

## ESI expatriate plan *“ Health declaration „*

First name(s)	Surname(s)	Date of birth (DD-MM-YY)		
Nationality	Occupation			
E-mail	Tel.			

### Important details before you fill in this document!

- You have to fill in the declaration yourself and answer all the questions carefully.
- You must not fail to disclose anything, even though you think it is of no importance to EUROPÄISCHE Reiseversicherungs AG and Nordic Health Care.
- In case of incorrect or incomplete answering the insurance cover can be limited or cancelled in accordance with the Insurance Contract Act.
- If you are in doubt about answers, you can – on your own account – contact your doctor for assistance.
- If you have medical records or similar, which can contribute in answering questions, it would be an advantage to enclose copies of these.
- If space is not sufficient, when you fill in the form, please attach enclosure.

### Step 1.

Have you undergone surgery at any time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in illness/disorder and month/year below:
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### Step 2.

Have you suffered from hepatitis/ liver diseases at any time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in type and month/year below:
Have you undergone surgery at any time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in consequences below:
Are you receiving treatment now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in method of treatment below:
When was the last medical check?			
When is the next medical check?			

### Step 3.

Have you suffered from cancer at any time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in type and month/year below:
Which treatment did you receive?			
Have you suffered from cancer at any time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please fill in type and month/year below:
When was the last medical check?			
When is the next medical check?			

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## Step 4.

Do you have any inherited bodily imperfections or consequential damages from injuries ?

Yes  No

If yes, please fill in imperfections / damages below:

## Step 5.

Have you within the last 10 years consulted, been examined or treated by a doctor or a medical specialist ?

Yes  No

If yes, please fill in illness / disorder, method of treatment and month/year below:

(Records on colds, inflammation of the throat, transitory infections, ordinary childhood diseases and health checks shall not be listed)

When did you last feel any symptoms of the above illnesses / disorders ?

## Step 6.

Have you within the last 10 years been examined or treated by physiotherapist, chiropractor or other therapists (including alternative therapists) ?

Yes  No

If yes, please fill in illness / disorder, method of treatment and month/year below:

When did you last feel any symptoms of the above illnesses / disorders ?

## Step 7.

Have you within the last 10 years been hospitalised, examined or treated in hospital or private clinic ?

Yes  No

If yes, please fill in illness / disorder, method of treatment and month/year below:

When did you last feel any symptoms of the above illnesses / disorders ?

## Step 8.

Have you within the last 10 years consulted or been treated by psychiatrist, psychologist or psychotherapist ?

Yes  No

If yes, please fill in illness / disorder, method of treatment and month/year below:

When did you last feel any symptoms of the above illnesses / disorders ?

## Step 9.

Do you currently use medicine prescribed by doctor or other therapist ?

Yes  No

If yes, please fill in details below:

Medicine	Daily dose	Ailment / illness	Treatment started

## Step 10.

Have you within the last 3 months had medical symptoms or discomforts, which have not been examined or treated by doctor or other therapist?

Yes  No  If yes, please fill in discomforts / symptoms below:

(Records on colds, inflammation of the throat, transitory infections and ordinary childhood diseases shall not be listed)

## Step 11.

Do you have reduced eyesight?

Yes  No  If yes, please fill in details below:

Cause:

Strength right eye:  Strength left eye:

## Step 12.

Do you have reduced hearing?

Yes  No  If yes, please fill in below, cause and if you use hearing:

## Step 13.

Do you drink alcohol?

Yes  No  If yes, please fill in number of units (on average) per week:

consumption:

Did you previously have a larger consumption of alcohol?

Yes  No  If yes, please fill in number of units (on average) per week:

consumption:  Period/year:

## Step 14.

What is your height and weight?

Height:  cm Weight:  kg

## Step 15.

name and address of your present doctor :

- I hereby declare that the information I have given is the truth, and I have not failed to disclose anything. I fully accept that giving false information can result in cancellation of the insurance.
- I accept that Nordic Health Care reserves the right to keep the information submitted - also in case of negative response to the application of insurance cover.
- In case insurance for dental treatment is requested : I hereby confirm that I am not receiving dental treatment at the moment and/or have pending dental treatments.

Insured's signature :

Date

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