periods? _____

Health declaration, continued

6.	Have you within the last 5 years consulted, been referred to, been examined or treated by a physician/medical specialist, hospital/private medical clinic, outpatient clinic, psychologist, psychiatrist, psychotherapist, chiropractor, physiotherapist or other therapists, including laboratory, x-ray clinic and physiotherapy clinic?	No ☐ Yes ☐	If Yes, state the following: Reason? _____ When? _____ Month/year Which kind of treatment? _____ Therapist: Name _____ Address _____ _____ Do you have sequelae/discomfort ☐ No ☐ Yes If yes, describe: _____
7.	Have you been referred to or been included on a waiting list for examination, treatment or admission?	No ☐ Yes ☐	If Yes, state the following: Reason? _____ Where/with whom? _____
8.	Have you within the last 5 years had any illnesses in or discomfort, including pain, muscle tension, arthritis etc., from your head, neck, back or lower back?	No ☐ Yes ☐	If Yes, state the following: Which? _____ When did you last have this? _____ Month/year
9.	Have you within the last 5 years had any illnesses in or discomfort, including pain, muscle tension, arthritis etc., from shoulders, arms, elbows, hands, hips, pelvis, legs, knees or feet?	No ☐ Yes ☐	If Yes, state the following: Which? _____ When did you last have this? _____ Month/year
10.	Do you have any congenital bodily defects or sequelae (impairment) after injuries?	No ☐ Yes ☐	If Yes, state the following: Which? _____
11.	Do you have a hearing impairment?	No ☐ Yes ☐	If Yes, state the following: Reason? _____
12.	Do you have a vision impairment?	No ☐ Yes ☐	If Yes, state the following: Reason? _____ Strength of glasses/contact lenses: Right: +/- _____ Left: +/- _____

Health declaration, continued

13.	Do you use or have you used medication (prescription or over-the-counter) prescribed by a physician or other therapist within the last 5 years?	No ☐ Yes ☐	If Yes, state the following: Which medications? _____ _____ For what? _____ _____ Period: _____
14.	a. Do you drink beer, wine, dessert wine or spirits? b. Have you within the last 5 years had a major consumption of beer, wine, dessert wine or spirits?	No ☐ Yes ☐ No ☐ Yes ☐	If Yes, state the following: Average number of drinks per week: _____ Average number of drinks per week: _____
15.	a. Do you smoke? b. If not, have you been smoking within the last 5 years? c. Do you use or have you used hash, "hard drugs" (such as heroin, speed, cocaine, ecstasy, LSD), anabolic substances, organic solvents or other stimulants?	No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐	If Yes, state the following: What is your daily consumption? _____ number of cigarettes, cigars, pipes, When did you stop? _____ Month/year What is your daily consumption? _____ number of cigarettes, cigars, pipes, Which substances? _____ During which periods? _____ Have you received treatment/counselling for this? ☐ No ☐ Yes
16.	What is your height and weight?		Height in cm. _____ Weight in kg. _____
17.	Who is your physician?		Name: _____ Address: _____ Postal code: _____ City:_____

Processing of personal data

In connection with the continuous administration of the insurance agreement, Euro Accident processes personal data for which Euro Accident is data controller. Our privacy policy, which you can find on our website www.euroaccident.dk, includes more detailed information on how Euro Accident processes your personal data, including your rights. We may change our privacy policy at any time, and we recommend that you check our privacy policy regularly for any changes.

Signature and declaration.

It declare that my answers and information are truthful and that I have not concealed any information. I am aware that the insurance cover may be reduced or terminated if the answers are not completely truthful or if information has been concealed.

Date Signature

_____ _____

Consent form on the next page must also be completed and signed in order for Euro Accident to process the application.

Consent form for new policy and change of policy
Loss of earning capacity, Waiver of premium, Disability lump sum benefit, Lump sum on death, Children's pension, Critical illness

The completed form must be sent to Euro Accident via the contact form on Euro Accident's website www.euroaccident.dk, under Contact information.

Consent giver's name: _____

By my signature, I consent to Euro Accident, in connection with my application for new policy/change of policy, obtaining, using and disclosing any information necessary for the company's assessment of my application and to Euro Accident disclosing information in this connection for the identification of me and my application to those from whom the company obtains the relevant information. Euro Accident will notify those from whom information is obtained of the relevant information.

From whom can information be obtained?

With this consent, Euro Accident may obtain relevant information from the following parties, with whom I have been, are or will be in contact:

- My present and former physician
- Public and private hospitals and laboratories, outpatient facilities and clinics
- Specialists, physiotherapists, chiropractors and psychologists
- Alternative therapists
- My present and former municipality of residence
- Other insurance companies and pension funds
- My present and former employer
- Other parties of whom I have notified Euro Accident in connection with my application

With this consent, the mentioned parties may disclose the relevant information to Euro Accident.

To whom may the obtained information be disclosed?

With this consent, Euro Accident may disclose the obtained information to the following parties, who are affiliated with Euro Accident:

- Physicians, specialists and psychologists
- Reinsurance company

In addition, with this consent, Euro Accident may disclose the obtained information to the following parties:

- Public authorities such as municipalities and the National Board of Industrial Injuries
- Insurance companies and pension funds

Which information may be processed?

The consent includes obtaining, using and disclosing the following categories of information:

- Health information, including disease information and information on contacts with the health service
- Information on social and financial matters
- To my employer: Name, civil reg. no. and that this is an insurance case
- From my employer: Working hours, absence due to illness, salary and special working conditions

The consent does not include information on:

- The current or former state of health of other persons, such as relatives
- The result of genetic testing carried out to clarify the applicant's future risk of having certain illnesses (predictive genetic testing)
- Participation in and the result of preventive examinations. However, the result of such examinations may be stated if they reveal current signs of illness or concern illnesses that the applicant has previously had or that have already broken out.

For which period may information be obtained?

The consent comprises information for a period of 5 years prior to the time of my signing of this consent and until the time when Euro Accident has decided on my application. If justified by the information for this period, Euro Accident may, for a specific reason, obtain information prior to this period.

Time restriction, notification etc.

The consent applies for one year. I may at any time withdraw my consent and/or have any incorrect or misleading information rectified or erased. Withdrawal may influence Euro Accident's ability to process the insurance application. Those who are involved in my case are informed of my consent.

I receive notification each time Euro Accident obtains information. I am informed why the information is obtained, which information is obtained and disclosed and for which period and from whom the information is obtained and to whom it is disclosed.

Date Signature by the insured Civil reg. no.

_____ _____ _____-_____

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