EURO ACCIDENT
försäkring + hälsa

Health declaration Standard

☐ Insured/group member ☐ Co-insured

» Personal data

Name insured	Personal identity (ID) number insured
Personal identity (ID) number group member	E-mail address insured

» Health issues – for group member and co-insured

The information contained in this health declaration forms the basis of the insurance agreement and its performance, and shall be provided personally by the person to be insured. All 23 questions below shall be answered, if not indicated otherwise. If you are not fully capable of working, you can apply for insurance once you are fully capable of working.

» Fully capable of working

1. Are you fully capable of working? That is to say can you carry out your normal work without restrictions and do not receive sick pay from your employer or compensation from the Social Insurance Agency, such as sickness or rehabilitation benefit, activity co pensation, temporary sickness compensation, sickness compensation or other compensation owing to work disablement, nor payment of occupational injury annuity. You are not deemed fully capable of working if you have been granted dormant activity/sickness compensation or corresponding, wage subsidy employment or have been allocated adapted work owing to health reasons.The 'Social Insurance Agency' and	☐ Yes ☐ No
2. Have you been fully capable of working for the last 3 months?	☐ Yes ☐ No

» General informaion

3. State height cm and weight kg	cm kg
4. Do you smoke?	☐ Yes ☐ No

» Illness, symptoms or injury the last three years

Have you during the last three years received care, treatment, been for a check-up or examined at a hospital, health care centre, treatment institution or other care establishment or otherwise consulted a physician ot other care provider (for example nurse, psychologist, chiropractor, physiotherapist or naprapath) regarding any of the illnesses symptoms or injuries below?

5. Allergic complaints, asthma, respiratory tract complaint or other lung disease?	☐ Yes ☐ No
6. Skin disorder/skin disease?	☐ Yes ☐ No
7. Metabolic disorder, endocrine system disease, goitre and/or thyroid problem?	☐ Yes ☐ No
8. Disease of the eye, visual defect, disease of the ear and/or tinnitus?	☐ Yes ☐ No
9. Symptom/illness? Insured: ☐ back ☐ neck ☐ shoulders ☐ arms ☐ hips ☐ legs ☐ knees ☐ feet ☐ hands?	☐ Yes ☐ No
10. Repetitive strain injury/complaint or impairment of joints or muscles?	☐ Yes ☐ No
11. Mental complaint, sleep disorder, mental disorder, stress-related symptom, burn-out, etc?	☐ Yes ☐ No
12. Disease of the stomach, intestines, liver, pancreas or other abdominal organ?	☐ Yes ☐ No
13. Disease/complaint of the kidneys, urinary tract, genitalia/pelvic organs and/or prostate gland?	☐ Yes ☐ No
14. Diet, pill or insuline treated diabetes?	☐ Yes ☐ No
15. Raised blood pressure and/or raised blood lipids?	☐ Yes ☐ No

16.	Heart disease or disease/complaint of coronary artery	☐ Yes ☐ No
17.	Blood clot/cerebral haemorrhage or similar?	☐ Yes ☐ No
18.	Epilepsy, dementia, headaches or other neurological symptoms or diseases?	☐ Yes ☐ No
19.	Tumour diseases, disease of the lymph vessels, blood diseases?	☐ Yes ☐ No
20.	Other sickness/disease/complaint/symptom than those in questions 5–19?	☐ Yes ☐ No
21.	Do you use any pharmaceutical (prescription or over–the–counter)?	☐ Yes ☐ No
22.	Have you been on sick leave or been work disabled (full or partial) for more than 14 consecutive days during the past fi e years?	☐ Yes ☐ No

» In addition to the above

Do you have, have you had or is there any suspicion of some kind of problem with your internal organs, physical or mental disability, sickness, injury, HIV, or other physical defect? Also state visual and hearing defects. In the case of short–sightedness/long–sightedness, state the dioptric number.	☐ Yes ☐ No

» Processing of personal data

As a Controller, Euro Accident processes personal data to be able to offer and provide the insurance and services on which we have agreed and for other purposes such as, for example, compliance with laws and other rules. Further detailed information about the processing of personal data is available from Euro Accident's Integrity Policy (available at www.euroaccident.se) or by contacting Euro Accident. Our Integrity Policy not only includes information about how Euro Accident collects and uses your personal data, but also information about your rights in conjunction with the processing of personal data, such as the right to information, rectification, data portability, right to be forgotten and to object, etc."

» Signature

The information contained in this health declaration forms the basis of the insurance agreement and its performance. According to the existing application and underwriting regulations, I certify that I am resident and registered as resident in Sweden and entitled to compensation from a Swedish social insurance agency (in case of being resident and registered as resident in another Nordic country, I certify that I have taken part of the specific application and unde writing regulations stated in the pre-purchase information and the corresponding terms and conditions). I am aware that incorrect or incomplete information may render the insurance invalid and that any rights to insurance compensation may lapse. I consent to Euro Accident, and the companies that Euro Accident engages for risk assessments or claims handling, processing the personal data necessary for claims handling, administration and the performance of the insurance agreement.

Place and date	Signature insured
Name insured	

Insurer: Euro Accident Livförsäkring AB

Supplementary information to health declaration

Supplementary information to question number: ☐ Insured/group member ☐ Co–insured

» Personal details

Name	Personal idientity (ID) number

» Supplementary information

1. Profession and work duties:		
2a. Which sickness, injury, symptom or disability does this relate to?		
2b. Describe the complaints/symptoms with you own words:		
2c. Which is the reason to these complaints/symptoms (accident, sickness, work-related or other)?		
3a.When did the sikness/complaint appear?? Year Month	3b. Did you have similar complaints prior to this? ☐ Yes ☐ No **If Yes**, which kind? Year Month	
3c. What kind of care and treatment have you received/undergone?		
3d. When was the last time you were treated for this sickness, injury, symptom or disability? Year Month		
3e. Have further checks or treatment been planned? ☐ Yes ☐ No **If Yes**, which kind?		
4a. Are you free from symptoms and complaints? ☐ Yes ☐ No Year Month **If Yes**, when did you get free from symptoms and complaints?		
4b. If you are not free from symptoms and complaints, which remaining symptoms or complaints do you have?		
5. State the names and complete addresses of the physicians and/or care providers that you have consulted the last 3 years:	For which reason/diagnosis?	When was the last time you consulted the physician/care provider? State date below:
6.State diagnosis and sickness period	Fr. o. m	T. o. m
7. State what pharmaceutical(s) you take and the name of the physician/care provider who prescribed them:		

» Signature

Place and date	
Signature	Name