

# Health declaration

fill in form correctly to ensure you get the right protection

When you apply for insurance, sometimes you are required to answer questions about your health by filling in a health declaration. In some cases we also want you to visit a doctor for a health examination. This information also applies for persons who want to make a change to an existing policy.

## Why so many questions?

When you fill in a health declaration, it is important that you answer all of the questions, as many as they may be. If you feel certain information is not significant for the insurance or change in your policy, you must nevertheless provide it. Provide too much rather than too little information, and it will help us make a correct assessment.

## Right benefits

You are responsible for making sure that your application is completely filled in. If it is not correctly filled in, you risk receiving lower or no benefits at all in the event of a claim.\*

## Right premium

To be able to determine what premium you should pay, we assess the risk of you needing medical care, taking time off on sick leave, or dying.

If you are not in fully good health, the risk of you needing to take time off for sick leave or suffering an injury/illness is higher than normal. In such case you may have to pay a higher premium for your insurance protection.

If you are not in fully good health, there is also the alternative of offering you insurance with an exclusion clause. You would then pay the normal premium for your insurance, but you would not receive any cover for the injury/illness that the exclusion pertains to. In certain cases we would not be able to offer any insurance at all.

## What happens next?

Once you have answered the questions in the health declaration, send it to us together with your application.

If you have provided any information that we judge can be significant for the insurance or change in policy, we will decide if we will need to request additional information from your doctor or health centre, for example. In such case, we will need to get in touch with you and request that you give us your consent to retrieve this information. Of course, all handling of health declarations and complementary documents is done under strict confidentiality.

## If something happens

If you file a claim,\* we need to know what has happened before we can pay any benefits. Consequently, after receiving your consent, we may need to retrieve information from doctors, other care providers, hospitals or social insurance offices. This information is compared with the answers you provided in your health declaration in connection with your insurance application.

## Questions?

If there is anything you do not understand or wonder about, please do not hesitate to contact our customer service on 0771-55 55 00.

\* By claim is meant what we also refer to as an insurance event. This can be an illness, accident or death.

## Keep in mind before filling in the health declaration

This health declaration is to be used for applicants who are 16 years of age or older. The information we want shall be provided personally by the applicant. Please write legibly in ink (not pencil).

We have tried to formulate our questions as clearly as possible. If there is nevertheless something you do not understand, please note this in your response to us. It is important that you answer all of the questions – even complementary questions.

False or incomplete information can render your application or change in policy invalid. We want your information within 14 days from the date you signed your health declaration. If it is submitted later than this, we must request that you fill in a new health declaration, which will result in a delay in your insurance application.

# Health declaration



Send this form to:  
Skandia  
Dokumenthantering  
106 37 Stockholm  
Tfn: 0771-55 55 00

Submit this health declaration together with your insurance application/application for change in policy.

Personal information	
Surname, first name	National registration number
1. Indicate the nature of your work, studies or other activities	
2. Are you a resident of Sweden and registered with a Swedish social insurance office for at least the past two years?	<input type="checkbox"/> No <input type="checkbox"/> Yes If no, how long have you lived in Sweden and been registered with the Social Insurance Agency?
3. Are you fully fit for work?*	<input type="checkbox"/> No <input type="checkbox"/> Yes

By fully fit for work\* is meant that the person to be insured

- can perform his/her ordinary duties without exception
- is not receiving benefits related to his/her own illness, injury or functional disability, or does not have such benefits pending
- does not have specially adapted work for health reasons, is not employed in a subsidised pay scheme or similar. A person with subsidised pay/employment

support as a result of non-medical grounds can apply for disability insurance and waiver of premium cover, provided he/she completes a normal health evaluation.

To be considered fully fit for work in the event of a change in policy, the insured also must have been fully fit for work, with the exception of periods of not more than 15 consecutive days, during the three months immediately preceding the date on which the change is requested.

Medical history	
4. Your height and weight	Height in cm   Weight in kg
5. Have you been tested for HIV (AIDS virus)?	<input type="checkbox"/> No <input type="checkbox"/> Yes When?   Where? Result <input type="checkbox"/> Negative (i.e., no HIV infection) <input type="checkbox"/> Positive (HIV infection)
6. Do you smoke on a daily basis?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I have quit smoking Since when? (YY-MM)
7. Have you used narcotics or doping agents?	<input type="checkbox"/> No <input type="checkbox"/> Yes Type of agent?   When was the last time?

## 8. Do you have or have you had (regardless of when) any of the following illnesses or conditions?

If you answer yes to any of questions 8 a-v and 9-13, please provide additional information on page 3.

a. Eye disease or impaired vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify dioptr count for near-sightedness that requires correction of at least 8 dioptr. If you are unsure, please include a copy of your most recent eyeglass prescription.	Indicate which disease and the nature of the problems, and which eye.	<input type="checkbox"/> Right <input type="checkbox"/> Left
b. Ear disease, impaired hearing or tinnitus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify the name of the disease or the degree of hearing loss and which ear.	<input type="checkbox"/> Right <input type="checkbox"/> Left
c. Problems, disease or injury to the joints (knees, hip, shoulders, elbows, etc.), muscles or tendons?	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Right <input type="checkbox"/> Left
d. High blood pressure? Heart disease? Pressure or pain in your chest? Angina? Arrhythmia, irregular heart beat or shortness of breath?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
e. Stroke (brain haemorrhage or blood clot)?	<input type="checkbox"/> No <input type="checkbox"/> Yes		



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Signature

If you answer yes to any of questions below, please provide complementary information on page 3.

f. Other vascular disease? Varicose veins?	<input type="checkbox"/> No <input type="checkbox"/> Yes
g. Elevated cholesterol?	<input type="checkbox"/> No <input type="checkbox"/> Yes
h. Problems with snoring? Sleep apnoea? Nasal polyps?	<input type="checkbox"/> No <input type="checkbox"/> Yes
i. Asthma or other lung disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes
j. Skin disease/dermatitis, eczema or allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
k. Problems/disease in stomach or intestines? Haemorrhoids? Hernia?	<input type="checkbox"/> No <input type="checkbox"/> Yes
l. Liver disease? Jaundice? Gallstones or bile duct problems? Problems with the pancreas or other abdominal organ?	<input type="checkbox"/> No <input type="checkbox"/> Yes
m. Problems with the kidneys or urinary tract? Prostate problems? Kidney stones?	<input type="checkbox"/> No <input type="checkbox"/> Yes
n. Protein or sugar in urine? Diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
o. Genital problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
p. Rheumatic problems/rheumatism? Connective tissue disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes
q. Problems, disease or injury in the back, including neck? Problems with legs or arms? Tension headache? Sciatica? Herniated disk?	<input type="checkbox"/> No <input type="checkbox"/> Yes
r. Tumours? Lymphatic disease? Blood disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes
s. Nervous system disorders? Epilepsy? Seizures? Paralysis? Vertigo? Fainting spells? Migraine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
t. Hormonal disease or metabolic disorder? Goitre?	<input type="checkbox"/> No <input type="checkbox"/> Yes
u. Mental problems, insomnia, mental disease, crisis reaction, burnout or stress?	<input type="checkbox"/> No <input type="checkbox"/> Yes
v. Problems with alcohol, other substance abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes

9. Are you currently taking any medication – <b>in addition to</b> any medicines you have mentioned in previous questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Name of medicine(s)	
Reason	
Name/address of prescribing physician	
10. Have you been on sick leave or incapacitated from working, fully or partly, for more than 14 consecutive days during the past 5 years – <b>in addition to</b> any periods that you have mentioned in previous questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes
11. During the past 5 years, have you been examined or treated at a hospital, healthcare centre or other care facility or otherwise visited a doctor or other healthcare professional (including chiropractors, naprapaths, psychologists, psychotherapists or similar) – <b>in addition to</b> what you have mentioned in previous questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes
12. Do you have planned or have you been recommended for any form of doctor's visit, examination, treatment or operation – <b>in addition to</b> what you have mentioned in previous questions?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**To be answered only if you are applying for private healthcare insurance.**

If yes, please provide additional information on page 3.

13. Are you now or have you previously suffered from some other chronic illness, injury or other problem than those described above? This also includes bodily defect, physical or mental disability. State whether you receive some form of financial support as a result of a functional disability.	<input type="checkbox"/> No <input type="checkbox"/> Yes
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**Additional information** if you answered Yes to any of questions 8-13.

Give the number and letter of the question. Complete the additional questions. Use a separate piece of paper if there is not enough space (don't forget to sign the paper, print your name, and include your national registration number and date).

<b>Question no.</b>	
Disease, injury or functional disability. If no diagnosis has been given, indicate symptoms.	
When did the symptoms, injury or functional disability first appear?	
When did you seek treatment from a doctor/ healthcare professional for the first time?	When was your last appointment?
Name and address of care provider/doctor, etc.	
What treatment/examination did you receive? (e.g. physiotherapy, operation, medication, X-ray, health check-up)	
Are you still receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No   When did your treatment end?
Are you still going for follow-up appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No   When were these ended?
Fully recovered/symptom-free since when?	
If you are not symptom-free, indicate remaining problems.	
During which dates were you ill/on sick leave?	
<b>Question no.</b>	
Disease, injury or functional disability. If no diagnosis has been given, indicate symptoms.	
When did the symptoms, injury or functional disability first appear?	
When did you seek treatment from a doctor/ healthcare professional for the first time?	When was your last appointment?
Name and address of care provider/doctor, etc.	
What treatment/examination did you receive? (e.g. physiotherapy, operation, medication, X-ray, health check-up)	
Are you still receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No   When was the treatment completed?
Are you still going for follow-up appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No   When were these ended?
Fully recovered/symptom-free since when?	
If you are not symptom-free, indicate remaining problems.	
During which dates were you ill/on sick leave?	

## Signature

### I certify that:

I have answered and filled in this health declaration and that the information provided is complete and true.

### I am aware that:

False or incomplete information can render the insurance invalid and health information not provided on this form or accompanying documents cannot be referred by me at a later date.

The information that Skandia receives on my health status and Skandia's risk assessment may be shared with a reinsurance company in the case of reinsurance.

In the case of occupational pension insurance/private healthcare insurance, I give the insurer the right to inform my employer if the insurance is granted with exemptions (however, without indicating the medical cause).

Date (YYYY-MM-DD)		Signature (of person to be insured)	
2   0       -       -			
Name (in BLOCK LETTERS)			
Phone (daytime)		Signature(s) (of guardian(s))	Name (in BLOCK LETTERS)

## Skandia's notes

Date (YYYY-MM-DD)	Distributor's name and phone number	Code
2   0       -       -		

This health declaration must be submitted not later than 14 days after the date of signature.

## Information on the Act (2006:351) on genetic integrity, etc.

Effective 1 January 2007, the following legislation applies with respect to the handling of genetic information. The aim of the law is to safeguard the integrity of individuals.

### Definitions

By genetic study is meant: a study in health and medical care or medical research which aims to gain information about the human genetic makeup.

By genetic information is meant: information on the results of a genetic study, but not to such extent that the information only contains information about the study subject's current health status.

### Prohibition against using genetic studies and information

An insurance company may not, without legislative support, make the condition for a contract that a policyholder or insured must participate in a genetic study or provide genetic information about him-/herself. However, an insurance company may, if needed, retrieve family information directly from the policyholder or insured.

### Limitations of the law

The above-described prohibition does not apply if the insured has turned 18 years of age and the insurance amount, which would be payable in lump-sum for an insurance event, exceeds 30 times the Price Base Amount or, in cases of periodic payment of benefits (such as a survivors' pension or disability benefits), exceeds 4 times the Price Base Amount per year. The insurance amount also includes payments from healthcare insurance.

By insurance amount is meant the total risk-assessed insurance amount for insurance that is applied for and insurance already purchased from one and the same insurance company. Insurance that is applied for also includes changes to or increases in existing insurance.