INDIVIDUAL APPLICATION
WITH DECLARATION OF HEALTH

KTN

The application is sent post-free to:
DKV Hälsa, Frisvar 121 420 300, 110 00 Stockholm

Insurance agent

NAME OF INSURANCE AGENT

SALES CODE

COMPANY

TELEPHONE

ADDRESS

POSTAL CODE/CITY

EMAIL

Insured party

SURNAME

FIRST NAME

PERSONAL IDENTITY NUMBER

ADDRESS

PRIVATE TELEPHONE NUMBER

WORK TELEPHONE NUMBER

POSTAL CODE/CITY

EMAIL

Choice of insurance

- ☐ Top
- ☐ Plus
- ☐ Basic
- ☐ No referral, no excess
- ☐ No referral, with excess 500 kr
- ☐ No referral, with excess 500 kr
- ☐ With referral requirement

A referral requirement means that the insurance only becomes applicable once the treating physician in the primary care system has written a referral for continued treatment.

With excess, you pay SEK 500 per condition at the first doctor's visit.

Referral requirement and excess cannot be combined.

Policyholder (if other than the insured party, e.g., parent/guardian)

SURNAME/COMPANY

FIRST NAME/COMPANY CONTACT

PERSONAL ID NUMBER/C.I.N. NUMBER

ADDRESS

PRIVATE TELEPHONE NUMBER/COMPANY CONTACT

WORK TELEPHONE NUMBER

POSTAL CODE/CITY

EMAIL PRIVATE/COMPANY CONTACT

Payer (if other than policyholder)

SURNAME/COMPANY

FIRST NAME/COMPANY CONTACT

PERSONAL ID NUMBER/C.I.N. NUMBER

ADDRESS

PRIVATE TELEPHONE NUMBER/COMPANY CONTACT

WORK TELEPHONE NUMBER

POSTAL CODE/CITY

EMAIL PRIVATE/COMPANY CONTACT

Premium payment

I want to pay by direct debit: ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Annually

Name of bank

Bank account number (clearing number, 4 digits and account number)

I want to receive an invoice: ☐ Quarterly ☐ Every six months ☐ Annually

Account number or bank giro number in case of outstanding premium that is to be refunded.

Bank giro number/bank account number (clearing number, 4 digits and account number)

Terms and conditions

TERMS AND CONDITIONS FOR DIRECT DEBIT

General
Direct debit is a payment service in which payments are transferred from the payer's account at the recipient's initiative. In order to pay by direct debit, the payer shall give their consent for the payment recipient to initiate payments from the payers account. In addition, the payer's payment service provider (e.g., a bank or payment institution) must approve the use of the account for direct debit and the payment recipient must approve the payer for payment by direct debit. The payer's payment service provider is not obligated to evaluate the authorisation or to inform the payer ahead of requested withdrawals. Withdrawals are charged to the payer's account in accordance with the regulations applied by the payer's payment service provider. The payer will receive notification of withdrawals from their payment service provider. At the payer's request, their consent can be transferred to another account with the same payment service provider or to an account with a different payment service provider.

Definition of banking day
Banking days are all days except Saturday, Sunday, Midsummer's Eve, Christmas Eve, New Year's Eve or other public holiday.

Information about payment
The payer will be notified by the payment recipient of the amount, due date and payment method no later than eight banking days before the due date. This notification can be made ahead of each individual due date or at a single occasion in reference to several future due dates. If the notification refers to several future due dates, the notification shall be made no less than eight days ahead of the first due date. However, this does not apply in cases where the payer has approved the withdrawal in conjunction with a purchase or order of a product or service. In that case, the payer will receive a notice from the recipient regarding amount, due date and payment method in conjunction with the purchase and/or order. By signing this consent, the payer agrees to the execution of payments covered by the payment recipient's notification in accordance with this point.

There must be sufficient funds in the account
The payer shall ensure that there are sufficient funds in the account no later than 00:01 on the due date. If the payer does not have sufficient funds in the account on the due date, it may result in payments not being made. If there are not sufficient funds for the payment on the due date, the payment recipient may make further attempts to withdraw the money in the following banking days. The payer may request information from the payment recipient regarding the number of withdrawal attempts.

Stop payment (cancellation of a payment order)
The payer may stop a payment by contacting the payment recipient no later than two banking days ahead of the due date or their payment service provider no later than the banking day prior to the due date at the time specified by the payment service provider. If the payer stops a payment in accordance with the above, it means that the payment in question is stopped on that specific occasion. If the payer wishes for all future payments initiated by the payment recipient to be stopped, the payer must withdraw their consent.

Validity of the consent, withdrawal
The consent is valid until further notice The payer is entitled at any time to withdraw their consent by contacting the payment recipient or their payment service provider. The notification regarding the withdrawal of consent shall, in order to stop payments that have not yet been effectuated, have been received by the payment recipient no later than five banking days ahead of the due date, or by the payer's payment service provider no later than on the banking day before the due date at the time specified by the payment service provider.

The right of the payment recipient and the payer's payment service provider to cancel the direct debit
The payment recipient is entitled to cancel the payer's direct debit 30 days after notifying the payer of such action. However, the payment recipient is entitled to immediately cancel the payer's direct debit if the payer has repeatedly had insufficient funds in their account on the due date or if the account for which consent has been given is closed or if the payment recipient otherwise deems it inappropriate for the payer to pay through direct debit. The payer's payment service provider is entitled to cancel the payer's direct debit in accordance with the terms and conditions that apply between the payment service provider and the payer.

Payer's signature

The undersigned undertakes to pay the premium for the stated insurance policy. In case the payment is made by direct debit, I have read and accepted the terms and conditions for direct debit.

Place | Date | Account holder/Payer's signature

Declaration of health

The declaration shall be filled out by the insured party. All questions must be answered. As this insurance covers treatment, all information regarding previous and current health conditions are of significance. If you forget to fill out any of the information, we will return the declaration to you for completion. All information submitted to us is processed under absolute confidentiality.

SURNAME	FIRST NAME	PERSONAL IDENTITY NUMBER
ADDRESS	PRIVATE TELEPHONE NUMBER	WORK TELEPHONE NUMBER
POSTAL CODE/CITY	EMAIL	

Questions regarding your health

HEIGHT (CM)	WEIGHT (KG)

1. Do you smoke or have you been smoking in the last 12 months? ☐ Yes ☐ No

2. Do you have or have you ever had any cardiovascular disease? (e.g. angina pectoris, cardiac infarction, congenital heart condition, cardiac insufficiency, valvular disorder, arrhythmia, blood clot, high blood pressure, high cholesterol or diabetes)? ☐ Yes ☐ No

If yes, please indicate which illness(es)	
What treatment have you received/ are you receiving?	
When (year/month) did you last experience symptoms? For what illness?	

3. Do you have or have you ever had: disorder of the nervous system or brain (e.g., migraines, recurring headaches, epilepsy, paralysis, fainting spells, multiple sclerosis, Parkinson's, TIA, cerebral haemorrhage/stroke)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving?	
If you suffer from epilepsy or migraines/headaches, indicate how often you experience spells	

4. Do you have or have you ever had: pulmonary diseases (e.g., asthma, allergy, bronchitis, COPD, emphysema)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving?	

5. Do you have or have you ever had diseases affecting the kidneys or urinary tract (e.g., blood or albumin in urine, urinary symptoms) liver, gall bladder, pancreas (e.g., hepatitis, enlarged liver, abnormal liver values, pancreatic inflammation, gallstones, gall bladder inflammation)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving? When and for how long?	
When (year/month) did you last experience symptoms? For what illness?	
If you have had a urinary tract infection/gallstones, indicate the number of treatments in the last 3 years	

6. Do you have or have you ever had any diseases affecting the digestive organs (e.g., esophageal inflammation, reflux, catarrh, ulcer, ulcerative colitis, Crohn's disease, irritable bowel syndrome)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving? When and for how long?	
When (year/month) did you last experience symptoms? For what illness?	

7. Do you have or have you ever had: skin conditions (e.g. psoriasis, eczema), skin cancer or benign abscesses, or have you biopsied or removed any birthmarks? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving? When and for how long?	
Results?	

8. Do you have or have you ever had: rheumatic diseases (e.g. gout, Bechterew's, rheumatism)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving? When and for how long?	

9. Do you have or have you ever had: eye diseases (e.g., large visual impairment, retinal detachment, iritis, cataract or glaucoma)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented	
What treatment have you received/ are you receiving? When and for how long?	

10. Do you have or have you ever had: aural diseases (e.g., impaired hearing, ringing in your ears/tinnitus, BPPV)? ☐ Yes ☐ No

If yes, indicate what illness and when (year/month) it first presented		When did you last experience symptoms? When and for how long?	
What treatment have you received/ are you receiving? Indicate when			

11. Have you been examined or treated by a physician in the last 5 years? If you have had several examinations or treatments, we wish to be informed of all of them. ☐ Yes ☐ No

If yes, when? And why/diagnosis?

By whom (name and address)?

Results?

Are you in need of further treatment/ examination?

12. Have you been examined, treated or been to a checkup at a hospital, clinic or other healthcare institution in the last 10 years, or have you been recommended examination, treatment or operation? If you have had several examinations or treatments, we wish to be informed of all of them. ☐ Yes ☐ No

If yes, when? And why/ diagnosis?

By whom (name and address)?

Results?

Are you in need of further treatment/ examination?

13. Have you been examined or treated by a psychologist in the last 5 years and/or received treatment/counselling for: burnout, anxiety, depression, eating disorders, concentration disorders or other psychological illness? ☐ Yes ☐ No

If yes, for how long?

Have you been on sick leave for such illness? When and for how long?

By whom (name and address)?

And why/diagnosis?

Are you in need of further treatment/examination? ☐ Yes ☐ No

14. Do you take or have you taken any medicine or other preparations in the last 5 years? ☐ Yes ☐ No

Medicine	For what?	When and for how long?	Are you still taking this medicine?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

15. Do you have or have you ever had symptoms/illness for which you have not consulted a doctor, sought treatment or received a diagnosis? ☐ Yes ☐ No

Describe the symptoms/illness

16. Do you or have you ever abused alcohol, narcotics and/or performance-enhancing drugs (doping) and/or been recommended treatment in this regard? ☐ Yes ☐ No

If yes, describe them

When (year/month)?

17. Have you had any pain/symptoms in muscles, bones, tendons or joints, or any other diffuse pain in the last 5 years? If yes, describe them ☐ Yes ☐ No

Where?		When did these symptoms first occur?	When did you last experience symptoms?	Diagnosis/illness?	Treatment? Indicate what/by whom
Back					
Neck					
Pelvis					
Diffuse pain					
Pain in the joints, muscles or tendons					
Knee	☐ Left ☐ Right				
Hip	☐ Left ☐ Right				
Arm	☐ Left ☐ Right				
Shoulder	☐ Left ☐ Right				

18. Have you received treatment by a physiotherapist, chiropractor, naprapath or similar in the last 5 years? If you have had several examinations or treatments, we wish to be informed of all of them. ☐ Yes ☐ No

If yes, when (year/month)?

Results?

By whom (name and address)?

And why/diagnosis?

Are you in need of further treatment/examination?

Number of treatments in the last 3 years

Information and power of attorney

INSURANCE AGREEMENT:
I hereby confirm that the information provided constitutes the basis for the insurance agreement with DKV Hälsa.

I am aware:
- that the insurance company's representative is not authorised to make a binding assessment on behalf of the company and that I am responsible for ensuring that all the information is correct, even if the form is completed by the insurance company representative.
- that the insurance does not cover all forms of treatment, and that there are certain limitations, which are detailed in the agreement documents.
- that a risk assessment may entail additional charges to the premium, reservations regarding or rejection of all or parts of the insurance.
- that the insured party shall reside in a Nordic country and be registered with a Nordic social insurance office.
- that the insurance agreement is subject to Swedish law.
- that the healthcare insurance is regulated in the Swedish Insurance Contracts Act (2005:104).
- that the payment of any compensation is conditioned on whether I or the party making a claim provides the insurance company with the necessary powers of attorney to gather further information.

PREMIUMS AND PAYMENTS
I am aware:
- that the current premiums are subject to change following the risk assessment.
- that premiums and insurance terms are applicable for 1 year and are subject to change by the insurance company at the annual contract renewal;
- that for the insurance agreement to enter into effect (be valid) and the insurer to be liable, the first premium must be paid no later than on the day specified as the final payment day on the premium payment slip. Provided that the premium is paid no later than on this day, the insurance agreement enters into effect on the day the premium was paid; however, no earlier than on the date specified in the insurance policy. The insurer becomes liable as of the same date and under the same conditions. Payment of the first premium after the stated due date is considered a new insurance application.
- that the premium increases with age.

DECLARATION OF HEALTH – DISCLOSURE REQUIREMENT
- I hereby assert that the information provided is as accurate and complete as possible. I am aware that incorrect or incomplete information may make the insurance invalid or eligible for termination, and that no payments will be made in accordance with the Swedish Insurance Contracts Act.

POWER OF ATTORNEY
I consent to:
- DKV Hälsa obtaining/providing information about our customer relationship from/to companies within the Storebrand Group and Deutsche Krankenversicherung (DKV). The reason for this is to provide them with a general idea of the policyholder's commitments in the insurance company and the Storebrand Group/DKV, to enable them to adapt the services of the insurance company and group to the policyholder and to carry out statistical analyses of their insurance portfolios. This consent does not pertain to health data or other information that is considered sensitive in accordance with the Personal Data Act, unless such data is processed in view of verifying an individual risk assessment and/or to combat fraud.
- DKV Hälsa registering and communicating as well as receiving health data to and from the treatment facilities involved, should I be in need of treatment.

DKV HÄLSA IS PROCESSING YOUR PERSONAL DATA.
- We process personal data in order to register and administer the health insurance at DKV Hälsa and to determine correct terms for your contract.
- The personal data that you have provided to DKV Hälsa are necessary for us to manage your customer relationship and fulfill our contractual obligations. Personal identity number is required to secure identification and ensure proper reporting to the authorities.
- We store information as long as you are customer with us. The data is deleted when we no longer have obligations under the agreement or other regulations.
- You can read more about your rights, such as the right of access, rectification and erasure, in our privacy policy at www.dkvhalsa.se.
- The CEO of DKV Hälsa is responsible for how your personal data is being processed. If you have any questions about the processing of personal data you can send an email to admin@dkvhalsa.se. You can also send a letter to DKV Hälsa, 105 39 Stockholm.

Signature

Processing of your personal data

In order for DKV Hälsa to offer you a health insurance you must give your consent to DKV Hälsas treatment of your health information.

☐ I give my consent that DKV Hälsa can process my health information to fulfill obligations under the contract signed for the health insurance.

I also confirm that I have received pre-purchase information from DKV Hälsa relating to this application and I have had the opportunity to read it before completing this application.

Insured party's signature (if the person is under 18 years old, the application shall be signed by a guardian)

Place	Date	Insured party's/guardian's signature

Policyholder's signature (if other than insured party)

Place	Date	Policyholder's signature (if other than insured party)

Note! No more than one month may pass from the date of signing the application until the declaration of health is received by DKV Hälsa.
The information received will be archived by DKV Hälsa regardless of whether or not the application is approved.