Life Insurance, Critical Illness Insurance and Unit linked Life Insurance

SJÓVÁ

☐ Life Insurance ☐ Change

☐ Critical Illness Insurance ☐ Group Insurance

☐ Unit linked Life Insurance ☐ Cancellation attached

Salesperson _____

Adviced by _____

Please fill in the insurance application yourself. When filling in the application, you will need to answer all the questions and be as accurate 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 in the application, please cross out the mistake, correct it and place your initials as close to the correction as you can. Do not use correction fluids such as Tipp-Ex. In order for the application to be considered complete and to allow it to enter into effect, all questions must be answered and the appropriate documentation must be attached.

The company's purpose in obtaining information on risks

The information provided by the applicant in this application will be used to assess the company's risk. The company's authorisation to obtain the information is based on Article 82 of Act No. 30/2004 on Insurance Contracts. The company's employees, consulting physician and, as the case may be, reinsurance entities, will assess the application and decide whether further information is required on the earlier health of the applicant from a physician, a medical institution or others possessing such information, or whether a medical examination is necessary before being able to make a final decision on the application.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 to specified risks being excluded from the insurance or to the insurance being denied. The provisions of applicable data protection and personal data processing legislation are always followed whenever personal data is processed. The consulting physician and company staff dealing with the information are bound to secrecy and lifelong confidentiality on anything contained in the information. All service to clients of Sjóvá-Almennar líftryggingar hf. is provided by employees of Sjóvá-Almennar tryggingar hf.

I. Basic information

The insured (he policyholder unless otherwise specified)_____

ID No. _____ Address_____Post code _____

Town/City _____ E-mail address _____

Telephone_____Mobile _____ID No. of spouse _____

Payer (if other than the insured) _____ID No. of payer _____

E-mail address of payer _____ ☐ The policy holder shall be the payer.

II. Insurance type, sums insured and effective date

Do you have other life and/or health insurance? ☐ Yes ☐ No

If yes

Type of insurance:	Sum insured	Name of the insurance company?	Should the older policy be cancelled?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Initials of applicant in confirmation of completion: _____

Life insurance

1.a) Increased term premium, sum insured ISK _____

1.b) Level term premium, sum insured ISK _____

Valid until: ☐ 50 yrs ☐ 55 yrs ☐ 60 yrs ☐ 65 yrs ☐ 70 yrs

2. Life insurance effective date:

☐ Immediately – on receipt of fully completed application

☐ Later - on termination of current insurance.

☐ Later: _____

Critical illness insurance

1.a) Increased term premium, sum insured ISK: _____

1.b) Level term premium, sum insured ISK _____

Valid until: ☐ 50 yrs ☐ 55 yrs ☐ 60 yrs ☐ 65 yrs

2. Critical illness insurance effective date:

☐ Immediately – on receipt of fully completed application

☐ Later - on termination of current insurance.

☐ Later: _____

Unit linked life insurance

1. Sum insured ISK _____

2. Savings life insurance to come into effect:

☐ Immediately – on receipt of fully completed application

☐ Later - on termination of current insurance.

☐ Later: _____

3. Valid until _____ aged yrs.

4. Payment per month ISK _____

5. Request Waiver of Premium ☐ No ☐ Yes

Note: If no premium insurance is requested and the insurance amount is not higher than ISK 250,000, the questions on health in Section VI need not be answered.A separate form must be completed as regards fund selection and reliability according to the rules of the company.

III. Options in the designation of beneficiary - due to an application for life insurance

☐ **No beneficiary appointed**

If no beneficiary of compensaion is appointed, the entitlement to the payment of death benefits is governed by Article 100 of Act No. 30/2004. This means that the life insurance amount will be paid to the spouse of the insured. If the insured does not leave a spouse, the insurance amount will be paid to the inheritors of the insured according to law or a will. The term spouse in Act No 30/2004 means the married spouse of the person and not a cohabiting partner. A cohabiting partner can only earn the right to payment of the life insurance amount if specifically appointed as a beneficiary.

☐ **Legal heirs**

This appointment means e.g. that if the life insured person is survived by his/her spouse and children, 1/3 of the life insurance amount will be paid to the spouse while 2/3 will be paid to the children. Please note that the term spouse means that the individual is in a formal marriage and is not cohabiting.

☐ **Registration of beneficiary's name**

One or more beneficiaries of the insurance amount may be appointed. If the insured is married or in a registered partnership, the company is under obligation, according to Article 101 of Act No. 30/2004, to notify the spouse of the designation of beneficiaries.

Name	ID No.	Proportion %

Note that there may be reason to revise the designation of benificiary in the event of a change in the marital status or family arrangements of the insured.

Initials of applicant in confirmation of completion: _____

IV. Premium payments.

In the event of a payment agreement with the company, the premium will be debited in accordance thereto. The following means of payment are available:

☐ **Automatic bill payments** – monthly charge on credit card.

☐ **Direct payments** – monthly charge on bank account, a separate form must be completed.

☐ **Payment note** - those who have payment services in a bank are to mark this option as well.

V. Employment/special risk

***If the answer to asterix-marked questions is "yes", it is nevessary to fill in a seperate form in order for the application to be considered completed.**

1. Job title: _____

More detailed description of job: _____

2. Do you engage in any activities which involve significant risk such as mountain climbing abroad, private aviation, gliding, parachuting, scuba diving, motor sports or other such activities?* ..... ☐ No ☐ Yes

3. Do you intend to live, or have you lived overseas? (not including holidays) ..... ☐ No ☐ Yes

If yes, specify country and length of stay: _____

4. Over the next three years, do you intend to travel to war-torn countries or countries where there are conflicts?

..... ☐ No ☐ Yes

If yes, specify country and length of stay: _____

5. Do you smoke? ..... ☐ No ☐ Yes

If yes, how many per day: _____Smoked from: _____ month/year

If no, have you smoked? ..... ☐ No ☐ Yes

If yes, when did you quit smoking? _____month/year How many per day?_____

VI. Health information

***If the answer to asterix-marked questions is "yes", it is nevessary to fill in a seperate form in order for the application to be considered completed.**

1. Name of family doctor/healthcare centre _____ Address _____

2. Your height _____ cm. Your weight_____ kg.

If pregnant when insurance is obtained: Estimated date of birth: _____ Weight before pregnancy _____ kg.

3. Do you presently have or have you had the following:
Please answer yes or no to all the questions from a to o.

a. Disease/problems or symptoms from the heart, vascular system, cerebro vascular system (e.g. stroke/embolism) or high blood pressure?* ..... ☐ No ☐ Yes

b. Disease/problems or symptoms fro the stomach, liver, gall bladder, duodenum, pancreas, small intestines, colon, rectum, kidneys or urinary system?* ..... ☐ No ☐ Yes

c. Lung disease, asthma, bronchitis, allergies, shortness of breath or other respiratory symptoms?* ..... ☐ No ☐ Yes

d. Disease/problems or symptoms from bones, joints, muscles or skin?* ..... ☐ No ☐ Yes

e. Prolapsed disc (Slipped Disc), lumbago, neck pain, back pain or other back diseases?* ..... ☐ No ☐ Yes

Initials of applicant in confirmation of completion: _____

f. Disease/problems or symptoms from the nervous system, paralysis, multiple sclerosis (MS), motor neuron disease (MND), epilepsy, dizziness, numbness, tremours, headaches or migraine?* ☐ No ☐ Yes

g. Disease/problems or symptoms from the eyes or ears? ☐ No ☐ Yes

h. Received abnormal results from medical tests, such as increased blood lipids or blood glucose?* ☐ No ☐ Yes

i. Cancer or other malignant diseases or related medical problems, changes of the cells, or growths, tumours, blood diseases, lymph diseases or benign brain tumours?* ☐ No ☐ Yes

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

k. On testing, been diagnosed with AIDS, are you waiting the results of such testing or have you reason to believe that you are HIV positive? ☐ No ☐ Yes

l. Have had any diseases, symptoms or suffered physical injury, accidents or poisoning that have required or could require medical examination, surgery or treatement? ☐ No ☐ Yes

m. Been assessed as disabled or are you waiting for a disability assessment? ☐ No ☐ Yes

If yes, disability assessment: _____ % Why? _____

n. Depression, anxiety or other mental illnesses?* ☐ No ☐ Yes

o. Other diseases/illnesses and/or symptoms? ☐ No ☐ Yes

This section may be skipped if a special form has been completed.

If your answer to any of the questions from a to o was "yes", please provide further details:

Regarding question: _____

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 persist or the consequnces of the accident: _____

IV. Was recovery complete or partial: _____

V. When medical care began and when it ended: _____

VI. Which medical centre was used, the name of the doctor who attended you and at which clinic:

_____

4. Has your application for personal insurance been denied, postponed or have its premiums been raised? ☐ No ☐ Yes

If yes, why? _____

5. Are you undergoing or have you undergone treatment, testing and/or radiograph investigations? ☐ No ☐ Yes

If yes, explain why, when and provide the name and address of the physician: _____

_____

6. Are you and have you been perfectly healthy and able to work for the past three years? ☐ No ☐ Yes

If no, why? _____

_____

7. Have you sought the assistance of a doctor or medical institution over the past three years for problems other than flu or other brief illness? ☐ No ☐ Yes

If yes, explain why, when and provide the name and address of the physician: _____

_____

_____

Initials of applicant in confirmation of completion: _____

8. a) Are you taking any medicines? ☐ No ☐ Yes

b) Have you previously been taking any medicines? ☐ No ☐ Yes

If yes, what medicines, in which doses, the reason why and state the duration of medicinal use:

9. Do you use or have you used sedative substances or stimulants? ☐ No ☐ Yes

If yes, fill in a separate form relating thereto.*

10. Is or has the use of alcohol and/or other intoxicants been a problem for you? ☐ No ☐ Yes

If yes, fill in a separate form relating thereto.*

11. Have you sought a doctor or been in treatment due to your use of alcohol and/or other narcotics? ☐ No ☐ Yes

If yes, fill in a separate form relating thereto.*

12. Have your parents or siblings had cardiovascular diseases, stroke, high blood pressure, diabetes, kidney disease, cancer, MS, MND, Parkinson's disease, Alzheimer's disease, Huntington's disease or other chronic diseases before the age of 65? ☐ No ☐ Yes

If yes, specify the disease, age when diagnosed and the type of cancer or diabetes.

I hereby confirm that the information that I have provided on the diseases of my parents or siblings is provided with their permission, given that it is fair to expect me to be able to obtain such permission.

Confirmed hereby with the initials of the applicant:_____

VII. Own statement and signature

Applicant's statement and approval for the collection of health information from others.

I, the undersigned, hereby declare that I have answered all the questions in this application myself, and confirm that my answers are correct and representative of the truth, and that no facts have been omitted which could make a difference to the outcome of the company's risk assessment under this insurance policy. I have completed this application myself and understand that inaccurate or incomplete information about my health may lead to me losing the right to compensation in part or in whole, and that paid premiums are non-refundable. I am aware of the purpose for which the information in this application or from others has been collected and that it forms, along with the terms and conditions of the insurance policy which I have familiarised myself with, the basis of the agreement between me and Sjóvá-Almennar líftryggingar hf. I am aware that this insurance policy does not cover any pre-existing illnesses or injuries or their effects.

If a doctor's certificate and/or the results of a medical examination are not submitted to the company within three months of this application being signed, the company reserves the right to request a new application.

I consent to Sjóvá-Almennar tryggingar hf./Sjóvá-Almennar líftryggingar hf. processing the personal data provided in this application. This processing may take place on behalf of employees, company doctors or reinsurers, not only for the processing of this application but also at a later date when taking out an insurance policy and/or processing a claim. In addition, I authorise doctors, health institutions, insurers, Icelandic Health Insurance, the Icelandic Social Insurance Administration and others who have access to information about my health or insurance policies to provide the company and its company doctor with all information that may be required when taking out an insurance policy or processing a claim.

I have been made aware of how the company ensures the protection of personal data and that I am permitted to withdraw my consent for the processing of such data. *(Withdrawal must take place in writing.)*

Date _____ Signature of the insured _____

Location _____ Witnessed by consultant _____