HEALTH DECLARATION – ADULT

EUROPEISKA ERV

Employees stationed abroad
Health declaration for adults (16 years or older) when applying for personal insurance.

Please fill in the form digitally, then print it out and send it to: Europeiska ERV, Hantverkargatan 11B, 112 21 Stockholm, Sweden. Or send the form by e-mail to: hd@erv.se. Remember to sign your health declaration before sending it.

The individual who shall be insured shall personally provide the information. Every question must be answered.

Company name	Company registration no.	Insurance policy no.
E-mail address to company or contact person	City where the employee shall be stationed	
Duration of the contract (start and end date)	Country where the employee shall be stationed	
Name of the employee on contract	Date of birth (yy-mm-dd) of employee on contract	

Particulars concerning the person to be insured

Surname and first name	
Date of birth (yy-mm-dd)	Female ☐ Male ☐
E-mail address	Citizenship

Height in cm (without shoes)	Weight in kg (without clothes)	Do you smoke regularly? Yes ☐ No ☐	Are you pregnant Yes ☐ No ☐

Are you being examined or treated for any disease, injury or other bodily disorder? Yes ☐ No ☐
If Yes, please state details

Do you have any defect in any internal organ, or any physical or mental handicap, or any other bodily disorder? Yes ☐ No ☐
If Yes, state details.

Do you have any visual defect? Yes ☐ No ☐
If Yes, state details * One-sided ☐ Double-sided ☐
*In case of myopia of at least 6 diopters in either eye, state the value of the diopters. Right ..... Left .....

Do you have any hearing defect? Yes ☐ No ☐
If Yes, state details. Hearing aid: Yes ☐ No ☐

Have you been tested for HIV? Yes ☐ No ☐
If Yes, when? HIV-positive ☐ HIV-negative ☐

Are you taking any prescription drug? Yes ☐ No ☐
If Yes, state details*?
Reason

Dosage
*If you use prescribed blood pressure medication please indicate blood pressure reading: /

Do you recieve sickness benefit, rehabilitation allowance, sickness compensation, life annuity due to work injury or are you taking part in work-oriented rehabilitation or training? Yes ☐ No ☐
If Yes, for what reason? To what extent ..... %

Have you during the past five years
received medical treatment, or been examined at a hospital, health care center, maternity clinic or other medical establishment **or** been sick-listed (fully or partly) for more than 14 consecutive days, or otherwise consulted a doctor or other medical staff? (Also examinations in connection with pregnancy shall be listed).

Yes ☐ No ☐

If Yes, answer the questions below in their pertinent parts and please enclose a copy of the medical records. If you have more than four diagnoses please enclose additional information in separate document or enclose medical records.

Illness/injury/handicap 1:	
Illness/injury/handicap 2:	
Illness/injury/handicap 3:	
Illness/injury/handicap 4:	
During what period of time were you sick?	Diagnosis 1: Diagnosis 2: Diagnosis 3: Diagnosis 4:
When were you examined, checked-up or treated?	Diagnosis 1: Diagnosis 2: Diagnosis 3: Diagnosis 4:
Which doctor or medical institution was consulted?	Diagnosis 1: Diagnosis 2: Diagnosis 3: Diagnosis 4:
What treatment did you recieve?	Diagnosis 1: Diagnosis 2: Diagnosis 3: Diagnosis 4:
Do you have any remaining problems?	Diagnosis 1: Diagnosis 2: Diagnosis 3: Diagnosis 4:

In case of a claim where a pre-existing medical condition is discovered, Europeiska ERV may decline compensation.

Signature of the person to be insured
I hereby declare that the given information is true. I am aware that Europeiska ERV's coverage can be reduced or waived according to law, if I state untrue information. Europeiska ERV is data controller under the General Data Protection Regulation (GDPR). I give Europeiska ERV my consent to obtain and disclose my health information to collaborators and health care providers as part of the proceedings of my claim(s) or in relation to assistance. Furthermore, I give Europeiska ERV my consent to store my health information as long as it is necessary due to legitimate purposes.

Date (yyyy, mm, dd)	Telephone (during office hours)	Date of birth (yy-mm-dd)
Signature		
Clarification of signature		