

Individual application and declaration of health

PLEASE USE CAPITAL LETTERS

Insurance broker's/agent's name	Sales code	Agreement no. (to be entered by DKV Hälsa)
Company		
Address		Telephone (incl. area code)
Postcode and town		E-mail

I consent to the use of one of the following alternatives for sending me my insurance documents

Alt 1. I agree to the new policy document being sent via the insurance broker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alt 2. DKV Hälsa may e-mail the following documents to me; welcome letter, policy document, insurance conditions, invoice, renewal notice for the insurance and letter on termination of the insurance. I also agree to receive newsletters (not more than twice a year) and a voluntary customer questionnaire for completion (not more than once a year). (Communications are preceded by my being sent a special message that information has been put on the personal page to which I have access via a password allocated to me.) I may withdraw my consent at any time.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Choice of insurance

SjukvårdsGaranti	<input type="checkbox"/> Topp	<input type="checkbox"/> Plus	<input type="checkbox"/> Bas
Compulsory choice	<input type="checkbox"/> Referral*	<input type="checkbox"/> No referral*	* Referral means: to use this health insurance you must first have a visit at the local primary health care to get a referral to further health care.

The insured (THE PERSON WHOSE HEALTH IS COVERED BY THE INSURANCE)

Surname and first name (max 35 characters)	Personal identity number
Address	Telephone (home) incl. area code
Postcode and town	Telephone (work) incl. area code
E-mail	Mobile phone
Occupation	Fax incl. area code
Branch	

The policyholder (e.g. A PARENT)

Surname	Personal identity number/corporate registration number
First name(s)	Telephone (home) incl. area code
Address	Telephone (work) incl. area code
Postcode and town	Mobile phone
E-mail	Fax incl. area code

Payer (IF NOT THE INSURED, E.G. THE EMPLOYER)

Surname/company name	Personal identity number/corporate registration number
First name/contact person	Telephone (home) incl. area code
Address	Telephone (work) incl. area code
Postcode and town	Mobile phone
E-mail	Fax incl. area code

Payment of premium

<input type="checkbox"/> Notice of payment	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Six-monthly	<input type="checkbox"/> Annually	
<input type="checkbox"/> Direct debit (please fill in the details below)	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Six-monthly	<input type="checkbox"/> Annually
Name of bank	Bank branch (clearing no., 4 digits + account number)			

Conditions

AUTHORISATION OF PAYMENT VIA AUTOGIRO DIRECT DEBIT FOR CONSUMERS

The undersigned payer hereby authorises withdrawals to be made from my bank account at the request of the specified payee for payment by direct debit. The bank holding the account is not obliged to verify authorisation of withdrawals requested or to notify the payer of them in advance. Withdrawals will be made from the payer's account in accordance with rules of the bank holding the account, which will notify the payee of the transaction. Authorisation may at the request of the payer be transferred to another account at the bank holding the account or to an account at another bank.

The following also applies to withdrawals:

APPROVAL/INFORMATION IN ADVANCE

The payee may request a withdrawal from the payer's account on the due date - if the payer has been notified of the amount, the due date and the method of payment not later than eight working days before the due date, or - if the payer has approved a withdrawal in connection with a purchase or order of goods or services.

THERE MUST BE SUFFICIENT FUNDS IN THE ACCOUNT

The payer shall ensure that there are sufficient funds in the account to make a payment on the due date. If the credit balance is insufficient for a withdrawal to be made on the due date, the payee may attempt further withdrawals over the next few business days*, for up to a period of a week. Information about the number of withdrawal attempts will be provided by the payee.

STOPPING WITHDRAWALS

The payer may stop
- an individual withdrawal by contacting the payee not later than two working days before the due date,
- all withdrawals for the direct debit by contacting the bank not later than two working days before the due date.

PERIOD OF VALIDITY OF MANDATE, CANCELLATION

The direct debit mandate will apply until further notice. A payer who wishes to cancel this mandate may do this by contacting the bank holding the account or the payee. The mandate will cease not later than five days after notice of cancellation has reached the bank holding the account or the payee.

THE RIGHT OF THE BANK HOLDING THE ACCOUNT AND THE PAYEE TO CANCEL A DIRECT DEBIT

The bank holding the account and the payee are entitled to cancel the direct debit thirty days after the bank holding the account/payee has notified the payer of this. The bank holding the account and the payee are entitled, however, to cancel the direct debit immediately if the payer has on repeated occasions not had a sufficient credit balance on the due date or if the account to which the mandate is linked no longer exists.

AUTHORISATION OF PAYMENT VIA AUTOGIRO DIRECT DEBIT FOR BUSINESSES

The undersigned company ("Payer") hereby authorises withdrawals to be made from the bank account linked to the above bankgiro number at the request of the specified payee for transfer to the latter on a particular day (the due date). The bank holding the account is not obliged to check the authorisation of withdrawals requested or to specially notify the payer of withdrawals made.

A condition of this mandate is that the payee vouches for the correctness of the payments and, on request, repays any amount that is debited by mistake or otherwise incorrectly from the payer's bank account. Unless otherwise agreed with the payer's bank, the payer undertakes to have sufficient funds available in his or her account not later than on the banking day before the due date. If the account does not contain sufficient funds, the payer is aware that this may mean that the payments are not made. Should payments, nevertheless, be made, the payer's bank is entitled to charge interest and fees according to the bank's rules in force from time to time to cover the debt.

The payee's account will be credited on the same day that withdrawal takes place. If the payer's account does not contain sufficient funds on the withdrawal date, but funds are later paid into the account, a transfer may be made later (by agreement between the payee and the payee's bank) within five banking days, provided that the amount is then available.

The payer's bank is entitled to cancel the direct debit linked to a bank account which, in the judgment of the bank, should not be used for a direct debit because it is repeatedly overdrawn or for any other reason. Bankgiro-centralen BGC AB administers the direct debit procedure on behalf of the banks.

A direct debit mandate will apply until further notice. It ceases not later than five banking days after being cancelled by the payer. If the payer wishes to cancel the mandate, he or she may do this by notifying the payee, the payer's bank or BGC in writing.

* A business day does not include Sundays, public holidays, Saturdays, Midsummer Eve, Christmas Eve or New Year's Eve.

Signature of the payer

1. I undertake to pay the premium for the above insurance. I have read and agree to the above terms and conditions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. I consent to DKV sending the invoice to my e-mail address. I also agree to receive newsletters, though not more than twice a year, and a voluntary customer questionnaire for completion not more than once a year. I may withdraw my consent at any time.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

.....
Place and date (YYMMDD)

.....
Signature of account holder/authorised company signatory

.....
Name in CAPITALS

Declaration of Health

The declaration must be completed by the insured. All questions must be answered. If you reply Yes to any of the questions, you must give a more detailed description.

PLEASE USE CAPITAL LETTERS

Surname and first name			Personal identity number			
Height, cm	Weight, kg	Do you smoke each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you have stopped smoking, when was this? Year, month	

Questions about your health

1. Do you suffer from any illnesses, complaints or reduced mobility (physical/psychological)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you been examined or treated by a doctor, physiotherapist, chiropractor, naprapath, nurse or other healthcare professional in the last three years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you received treatment/advice for psychological problems and/or alcohol abuse/other abuse in the last five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been examined, provided blood/urine samples and/or been treated at a hospital, clinic, treatment or rehabilitation centre or donated blood in the last five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has any form of examination, treatment or surgery been planned for or recommended to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you take or have you taken any drugs in the last five years regularly or for periods of time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have any symptoms of an illness or complaint or do you experience problems which you have not sought treatment for or had diagnosed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you received treatment/advice from a psychologist/psychotherapist or similar practitioner and/or treatment/advice for alcohol abuse/other abuse/psychological problems in the last five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Is there any information about your state of health that has not come to light in the above questions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have answered Yes to any of these questions, please answer all the questions below in as much detail as you can.

Additional information for the health questions

For what illness/symptoms?
State when you contracted the illness/symptoms and how they have developed as well as whether you are currently free from symptoms or have residual aftereffects/problems.
What tests/examinations have you had – what was the result? (Year/Month/Place)
What treatments have you had – what was the result? (Year/Month/Place)
State the number of days you have been off work sick (including when and
What drug(s) are you taking/have you taken?
For what reason?
The prescribing doctor and his or her full address.

What doctor, healthcare establishment, clinic, outpatient's department etc. have you visited?

.....

Have you applied for insurance in the last ten years that has been made subject to special conditions (i.e. an additional premium, an exclusion or rejection) because of your health? If Yes, give the name of the insurance company and the reason for the special condition(s):

Yes No

.....

Particulars and authorisation

Please read carefully through all the sections below and ask about anything you find unclear.

ABOUT THE INSURANCE AGREEMENT:

I confirm that the particulars given serve as the basis for the insurance agreement with DKV Hälsa.

I am aware that:

- the insurance company's representative has no authority to make an assessment that is binding on the company and that I am responsible for the accuracy of all the particulars, even if the representative has filled in the form
- I must obtain the approval of the insurance company prior to hospitalisation.
- the insurance does not cover every type of treatment and that certain restrictions exist that are specifically mentioned in the documentation relating to the agreement.
- a health assessment may result in an increase in the premium, a qualification or a rejection for all or parts of the insurance.
- the insured must be resident in Sweden, Norway, Denmark or Finland being registered with the Social Security Agency of one of the above.
- Swedish law applies to the insurance agreement.
- healthcare insurance is governed by the Insurance Contracts Act.
- the payment of any compensation may be dependent on myself or the claimant providing the insurance company with the necessary authorisation to obtain additional particulars.
- when I take out the insurance at a distance, e.g. over the phone or via the internet, or through a home visit, I have the right to change my mind about the agreement according to the Distance and Home Marketing Act. The right to cancel the insurance applies for 14 days after the agreement has been signed. Since the insurance agreement does not come into force until the initial premium has been paid, I agree to the insurance company starting to fulfil the insurance agreement before this cooling-off period has expired. If I wish to cancel the insurance, I must contact Storebrand Helseforsikring AS on +47 22 31 50 50. The agreement will then be void from the date on which it was signed. If I exercise my right to change my mind, DKV Hälsa will refund me the premium, with a deduction for the time that the insurance has been in force and for reasonable costs incurred by the insurance company.

PREMIUM AND PAYMENT

I am aware that:

- the existing premiums may be changed after the risk assessment is complete.
- premiums and insurance conditions apply for one year and may be changed by the insurance company at the time of the annual renewal of the insurance.
- the coming into force of the insurance and the commencement of the insurer's liability require the initial premium to be paid by the date specified as the last date for payment on the premium notice. Provided that the premium is paid by this date, the insurance will come into force on the date on which the premium was paid, though not earlier than the date specified in the policy document. The insurer's liability commences at the same time and on the same condition. Payment of the initial premium after the final date specified for payment will be treated as a new application for insurance.
- the premium increases with age.

HEALTH DECLARATION – DUTY OF DISCLOSURE

- I confirm that the particulars that have been given are as accurate and complete as possible. I am aware as a result of incorrect or incomplete particulars the insurance may become invalid or may be cancelled and that no compensation will be paid according to the Insurance Contracts Act.

AUTHORISATION

I consent to:

- a doctor or other healthcare staff, a hospital or other healthcare establishment, a social insurance office or other insurance office providing DKV Hälsa with the particulars, patient's notes, registration documents, certificates etc. that DKV Hälsa considers that it needs to process the current application for insurance or an insurance matter.
- a copy of the signed consent being sent to any of those mentioned in the previous paragraph as authorisation for DKV Hälsa, indicating that the company can have access to any particulars about my health that are of a confidential nature.
- DKV Hälsa obtaining/disclosing particulars of the customer relationship from/to a company in the Storebrand Group and Deutsche Krankenversicherung (DKV). The reason for this is to provide an overall review of the involvement of the policyholder in the insurance company and the Storebrand Group/DKV and to make clear to the policyholder the services of the insurance company and the Group, and also to perform statistical analyses of the sums insured. This consent does not include the disclosure of health particulars or other particulars that are considered to be sensitive under the Personal Data Act, unless this is done with regard to ensuring an individual risk assessment and/or combating fraud.
- DKV Hälsa recording and passing on health particulars to relevant treatment units, in the event of my needing treatment.

INFORMATION IN ACCORDANCE WITH THE PERSONAL DATA ACT

I consent to:

- DKV Hälsa recording and processing the personal data provided by me or a third party as described above to DKV Hälsa in connection with this application, including my personal identity number and details of my health for the risk assessment. DKV Hälsa may keep the data for up to ten years after the contractual relationship between me and the insurance company has ceased and for up to three years in the event of no agreement being made between the insurance company and myself.
- the data in the register being used by DKV Hälsa for assessing and administering this and any future insurance applications and also for the administration and fulfilment of any agreements. Certain data may also be used for marketing purposes, entailing, among other things, information about "services" etc. being automatically sent to me.
- my health particulars being sent to a reinsurer.

I am aware that:

- DKV Hälsa owns and is responsible for the customer register ("personal data officer").
- the provision of information in this application is voluntary. However, complete information is necessary to enable DKV Hälsa to make an accurate risk assessment of my application and to grant insurance.
- I am entitled to receive extracts from a file relating to me personally as well as details of the processing of my data by approaching DKV Hälsa.
- I am entitled to approach DKV Hälsa to request that my personal data be corrected, blocked or deleted.

NB Not more than one month may elapse from the date of the signature until the declaration of health reaches DKV Hälsa, regardless of whether or not the application is approved.

Signature

.....
 Place and date (YYMMDD)

.....
 Signature of the insured/guardian

.....
 Name in CAPITALS

.....
 Signature of policyholder (if other than the insured)

.....
 Name in CAPITALS

The application is sent free of postage to:

DKV Hälsa, Frisvar 121 420 300, 110 01 Stockholm