

# NHC HEALTH DECLARATION

Agency: 6010654

PLEASE USE BLOCK LETTERS

First name(s)	Surname(s)	Date of birth (DD-MM-YY)		
Nationality	Occupation			
E-mail	Tel.			

## Important details before you fill in this document!

- You have to fill in the declaration yourself and answer all the questions carefully.
- You must not fail to disclose anything, even though you think it is of no importance to Nordic Health Care.
- In case of incorrect or incomplete answering the insurance cover can be limited or cancelled in accordance with the Insurance Contract Act.
- If you are in doubt about answers, you can – on your own account – contact your doctor for assistance.
- If you have medical records or similar, which can contribute in answering questions, it would be an advantage to enclose copies of these.
- If space is not sufficient, when you fill in the form, please attach enclosure.

<b>1</b>	
Have you undergone surgery at <b>any time</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in illness/disorder and month/year below:
<b>2</b>	
Have you suffered from hepatitis/liver diseases at <b>any time</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in type and month/year below:
Are there any consequences?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in consequences below:
Are you receiving treatment now?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in method of treatment below:
When was the last medical check?	
When is the next medical check?	
<b>3</b>	
Have you suffered from cancer at <b>any time</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in type and month/year below:
Which treatment did you receive?	
Are you receiving treatment now?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in method of treatment below:
When was the last medical check?	
When is the next medical check?	

<b>4</b>		
Do you have any inherited bodily imperfections or consequential damages from injuries?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please fill in imperfections/damages below:
<b>5</b>		
Have you within the last 10 years consulted, been examined or treated by a <b>doctor or a medical specialist</b> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please fill in illness/disorder, method of treatment and month/year below:
(Records on colds, inflammation of the throat, transitory infections, ordinary childhood diseases and health checks shall <b>not</b> be listed)		
When did you last feel any symptoms of the above illnesses/disorders?		
<b>6</b>		
Have you within the last 10 years been examined or treated by <b>physiotherapist, chiropractor or other therapists (including alternative therapists)</b> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please fill in illness/disorder, method of treatment and month/year below:
When did you last feel any symptoms of the above illnesses/disorders?		
<b>7</b>		
Have you within the last 10 years been hospitalised, examined or treated in a <b>hospital or private clinic</b> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please fill in illness/disorder, method of treatment and month/year below:
When did you last feel any symptoms of the above illnesses/disorders?		
<b>8</b>		
Have you within the last 10 years consulted or been treated by a <b>psychiatrist, psychologist or psychotherapist</b> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please fill in illness/disorder, method of treatment and month/year below:
When did you last feel any symptoms of the above illnesses/disorders?		

**9**

Do you currently use medicine prescribed by a doctor or other therapists?

Yes  No

If yes, please fill in details below:

Medicine	Daily dose	Ailment/illness	Treatment started

**10**

Have you within the last 3 months had medical symptoms or discomforts, which have not been examined or treated by a doctor or other therapist?

Yes  No

If yes, please fill in discomforts/symptoms below:

(Records on colds, inflammation of the throat, transitory infections and ordinary childhood diseases shall not be listed)

**11**

Do you have reduced eyesight?

Yes  No

If yes, please fill in details below:

Cause:

Strength right eye:  Strength left eye:

**12**

Do you have reduced hearing?

Yes  No

If yes, please fill in below, cause and if you use hearing aid:

**13**

Do you drink alcohol?

Yes  No

If yes, please fill in number of units (on average) per week:

Did you previously have a larger consumption of alcohol?

Yes  No

If yes, please fill in number of units (on average) per week:

Period/year:

**14**

What is your height and weight?

Height:  cm Weight:  kg

**15**

Who is your present doctor (name and address)?

I hereby declare that the information I have given is the truth, and I have not failed to disclose anything. I fully accept that giving false information can result in cancellation of the insurance. I accept that Nordic Health Care reserves the right to keep the information submitted - also in case of negative response to the application of insurance cover.

**In case insurance for dental treatment is requested:** I hereby confirm that I am not receiving dental treatment at the moment and/or have pending dental treatments.

Date

Signature

