

NHC HEALTH DECLARATION

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.

1	
Have you undergone surgery at any time ?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please fill in illness/disorder and month/year below:
2	
Have you suffered from hepatitis/liver diseases at any time ?	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?	
3	
Have you suffered from cancer at any time ?	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?	

4		
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:
5		
Have you within the last 10 years consulted, been examined or treated by a doctor or a medical specialist ?	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 not be listed)		
When did you last feel any symptoms of the above illnesses/disorders?		
6		
Have you within the last 10 years been examined or treated by physiotherapist, chiropractor or other therapists (including alternative therapists) ?	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?		
7		
Have you within the last 10 years been hospitalised, examined or treated in a hospital or private clinic ?	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?		
8		
Have you within the last 10 years consulted or been treated by a psychiatrist, psychologist or psychotherapist ?	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

