CORPORATE BENEFIT PLAN
DECLARATION OF HEALTH

To be filled out by the applicant

Name of firm/organisation		Policy No.:
First name(s), surname		Date of birth (date, month, year)
Private address abroad		Postal code
Country	City/town	E-mail

GENERAL HEALTH INFORMATION

1. Do you suffer from any of the following conditions?		Name of the illness	Date of commencement	Duration of illness	Possible consequences of illness
a. Upper respiratory condition: Any existing, chronic or former condition with, e.g. frequent colds, sinusitis, coughs, throat infections, laryngitis, pharyngitis or allergies?	Yes ☐ No ☐				
b. Respiratory condition: Any existing or chronic disease or former condition with, e.g. lung embolism, COLD/Chronic obstructive lung disease, congential lung condition, chest pain, shortness of breath, bronchitis, asthma, tuberculosis or frequent pneumonia?	Yes ☐ No ☐				
c. Eye condition: Do you use spectacles/contact lenses? Please state your current prescription. Do you have any existing or chronic disease or former condition with your eyes?	Yes ☐ No ☐				
d. Ear condition: Do you have any existing, chronic disease or former condition with your ears or do you suffer from a hearing disability?	Yes ☐ No ☐				
e. Cardiovascular condition: Any existing or chronic coronary disease or complaints, e.g. hypertension, vascular/circulatory problems, chest pain (angina), myocardial infarction, heart failure, cardiac arrhythmia, congenital heart disease, heart and vessel surgery, foot or leg swelling, varicose veins, haemophilia?	Yes ☐ No ☐				
f. Digestive condition: Any existing or chronic disease in the digestive system, complaints from the gastrointestinal tract, ulcers, internal hemorrhaging, crohns disease, ulcerative colitis, hernias diverticulosis, esophagal varices or congenital disease in the digestive system?	Yes ☐ No ☐				
g. Gallbladder, liver, spleen and pancreas condition: Any existing or chronic disease or complaints, e.g. gallstones, hepatitis, pancreatitis, splenectomy or liver transplantation?	Yes ☐ No ☐				
h. Cerebral - neurological condition.: Any existing or chronic neurology or cerebral disease or complaints, e.g. intermittent headaches, dizziness or fainting, convulsions, seizures, neuropathic pain, dysesthesia or paralysis?	Yes ☐ No ☐				
i. Mental condition: Any existing or chronic psychiatric disease/disorder or complaints? e.g. personality disorders, anxiety neurosis, claustrophobia, agrophobia, bipolar disorders, depression, eating disorders, ADHD or Tourette syndrome?	Yes ☐ No ☐				
j. Kidney - urinary or genital condition: Any existing or chronic disease or complaints, e.g. prostate gland complaint, inflammation of the kidney/nephritis, intermittent urinary tract or bladder infections, kidney stone or other complaints related to kidney or bladder?	Yes ☐ No ☐				
k. Musculoskeletal and articular condition: Any existing or chronic disease or complaints, e.g. rhematoid arthritis, osteoarthritis or other kind of muscle or joint inflammation, bone fractures, back complaints including sciatica, lumbago, slipped disc or any autoimmune deficiency diseases, fractures < 10 years, joint related conditions in hip, shoulder, elbows, hands, knees and ankles?	Yes ☐ No ☐				

l. Oncological Condition: Any existing or chronic disease or complaints, e.g. cancer, tumors, haematological disorders or cell abnormality?	Yes ☐ No ☐				
m. Skin condition: Any existing or chronic disease or complaints: e.g. rash, wound, allergy, psoriasis, melanomas?	Yes ☐ No ☐				
n. Glandular/Endocrine, hormonal condition: Any existing or chronic disease or complaints, e.g. goitre or other thyroid disease, diabetes, growth disorders, pituitary gland disorder?	Yes ☐ No ☐				
o. Other condition or disease apart from ordinary childrens complaints?	Yes ☐ No ☐				

OTHER HEALTH INFORMATION

2. Have you been involved in any serious accidents? (injuries, fractures)? Yes ☐ No ☐

3.a. Are you using medication prescribed by a physician or another providing treater? Yes ☐ No ☐

If Yes, what?_____ For what? _____ Which period? _____

3.b. Have you previously taken medication for a longer period (more than a month)? Yes ☐ No ☐

If Yes, what? _____ For what? _____ Which period? _____

4.a. Have you ever been admitted to a hospital, clinic or other medical facility or institution, where purpose for the admission were observation and/or treatment? Yes ☐ No ☐

Where? _____ For what? _____ Date and duration _____

4.b. Have you ever had an operation? Yes ☐ No ☐

Where? _____ For what? _____ Date and duration _____

4.c Have you ever been examined or treated by a specialist? Yes ☐ No ☐

Where? _____ For what? _____ Date and duration _____

5. Are you at present completely well? Yes ☐ No ☐

6.a. Height? cm **6.b. Weight?** kg

7. Name and address of your present physician and, if possible, your previous physician.

Name and address of present physician: _____

Name and address of previous physician: _____

8. TO BE ANSWERED BY WOMEN

Have you ever suffered from any gynaecological disease or currently experiencing any complaints related to a gynaecological condition? Yes ☐ No ☐

Are you taking or have you taken hormones? Yes ☐ No ☐

If yes to any of above standing questions please elaborate which condition?

SIGNATURE

I hereby declare that the given information is true. I am aware that Europæiske ERV's coverage can be reduced or waived according to law, if I state untrue information. I hereby give my consent to Europæiske ERV to collect, use and keep my personal health information and to disclose this health information to authorised persons within the health care sector, hospitals and health care institutions, public authorities, insurance companies/pension funds, The Insurance Complaints Board, Labour Market Insurance etc. The consent/power of attorney only covers this claim. Remember that you, at any time, can withdraw your consent by contacting Europæiske ERV and stop any future use of your consent. Read more about your rights on our website at www.erv.dk under "Data Protection Policy". Please note, that withdrawing your consent may influence our capability to process your application and that we are bound by rules and legislation regarding storing and filing of your data from the time you conclude a valid insurance contract with us.

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Signature of the Insured Social Security no Date