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

Health Declaration

Life Insurance and Certain Critical Illnesses

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 write which question it concerns. Date and sign.

1 **In the last 3 years, have you had any serious illness?**

No ☐ Yes ☐

If yes:
What illness? _____
When? _____
For how long? _____

2 **In the last 3 years, have you been examined or treated by a doctor, psychologist, psychiatrist, 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? _____

3 **In the last 10 years, have you been sick or incapacitated for more than 1 month?**

No ☐ Yes ☐

If yes:
What was the cause? _____
When?(month/year) _____
For how long? _____
Any consequences/aftereffects? _____

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4 **a. Do you smoke or have you regularly smoked cigarettes/cigars/pipe?** No ☐ Yes ☐ If you have quit, when? _____

b. Do you drink beer, wine, or alcohol? No ☐ Yes ☐ If yes: Average weekly consumption: _____

c. Have you drunk more in the last 10 years? No ☐ Yes ☐ If yes: Average weekly consumption: _____

d. Do you or have you received treatment for this in the last 10 years? No ☐ Yes ☐ If yes: What treatment: _____

During what period? _____

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

6 **a. Are you undergoing vocational training orin 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? No ☐ Yes ☐ If yes: What is the reason? _____

When?(month/year) _____

7 **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? _____

8 **Have you previously applied for insurance for death or critical illness that has not been approved or has been approved with special conditions** No ☐ Yes ☐ If no: What is the reason? _____

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

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.

(Date&Place) _____ (Signature) _____

To be filled out by LÍV:

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

Dagfesting: | Forbókstavir +stempul: | Treytir: