TRYGGINGARFELAGIÐ LÍV
Postboks 206
Óðinshædd 11
FO-110 Tórshavn
Tel. 31 11 11
liv@liv.fo
www.liv.fo

# Health Declaration

## Life Insurance, Certain Critical Illnesses and Disability Insurance

Full name: | Personal ID:

Adress: | Telephone:

Postal Code: | City/Town:

Occupation: | Email:

**When writing the health certificate, it is important that:**

- you answer all questions carefully without omitting anything – e.g., issues such as back problems, psychological issues, and use of drugs and alcohol – even if it does not seem relevant for the insurance.
- you are responsible for ensuring that the description is correct.
- incomplete or inaccurate information may result in no compensation in the event of an insurance claim.
- you are not obligated to provide information about genetic tests, i.e., tests that describe your genes (hereditary factors) and future disease risks.

**If more space is needed, write on an extra sheet. Remember to wite which question it concerns. Date and sign.**

**1 In the 10 years, have you had:**

| | | **If yes: Which illness, where/who treated you, and what treatment was provided?** |
|---|---|---|
| Heart illness/blood vessels? | No ☐ Yes ☐ | |
| High blood pressure? | No ☐ Yes ☐ | |
| Stroke (apoplexy) | No ☐ Yes ☐ | |
| Nervous system diseases, including epilepsy, memory problems, paralysis? | No ☐ Yes ☐ | |
| Cancer, tumors, or other malignant diseases? | No ☐ Yes ☐ | |
| Diabetes? | No ☐ Yes ☐ | |
| Kidney disease or urinary tract disease? | No ☐ Yes ☐ | |
| Liver disease? | No ☐ Yes ☐ | |
| Asthma/bronchitis or other respiratory diseases? | No ☐ Yes ☐ | |
| Mental illness? | No ☐ Yes ☐ | |

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**2** **Have you now or in the last 10 years had illnesses or problems (pain or discomfort) from the neck, back, or lower back, including disc herniation, lumbago, whiplash, muscle tension, etc.?**

No ☐ Yes ☐

If yes:
Which? _____

When last?(month/year) _____

Who treated you? _____
Name and address

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**3** **Have you now or in the last 10 years had illnesses or problems (pain or discomfort) from shoulders, arms, elbows, hands, hips, knees, or feet, including joint and rheumatic diseases?**

No ☐ Yes ☐

If yes:
Which? _____

When last?(month/year) _____

Who treated you? _____
Name and address

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**4** **In the last 3 years, have you been examined or treated by a doctor, chiropractor, physiotherapist, had tests done in a lab, or been hospitalized or admitted to a day clinic?**

**(Including overuse of alcohol and drugs, etc.)**

No ☐ Yes ☐

If yes:
For what: _____

When? _____

Where? _____

For how long? _____

Possible consequences? _____

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**5** **Are you currently on a waiting list for examinations, treatment, or hospitalization?**

No ☐ Yes ☐

If yes:
Where/which facility? _____

For what? _____

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**6** **a.Have you had congenital physical defects or consequences (injuries) after an accident?**

No ☐ Yes ☐

If yes:
What/Which? _____

**b. Hevur tú niðursetta hoyrn?** No ☐ Yes ☐ What is the cause? _____

**c. Sært tú illa?** No ☐ Yes ☐ What is the cause? _____

**Glasses/contact lens strength:** **Right: +/-** _____ **Left: +/-** _____

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**7** **a. Are you using any medication prescribed by a doctor or other practitioner?**

No ☐ Yes ☐

If yes:
Which meds? _____

For what? _____

**b. In the last 10 years, have you undergone medical treatment for more than 1 month, including sedatives or painkillers?**

No ☐ Yes ☐

Which meds? _____

When? _____

For what? _____

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**8** **a. Do you drink wine, spirits, or alcohol?** No ☐ Yes ☐ If yes: Average _____ units per week

**b. In the last 10 years, have you had increased con sumption of beer, wine, spirits, or alcohol?** No ☐ Yes ☐ Average _____ units per week
Which time period?(month/year) _____

**c.Do you or have you received treatment for this?** No ☐ Yes ☐ If yes:
Which treatment and where? _____
Which time period?(month/year) _____

**d. Smoking?** No ☐ Yes ☐ How much every day? _____
number of cigarettes/cigars/pipes

**e. d.Do you or have you used "hard drugs" (e.g. heroin, speed, cocaine, ecstasy, LSD), cannabis, anabolic steroids, organic solvents, or other stimulants?** No ☐ Yes ☐ Which drugs? _____
In which periods?(month/year) _____

**f. Have you received treatment or counselling?** No ☐ Yes ☐ What treatment and where? _____
In which periods?(month/year) _____

**9** **In the last 10 years, have you been sick or incapacitated for more than 1 month?** No ☐ Yes ☐ If yes:
What was the reason? _____
When?(month/year) _____
For how long? _____
Are there any consequences? _____

**10** **a. Are you completely healthy?** Yes ☐ No ☐ If no:
What is the reason? _____

**b. Are you fully capable of working?** Yes ☐ No ☐ What is the reason? _____

**11** **a. Are you undergoing vocational training or in an adapted job?** No ☐ Yes ☐ If yes:
What is the reason? _____
When?(month/year) _____

**b. Are you receiving or applying for disability or retirement benefits from the public due to your health?** No ☐ Yes ☐ What is the reason? _____
When?(month/year) _____

**12** **How tall are you and what do you weigh?** Height _____ cm Weight _____ kg

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**Who is your doctor? (write the name and address of the doctor)**

**If you have additional comments, you can write them here. Remember to specify which question (number) they relate to.**

**If you need more space, you can write on an extra sheet. Remember to date and sign the supplement.**

**I understand that the insurance may be reduced or voided according to the provisions of the insurance contract law if the health information provided is not true or if any information has been omitted.**

**Regarding the collection and disclosure of information, please refer to the specific consent form (FP 601)**

(Date&Place)

(Signature)

**To be filled out by LÍV:**

**Lív-átekning:** ☐ Góðkend ☐ Ikki góðkend Viðgj. á læknafundi

| Dagfesting: | Forbókstavir +stempul: | Treytir: |
|---|---|---|
| | | |