

- Life insurance
- Unit linked insurance
- Critical illness insurance
- Disability income insurance

Skírteini nr.	
Söluaðili	Ábending

Life Insurance / Unit linked Insurance / Critical Illness Insurance / Disability Income Insurance

The insured must always fill out the insurance application himself or herself. Fill out the insurance application as accurately as possible. If you are in any doubt as to whether certain facts are relevant to our assessment of your application, please include them on the form.

If you make a mistake when filling out the application, please cross it out, make corrections and put your initials next to the corrections. Do not use correction fluids such as Tipp-Ex.

The company's purpose in obtaining information on risks

The information provided by the applicant in this application will be used for company risk assessment. Company employees will evaluate this information, assessing whether additional information on the applicant's previous health is needed from physicians, medical institutions, or others possessing such information, or whether a medical examination is required to allow for the possibility of arriving at a final decision on granting the policy to the applicant. Such information is provided to the company and its consulting physician, as well as being provided to reinsurers. If additional information is needed on health, no position will be taken on the application until that information is available. The information may lead to the insurance being issued with a special surcharge on the premium or with a specified latency period before the insurance takes effect or to specified risks being excepted from the insurance or to the insurance being denied.

The provisions of Act No. 77/2000, on the Protection of Privacy as Regards the Processing of Personal Data, are observed during any processing of personal information. The consulting physician and company staff dealing with the information are bound to secrecy and lifelong confidentiality on anything contained in the information.

I. Basic Information

The Insured		ID No.	
Address		Postcode	Town
Telephone/Home	Telephone/Work	Telephone/Mobile	Fax
Email		Spouse's ID No.	

II. Type of Insurance, Sums and Effective Dates

1. a) Do you presently have other life and/or health insurance? No Yes
If yes,

Type of insurance:	Sum insured: ISK	With what insurance company?	Should the old policy be cancelled?	
			<input type="checkbox"/> No	<input type="checkbox"/> Yes
			<input type="checkbox"/> No	<input type="checkbox"/> Yes
			<input type="checkbox"/> No	<input type="checkbox"/> Yes
			<input type="checkbox"/> No	<input type="checkbox"/> Yes

<p>Life Insurance</p> <p>1. Proposed sum insured: ISK <input type="text"/></p> <p>2. Life insurance effective date</p> <p><input type="checkbox"/> Immediately—when application has been approved</p> <p><input type="checkbox"/> Later—effective date <input type="text"/></p>	<p>Critical Illness Insurance</p> <p>1. Proposed sum insured: ISK <input type="text"/></p> <p>2. Critical illness effective date</p> <p><input type="checkbox"/> Immediately—when application has been approved</p> <p><input type="checkbox"/> Later—effective date <input type="text"/></p>
<p>Unit linked life insurance:</p> <p>1. Proposed sum insured: ISK <input type="text"/></p> <p>2. Effective date of Unit linked life insurance:</p> <p><input type="checkbox"/> Immediately—when application has been approved</p> <p><input type="checkbox"/> Later—effective date <input type="text"/></p> <p>3. Term of contract in years <input type="text"/></p> <p>4. Monthly contribution ISK <input type="text"/></p> <p>5. Waiver of premium? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Disability Income Insurance</p> <p>1. Monthly Proposed sum insured: ISK <input type="text"/></p> <p>2. Deferred period</p> <p><input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/> 104 weeks <input type="checkbox"/> 156 weeks</p> <p>3. Disability income insurance effective date <input type="text"/></p> <p><input type="checkbox"/> Immediately—when application has been approved</p> <p><input type="checkbox"/> Later—effective date <input type="text"/></p> <p>4. a) How long have you held your present occupation? <input type="text"/></p> <p>b) Do you have any other occupation? <input type="text"/></p> <p>c) What were your average monthly wages during the past 12 months? ISK <input type="text"/></p>

III. Occupation, Special Risks

1. Job title

a) Position/occupation of insured (Tick one option.)

Self-employed: Management, services/sales Skilled craftsman

Full-time employee: Management, services/sales Unskilled craftsman.

Unemployed

2. Do you engage in any activities that involve special risks, such as mountain climbing abroad, private aviation, glider flight, hang gliding, skydiving, diving, motor sports or other such activities? No Yes

If yes, you must fill out a special form.

3. Have you resided abroad for a period longer than a normal holiday? No Yes

If yes, specify the country and length of stay.

4. Do you intend to travel to any countries where there is war or civil conflict for the next three years? No Yes

If yes, to what country and length of stay:

5. Do you smoke, or have you ever smoked? No Yes

If yes, what is/was your daily consumption? Started smoking month/year Quit month/year

IV. Personal Health Information

1. Do you currently suffer or have you ever suffered from any of the following (please tick "No" or "Yes" to all questions from [a] to [o]):

a) Heart disease, symptoms or a heart condition, a disease of or medical problems relating to the vascular system, blood vessels of the brain (e.g. stroke), or high blood pressure? No Yes

b) A disease, symptoms of or medical problems with the stomach, liver, gall bladder, duodenum, pancreas, small intestine, colon, rectum, kidneys or the urinary system? No Yes

c) A disease, symptoms of the lungs, asthma, bronchitis, allergies, shortness of breath or any other symptoms in the respiratory organs? No Yes

d) A disease, symptoms of or medical problems with the bones, joints, muscles or skin? No Yes

e) Discus prolapsus (slipped disc), lumbago, neck pain, back pain or other back problems? No Yes

f) A disease, symptoms of or medical problems with the nervous system, e.g. paralysis, multiple sclerosis (MS), motor neurone disease (MND), numbness, epilepsy, dizziness, tremors, headaches or migraines? No Yes

g) A disease, symptoms of or medical problems with the eyes or ears? No Yes

h) Abnormal results from researches, e.g. increased level of cholesterol or blood sugar? No Yes

i) Cancer or other malignant diseases or related medical problems, changes of the cells, growths, tumours, blood disease, lymph disease or benign brain tumour? No Yes

j) Disease related to the body's metabolism, thyroid gland or other glands and/or diabetes? No Yes

k) Diagnosis of AIDS following tests, or are you awaiting the results of such tests or do you have reason to believe that you are HIV positive? No Yes

l) Any diseases or physical injuries, symptoms, accidents or poisoning that have required or may require medical examinations, operations or treatments? No Yes

m) Permanent disability according to government classification or are you awaiting the results of a disability evaluation? No Yes

If yes, disability: %, Why?

n) Depression, anxiety or other mental illnesses? No Yes

o) Other diseases/medical problems or symptoms? No Yes

If you have answered any of the questions from (a) to (o) in the affirmative, please specify:

i. Name of disease, description of symptoms/description of accident?

ii. When did you become aware of the disease, symptoms/When did the accident occur?

iii. How long did the disease, symptoms last/What were the consequences of the accident?

iv. Was your recovery total or partial?

v. When did medical care begin and end?

vi. What medical institution and what doctor attended you? Give the address of the doctor.

2. Name of your family doctor Address

3. Your height cm Your weight kg

If pregnant, give date of expected delivery: Weight before pregnancy

4. Has any insurance company ever declined or postponed your application for personal insurance or demanded an extra premium? No Yes
 If yes, please provide full details.

5. Are you currently under or have you ever received treatment and/or undergone tests or roentgenography by a medical doctor/specialist? No Yes
 If yes, explain why and when and give the name and address of the doctor.

6. Are you currently and have you been for the last three years in perfectly good health and able to work? No Yes
 If no, why?

7. Have you visited a medical doctor or a medical facility during the last three years for reasons other than a brief illness? No Yes
 If yes, explain why and when, and give the name and address of the doctor.

8. a) Are you currently taking prescription medicine/drugs? No Yes
 b) Have you taken prescription medicine/drugs? No Yes
 If yes, what medicine, at what dosage, and why?

9. Do you use or have you used tranquilizing or stimulating drugs? No Yes
 If yes, you must fill out a special form.

10. Do you use alcohol? No Yes

11. Has the use of alcohol and/or other intoxicants ever been a problem for you? No Yes
 If yes, you must fill out a special form.

12. Have you ever sought medical advice because of your use of alcohol or other drugs/narcotics? No Yes
 If yes, you must fill out a special form.

13. Are any of your parents or siblings deceased? No Yes
 If yes, state for each the age at death and the cause of death.

14. Have your parents or siblings suffered from heart or vascular diseases, stroke, high blood pressure, diabetes, kidney disease, cancer, MS, MND, Parkinson's disease or Alzheimer's disease before they reached the age of 60? No Yes
 If yes, please give exact diagnosis, type of cancer and the age of diagnosis.

V. Designation of a Beneficiary of the Sum Insured

Lawful holder not nominated
 This designation means that the spouse of the insured is the beneficiary of the insurance sum. If the spouse is not alive, the children of the insured are the beneficiaries; if the children are not alive, then the insured's legal heirs will be considered the beneficiaries. (Please note that the term "spouse" means that the individual is in a formal marriage and is not cohabiting.)

Legal heirs
 This designation means that if the insured leaves a spouse and children, one-third of the sum will go to the spouse and two-thirds of the sum will go to the children. (Please note that the term "spouse" means that the individual is in a formal marriage and is not cohabiting.)

Registration of the designated beneficiaries

<input type="text"/>	<input type="text"/>
Name	ID No.
<input type="text"/>	<input type="text"/>
Name	ID No.
<input type="text"/>	<input type="text"/>
Name	ID No.
<input type="text"/>	<input type="text"/>
Name	ID No.

VI. Fund Options— Unit linked life Insurance

Your monthly contribution after the deduction of the insurance premium and expenses will be invested into funds of your choice. The premium's allocation to each fund must be in whole percentages and the total allocation must add up to 100%.

The names of the Sjóvá- líftryggingar hf. funds:

<input type="checkbox"/> European Fund	<input type="text"/> %	<input type="checkbox"/> Treasury Fund	<input type="text"/> %	<input type="checkbox"/> Foreign Equities Fund	<input type="text"/> %
<input type="checkbox"/> Global Fund	<input type="text"/> %	<input type="checkbox"/> Domestic Equities Fund	<input type="text"/> %	<input type="checkbox"/> Icelandic Bonds	<input type="text"/> %
<input type="checkbox"/> Development Fund	<input type="text"/> %	<input type="checkbox"/> Equity Funds	<input type="text"/> %	<input type="checkbox"/> Mixed Equities Fund	<input type="text"/> %
<input type="checkbox"/> Bond Fund	<input type="text"/> %				

VII. Premiums

Payer (if other than the insured) ID No.

Tel./Home Tel./Work Tel./Mobile Fax Email

Recurring payment by credit card: VISA MASTERCARD Number of monthly payments

Credit card No. Valid thru /

Cardholder authorization signature ID No.

Sales slip

Direct debit payment from payer's checking account at any bank. (You must fill out a special form.)

VIII. Declaration and Signature of Applicant

Statement by the applicant, and her/his consent to medical data being acquired from others

I, the undersigned, hereby declare that I have myself answered all of the questions in this application, and I hereby confirm that my answers are, in accordance with the best of my knowledge, correct and in correspondence with the truth, and that no items have been left out which might matter for the company's risk assessment regarding this insurance. I have filled out this application in my own hand and realise that false or insufficient information about my health may cause a loss of compensation rights, in part or in whole, and that paid premiums will be unrecoverable. Moreover, the purpose of providing the information in this application or from others is clear to me, so that together with the insurance terms it becomes the basis of agreement between me and Sjóvá-Almennar líftryggingar hf. It is clear to me that this insurance does not cover previous illnesses or accidents, or their effects. At its offices throughout Iceland, Sjóvá-Almennar tryggingar hf. provides the full range of services for the customers of its subsidiary, Sjóvá-Almennar líftryggingar hf., according to a special agreement on services. I, the undersigned, hereby grant the latter company, Sjóvá-Almennar líftryggingar hf., permission to provide Sjóvá-Almennar tryggingar hf. access to the information about me which is necessary for performing the agreed services. I hereby confirm that information I have provided on diseases of parents or siblings are given with their consent in the cases where it is reasonable to expect that is could be obtained. I CONSENT TO INFORMATION PROCESSING BEING CONDUCTED IN THE MANNER DESCRIBED ABOVE, AND REALISE THE PURPOSE OF SUCH PROCESSING. IN ADDITION, I GRANT MY PERMISSION TO PHYSICIANS, MEDICAL INSTITUTIONS AND OTHERS POSSESSING INFORMATION ON MY HEALTH TO PROVIDE THE COMPANY AND ITS CONSULTING PHYSICIAN WITH ANY SUCH INFORMATION AS MAY BE NECESSARY FOR DECISIONS ABOUT ISSUING THIS INSURANCE AND FOR THE NECESSARY ASSESSMENT OF COMPENSATION CLAIMS. I have been informed of how privacy protection is guaranteed by the company and that I am allowed to revoke my consent to the processing of this information, if I do so in writing.

Any pledges and arrangements between the advisor and me are to appear on this application form.

I have noted the company terms that are in effect regarding the insurance for which I am herewith applying.

Date Place

Signature of the insured

Attested by the consultant

To be filled out by the company

Smoker status Non-smoker Special terms Extra premium
