ANNEX 5 to Notification HR3

FORENEDE GRUPPELIV

Group Life and Critical Illness Insurance

HEALTH DECLARATION

Group Life Agreement No. 27001-475

Name		Personal Registration No: Cpr.nr./ Date of birth
Occupation		Address
Postcode	Town	Country

You must fill out this declaration **personally** and answer **all** the questions carefully. You must not withhold information – even if you consider it to be of no importance to FG. If your answers are not completely truthful, or if you have withheld information, the insurance can in accordance with the Insurance Contracts Act (Lov om forsikringsaftale) be annulled, resulting in non-payment of the insurance sum.

If you are in doubt about answers to the questions, eg in connection with a diagnosis or date, you can contact your doctor before filling out the declaration. The doctor will often have the information in your medical journal. However, you are **personally** responsible for the information. Any resulting doctor's fees are **not** payable by FG.

If there is not enough space in the individual columns, you can enclose supplementary information, which must also be signed and contain your personal registration number (cpr.nr).

1

Have you ever suffered from:	No	Yes	If yes: which illness(es), where/by whom were you treated, and what was the treatment?
A heart condition or coronary thrombosis?	☐	☐	_____
Too high a blood pressure?	☐	☐	_____
A stroke (apoplexy)?	☐	☐	_____
Nerve disorders, including epilepsy, amnesia, paralysis?	☐	☐	_____
Cancer, tumours or other malignant illness?	☐	☐	_____
Diabetes?	☐	☐	_____
Kidney or urinary tract disorder?	☐	☐	_____
Liver illness?	☐	☐	_____

2

	No	Yes	
Have you been examined/treated by a doctor, chiropractor, physiotherapist or other healthcare person; had laboratory tests taken; been admitted to hospital, an outpatient's clinic or any other similar medical institution, within the last 3 years?	☐	☐	If yes: For what? _____ Where? _____ When? _____ Consequences? _____

3

	No	Yes	
Have you ever been ill or absent from work for longer than a month?	☐	☐	If yes: For what? _____ When? _____ How long? _____ Consequences? _____

		No	Yes	If yes:
4	a. Do you drink beer, wine or spirits?	☐	☐	On average _____ glasses daily
	b. Have you previously drunk a lot of beer, wine or spirits?	☐	☐	On average _____ glasses daily When? _____
	c. Are you receiving, or have you previously received treatment for this?	☐	☐	Which treatment? _____ When? _____

		No	Yes	If yes:
5	a. Do you smoke?	☐	☐	How often/much do you smoke? _____
	b. Have you previously smoked?	☐	☐	If yes: When? _____

		No	Yes	If yes:
6	Are you receiving treatment or are you on any type of medication at the moment?	☐	☐	Which? _____ For what? _____

7	a. How tall are you?	a. _____ cm
	b. How much do you weigh?	b. _____ kg

		Yes	No	If no: Why not?
8	a. Are you **completely well?**	☐	☐	a. _____
	b. Are you **in full working capacity?**	☐	☐	b. _____

9	Who is your doctor (state name and address)

I declare that the information given by me is in accordance with the truth, and that I have not withheld anything. I am aware that withheld or incorrect information can result in the annulment of the insurance. Information necessary for a complete assessment of the insurance risk may be obtained. This consent only applies to health information prior to the time that FG has accepted the insurance requested. When doctors give supplementary health information, a more explicit certificate is used, supplemented by copies or extracts of relevant medical journal material, if requested by FG. I am aware of the fact that FG reserves the right to keep the information received, also in case of rejection of the application for insurance.

Information may be obtained from authorised healthcare persons, hospitals and healthcare institutions, from the public authorities, as well as other insurance companies and pension funds.

Other insurance companies, pension funds, the National Board of Industrial Injuries (Arbejdsskadestyrelsen), and other authorised healthcare persons who are involved in handling the case, may be shown the information received.

_____ the / _____

Signature