# HEALTH DECLARATION FOR ADULTS

(age 16 years or older)



## TYPE OF INSURANCE?

Expatriate insurance	Private healthcare insurance	Embassy Personnel insurance		
People Abroad	Work interruption due to work disability	Foreign Visitors insurance		
Company name and company registration number		Insurance number		
Surname and first name		Swedish social security number (if applicable) or date of birth		
Postal Address		Postcode and place name		
E-mail		Telephone		
Citizenship		Sex		
If applying for insurance for Principal insured's name	private healthcare, expatriate, or for embassy per	rsonnel insurance, please fill in the following particula Principal insured's Swedish social security number (		e) or date of birth
If applying for expatriates in Country of posting	surance, please state Postcode and place name	State from which date insurance is to apply       Year     Month	l	
HEALTH DECLARAT	ION			
1. Your height in cm	Your weight in kg			
2. Are you fully capable of v	vorking?		Yes	No
that, at the time of admis – are not sick-listed, or re – do not have a subsidize	" means that you are able to perform the duties o ssion to the insurance, you: ceiving sickness benefit or activity compensation d job or similar type of employment ork program or school program due to health reas	benefit		
If your answer is "No" to	o question No. 2, please also answer the quest	ions on the next page.		
3. Do you have, or have you ever had, any illness, injury, physical or mental disorders, or any other physical defect (including vision or hearing problems), alcohol/drug/narcotics addiction, or are you receiving any disability benefits?			No	
4. During the last 5 years, have you been on full-time or part time sick leave for more than 14 consecutive days?			Yes	No
5. During the last 5 years, have you received care or been treated at a hospital, health care centre, maternity wel- fare clinic or other health care facility or otherwise consulted a doctor, nurse, physiotherapist, naprapath, chiro- practor, psychologist or other health care professional?			No	
If you are applying for pregnancies.	expatriates insurance, please state any examinat	tions you have undergone in connection with		
6. Do you use any prescript	ion drugs? (other than the contraceptive pill).		Yes	No
7. Have you planned to undergo any medical check-ups, treatments or surgery?			Yes	No
<ol> <li>Apart from what you have already stated, do you have, or suspect that you have, an internal organ disorder, physical or mental disability, illness, or other physical defect?</li> </ol>			Yes	No

If your answer is "yes" to any of the questions 3-8, please also answer the questions on the next page.

#### ADDITIONAL INFORMATION FOR QUESTIONS 2-8. ALL FOLLOW-UP QUESTIONS MUST BE ANSWERED.

All illnesses, injuries, disabilities and examinations must be disclosed. Write the number of the question and answer the questions that follow.

Question No.	What disease, injury or disability does it concern?	
What was the cause of the examination/incapacity?		During which dates where you ill/on sick leave?
When did you have an examination, check-up or treatment?		Which doctors/health care centres or medical facilities have been involved?
Which treatment (including medication) have you received?		What terms have doctors/nurses used to describe the disorders?
Are you free from all symptoms? If you answer "Yes" to this question, since when?		Do you have any after effects or problems?

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#### OTHER OR ADDITIONAL INFORMATION

Please use a separate sheet of paper if you need to add something from the other questions on the form. Write the number of the question, the name and date of birth (or, if applicable, Swedish social security number) of the person to be insured at the top of the paper and then sign it and write the date.

#### SIGNATURE

I am aware that the information I have submitted in this health declaration will constitute the basis of my insurance policy. I am aware that incorrect or incomplete information may render the insurance invalid.

Date and place

Signature	Name in block letters
Guardian's signature (if the applicant is under the age of 18)	Name in block letters

The information obtained in this application will kept on file at If. If the application is not approved, the information will kept on file at If for 6 months. Personal data will be handled in observance of the provisions of the Personal Data Act (Personuppgiftslagen, PUL).

### PLEASE SEND THIS HEALTH DECLARATION TO:

lf Personforsakring Foretag/Industri SE-106 80 Stockholm After answering all questions and signing, you may also send it by e-mail to: foretagscenter@if.se

