EURO ACCIDENT
försäkring + hälsa

Health declaration Special

☐ Insured/group member ☐ Co-insured

» Personal details (company details where appropriate)

Name	Personal identity (ID) number
Postal address	Postcode and district
Telephone	E-mail address
Name of the company (where appropriate)	Corporate ID number (where appropriate)

» Health issues – please answer all the questions

The information shall be provided personally by the person to be insured. All sicknesses, injuries, disabilities, symptoms/complaints and all sick-leave exceeding 14 consecutive days must be stated. This also applies to suspected HIV infection (AIDS virus).

1a. Are you fully capable of working? That is to say, that your normal work can be performed without restriction and that sick pay from the employer or compensation from the Social Insurance Agency is not being paid. 'Compensation from the Social Insurance Agency' means sickness or rehabilitation benefit, activity co pensation, sickness compensation or other compensation owing to work disablement. In order to be fully capable of working it is also required that no occupational injury annuity is being paid or that wage subsidy employment or dormant activity compensation/sickness compensation or corresponding compensation has not been granted. The 'Social Insurance Agency' and 'compensation' also mean the corresponding in the Nordic countries*.		☐ Yes ☐ No
1b. **If No**, what is the reason for your work disablement?	1c. When did you become work disabled?	
2. Have you been fully capable of working for the last 3 months?		☐ Yes ☐ No

*In respect of certain insurance products it is only the Swedish Social Insurance Agency that applies. See current product-specific nderwriting guidelines.

» General information

3. Profession (incl. incidental employment), studies, other activity		
4a. Nationality (to be answered by non-Swedish nationals)	4b. For how long have you been resident in Sweden (to be answered by non-Swedish nationals)?	
5. Enter height _____ cm and weight _____ kg		
6. Do you engage in any of the following: – martial arts or similar activity, professional diving, diving at depths greater than 18 metres, stunt activities, air acrobatics, mountain climbing, sky-diving, bungee jumping, extreme skiing (off-pist skiing), gliding/ballooning/hang-gliding, rock climbing (incl. on snow and ice) or participation in expeditions of a similar 'adventurous nature', – participating in motor sports, operations on an oil platform or on roofs on high buildings > 12 metres – flying therwise than in the capacity as passenger of a licensed multi-engine aircraft run by a commercial airline which is subject to government control. **If Yes**, state which?		☐ Yes ☐ No
7a. Do you smoke? **If Yes**, how many per day? ☐ <10 ☐ 10–20 ☐ >20 If more than 20, how many?		☐ Yes ☐ No
7b. If you have stopped smoking, state when and whether it was for medical reasons.		
8a. How much alcohol do you consume per week? Beer_____ cl/week Wine _____ cl/week Liquor _____ cl/week		
8b. Have you had a larger consumption previously? **If Yes**, how much? Beer_____ cl/week Wine _____ cl/week Liquor _____ cl/week		☐ Yes ☐ No
8c. Have you ever sought treatment for alcohol-related problems?		☐ Yes ☐ No

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9a. Do you have regular health checks? **If Yes**, answer the questions below.		☐ Yes ☐ No
9b. State the reason for the health checks	9c. State any underlying sickness/injury	
9d. Result of the health check ☐ No finding	9e. Other result	

» Illness, symptoms or injury

10. Is there a physician or other care provider you usually consult? **If Yes**, state the reason? Name and address of the physician/care provider?	☐ Yes ☐ No
11. Have you provided a blood sample for an HIV test (AIDS virus)? **If Yes**, when? Results: ☐ Negative (no HIV infection ☐ Positive (HIV infection)	☐ Yes ☐ No
12. Do you have any symptoms/complaints in respect of which you have not consulted a physician yet? **If Yes**, which?	☐ Yes ☐ No
13. Do you use any pharmaceutical (prescription or over-the-counter)? **If Yes**, which? Reason? Prescribed by (name and address of physician):	☐ Yes ☐ No
14. 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
15. Do you have or have you previously had:	
a. Heart disease? Sensation of pressure or chest pain? Leg swelling (edema)? Problems with palpitations, irregular heart activity or shortage of breath?	☐ Yes ☐ No
b. Blood clot? Cerebral haemorrhage? Vascular disease? Varicose veins?	☐ Yes ☐ No
c. Raised blood pressure? **If Yes**, state value below. State the blood pressure readings from the last two measurements, and also when the readings were conducted.	☐ Yes ☐ No
d. Asthma, respiratory tract complaint or lung disease?	☐ Yes ☐ No
e. Allergic complaints?	☐ Yes ☐ No
f. Disease of the stomach, intestines, live, pancreas or other abdominal organ? Hepatitis (Jaundice)?	☐ Yes ☐ No
g. Raised blood lipids?	☐ Yes ☐ No
h. Raised blood sugar? Diabetes?	☐ Yes ☐ No
i. Proteinuria, hematuria or glycosuria?	☐ Yes ☐ No
j. Disease/complaint of the kidneys or urinary tract?	☐ Yes ☐ No
k. Disease/complaint of genitalia/pelvic organs? Prostate gland problem?	☐ Yes ☐ No
l. Repetitive strain injury/complaint or impairment of joints or muscles? Rheumatic disease or other joint disease?	☐ Yes ☐ No
m. Symptom/complaint from ☐ back ☐ neck ☐ shoulders ☐ arms ☐ legs ☐ hips ☐ gluteal area ☐ sciatica ☐ intervertebral disc displacement	☐ Yes ☐ No
n. Symptom/complaint that has been treated by e.g. a chiropractor, naprapath, physiotherapist or similar?	☐ Yes ☐ No
o. Tumour disease (neoplasm)? Disease of the lymph vessels? Blood disease?	☐ Yes ☐ No
p. Disease to the nervous system, MS, epilepsy, headaches, migraine, vertigo, fainting episodes, dementia, etc.?	☐ Yes ☐ No
q. Mental complaint, sleep disorder, mental disorder, stress-related symptom, burn-out, etc.?	☐ Yes ☐ No

r. Eye injury, disease of the eye, visual defect? **If Yes**, put a cross for injury/disease/visual defect and also state right and/or left eye. ☐ Injury ☐ Disease ☐ Visual defect ☐ Right eye ☐ Left eye In the case of short-sightedness/long-sightedness, state the dioptric number: _____ If you are unsure, please attach a copy of the latest spectacle prescription.	☐ Yes ☐ No
s. Disease of the ear? Hearing loss? Tinnitus? Ear injury? **If Yes**, put a cross for disease of the year/hearing loss/tinnitus and also state right and/or left ear. ☐ Injury ☐ Disease ☐ Hearing loss ☐ Tinnitus ☐ Right ear ☐ Left ear	☐ Yes ☐ No
t. Skin disease or eczema? Psoriasis?	☐ Yes ☐ No
u. Metabolic disorder, endocrine system disease, goitre and/or thyroid problem?	☐ Yes ☐ No
v. Physical defect, physical or mental disability?	☐ Yes ☐ No
16. Have you received care for bodily injury, sickness or other problem in conjunction with consumption of alcohol or other misuse?	☐ Yes ☐ No
17. Have you used narcotics, doping substances or similar substances or over consumed pharmaceuticals? **If Yes**, what kind of substance? Over what period? Last occasion?	☐ Yes ☐ No
18. Have you been treated, cared or checked for other sickness/disease/complaint/symptom than those stated above?	☐ Yes ☐ No

» Complementing information

If you have answered 'Yes' to any of questions 9–18, you should provide information in accordance with questions A-H below. State in your answer to which of the questions 9–18 the clarification rela es. If there is insufficient space ou may continue on a separate sheet.

A) Which sickness, injury, symptom or disability does this relate to?
B) What examination/investigation has been performed and what was the result?
C) When did the sickness/complaint appear and during which periods have you had symptoms/complaint?
D) During which periods have you been on full or partial sick leave owing to such condition?
E) Which physician/care provider/care establishment have you consulted? State the name and address of the physician/care provider, hospital, clinic, ward, etc.
F) What kind of care and treatment have you received/undergone? (operation, radiotheraphy, medication, physiotherapist, massage, rest, etc.)?
G) Have further checks been planned? **If Yes**, where and when?
H) Have you recovered and without residual complaint? **If Yes**, since when? **If not, what consequences and complaints remain?**

» When applicable

Questions 19 and 20 shall only be answered if the applicant has attained the age of 18 and the application together with previous insurance policies applied for refer to:
– a sum insured that **exceeds 30 price base amounts** in aggregate, or
– a sum insured that in aggregate entails **periodic compensation exceeding 4 price base amounts** per year

19. Have you undergone any form of genetic examination? **If Yes**, state findings	☐ Yes ☐ No
20. Have any of your parents or siblings died before the age of 65? **If Yes**, state who, age and cause of death.	☐ 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 po tability, 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. I certify, in accordance with the current underwriting guidelines, that I am resident and registered as resident in Sweden and belong to a Swedish Social Insurance Agency (if I apply as a citizen of a Nordic country I certify that I have received and read the special underwriting guidelines referred to in the pre-purchase information). 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 the that Euro Accident, and the undertakings 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 (YYMMDD)	Insured's signature
Personal identity (ID) number	Print name

» Only refers to Disability Business Interruption Insurance – Company details, state annual amount

Sales	Number of employees	Date company started
Payroll expenses*	Fixed membership charges**	Premiums for business insurance
Fixed costs for accounting/audit	Fixed electricity and telecom costs	Operating interest expenses
Contracted rent costs under leasing contracts	Tax and insurance premiums for means of transport in the business	Rent for premises and other fi ed costs for premises
Place and date	Policyholder's signature (alt. insured, if the same person)	

* Refers to agreed salaries and payroll expenses for permanently active employees (note that salary and social charges for an insured do not constitute an indemnifiabl cost)

** Fixed membership charges for sector and employer organisations. Enclose a copy of the last annual accounts. Please certify below that the company details provided are correct.

Information regarding issues relating to genetic tests and family information

According to the Genetic integrity Act (2006:351), The Integrity of the individual is protected in concern of the use of genetic investigations and genetic information when purchasing personal insurance. The insurer can not, unless by virtue of the provisions laid down by law , stipulate as terms of an agreement that the other party must undergo a genetic investigation or provide genetic information about himself or herself. No person may have access to genetic information about another person without being given authority.

The Act (2006:351) states that, with regards to risk -rated personal insurance, an insurance company may inquire or use genetic information in connection with entering into, or the amendment or renewal of an existing agreement, provided that:

- the person insured is over the age of 18 years and the sum insured* that becomes payable in the event of an insurance loss is a lump sum in excess of 30 price base amounts as defined y the National Insurance Act (1962:381), or
- the person insured is over the age of 18 years and the sum insured* that becomes payable in the event of an insurance loss is a periodic indemnity in excess of four price base amounts per year.

* Sum insured refers to the total risk-assessed amount insured for applied insurance, including insurance already granted by one and the same company.