HEALTH DECLARATION HE

Name:……	**Occupation:**……
……	**Please describe your job/work function:** (you may tick more than one box)
Civil registration no./CPR-no……	☐ Office work ☐ Management
Address:……	☐ Craftsman work ☐ Transport/Driving
Postal code.:…. City/Town**:**….	☐ Teaching/Supervising ☐ Sales work
E-mail address:……	☐ Other:……

It is important that you read this before you fill out the declaration:
To create an insurance or make changes in your current insurance contract, (company name) needs information which may be of importance in assessing the insurance risk. This health declaration contains both the questions you must answer, and consents in order for (company name) to obtain additional information, if needed.

When filling out the health declaration, it is important that your information is as accurate as possible. According to the Danish Insurance Contract Act, inaccurate or incomplete information may cause cancellation of insurance or reduction of insurance coverage.

Therefore, when filling out the health declaration:
- Answer all questions and sub-questions carefully, without omitting anything, e.g. conditions such as back pain, psychiatric conditions and the use of pills and alcohol – even if you think it is irrelevant to the insurance company or has no impact on the insurance.
- Provide information about current and past illnesses.
- Provide information on permanent or temporary use of medication.
- Provide information on all examinations and treatments by doctors, chiropractors, physical therapists, psychologists etc.
- Provide information on all examinations and treatments at public and private hospitals, ambulatories, clinics and laboratories.

Do not inform about the results of genetic testing (DNA or RNA analysis), which only highlight the risk of developing disease in the future, or information about family members past or present medical condition. Do not include preventive examinations that are **not** related to disease or symptoms that you have or have had.

If in doubt about the answers – e.g. about diagnoses and dates - you may contact your doctor or go to www.sundhed.dk before filling out the health declaration. The insurance company does not pay Doctor's fees.

Remember that **you** are responsible for the correct completion of the health declaration. Please read the customer instructions on coverage and health information before completing the health declaration.

If your answer to a question is **YES**, please use the box on the right side of the form to elaborate your answers. If there is not enough space for your answer, please use a blank sheet of paper and add as annex to the health declaration – or use the box on the last page.

1	**Within the past 10 years, have you been in contact with doctors, hospitals, specialists or other therapists concerning:**		You must answer all the questions below. The questions include both physical and mental health issues. Please inform about all current and past illnesses, even if they are not listed as an example in the list. • *Only inform about healed fractures of fingers, toes, arms or legs, if there are permanent injuries or discomfort.* • *You only need to inform about examinations in connection with driver's license, group surveys and vaccinations if they have resulted in further examinations.* • *Only inform about your own contacts - not in connection with children or other people.*
	a. Tumours (benign and malignant tumours), e.g. cancer, including early stage cancer, blood and lymphatic cancer, polyps, cysts and other benign tumours or other illnesses? *NB: Contacts concerning birthmarks are to be stated here.*	**NO** ☐ **YES** ☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address

	NO	YES	
b. Diseases of the blood, e.g. anaemia, coagulation diseases or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
c. Metabolic disorders, e.g. diabetes and glycosuria, struma or metabolic disturbances, Graves' disease, hyperlipidemia, hormonal disturbances or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
d. Diseases of the nervous system, e.g. headache or migraine, vertigo/dizziness, epilepsy, fainting or cramps, paralyses or mobility disturbances, cerebral haemorrhage or blood clot in the brain, sensation disturbances, multiple sclerosis (MS) or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
e. Eye diseases, e.g. reduced sight, infections, cataract or glaucoma or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
f. Diseases of the ear, e.g. reduced hearing, tinnitus and vertigo or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)

	NO	YES	
g. Cardiac, circulatory or vascular disorders (including varicose veins), e.g. hypertension, chest pain (angina pectoris), palpitation or irregular heart rhythm, blood clot, heart or heart valve disease, varicose veins or phlebitis, blood clot in legs, intermittent claudication (claudicatio intermittens) or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address
h. Pulmonary or respiratory diseases, e.g. asthma, hay fever or allergy, bronchitis or COPD/-COLD, tuberculosis, blood clot in a lung, lung infections, silicosis, sarcoidosis or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address
i. Stomach, intestinal and oesophagus diseases, e.g. ulceration (ulcus) or bleedings, gastritis, oesophagus discomforts or reflux, indigestion (irritable bowel syndrome or allergy), colitis, ileus, polyps or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address
j. Liver, gall bladder and pancreas diseases, e.g. jaundice or hepatitis, gallstones, fatty liver (steatosis), abnormal liver count (demonstrated through blood tests), pancreatitis or other illnesses?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address
k. Skin diseases, e.g. eczema, psoriasis, infections (including abscesses), blisters or other illnesses? *NB: Contacts concerning birthmarks are included in 1b.*	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… name …… address

	l. Kidney or urinary diseases, e.g. nephritis, cystitis, kidney or bladder stone, blood, protein or bacteria in the urine, malformations or cysts or other illnesses?	NO ☐ YES ☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
	m. Diseases relating to male or female genitals, e.g. venereal diseases, complications during pregnancy, menstrual disturbances, prostatic enlargement or other illnesses?	NO ☐ YES ☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
	n. Infectious diseases (except ordinary colds), e.g. cerebrospinal meningitis, rheumatic fever, HIV/ AIDS, malaria or other illnesses?	NO ☐ YES ☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
	o. Other diseases – apart from childhood diseases and other ordinary non-recurring infectious diseases? *NB: Discomforts from the back, arms and legs (including rheumatism) and mental disorders are included in questions 2 and 3 below.*	NO ☐ YES ☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)
2	Within the past 10 years, have you been in contact with doctors, psychiatrists, psychologists or other therapists for **mental conditions**, e.g. depression, anxiety, nervousness, stress, mental reaction, case of poisoning or other illnesses?	NO ☐ YES ☐	If **YES**, fill in the following: Cause: …… When? …… (month/year) Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?…… Therapist: …… (name) …… (address)

3 Within the past 10 years, have you been in contact with doctors, hospitals, specialists, chiropractors, physiotherapists or other therapists due to **discomforts, injuries or diseases** concerning:

	NO	YES	If **YES**, fill in the following:
a. Neck or back (including the lower part of the back)?	☐	☐	Concerning: ☐ Muscle tensions ☐ Ischias ☐ Discusprolaps ☐ Whiplash ☐ Diseases of the spine ☐ Scoliosis When was the last time? ……..……..……..….. month/year Therapist: ……..…… name/address ……
b. Joints, tendons, bones or connective tissue (including arthritis/rheumatism)?	☐	☐	Concerning: ☐ Shoulder ☐ Elbow ☐ Hand ☐ Arm ☐ Knee ☐ Hip ☐ Pelvis ☐ Foot ☐ Leg When was the last time? ……..……..……..….. month/year Therapist: ……..…… name/address ……

4

	NO	YES	If **YES**, fill in the following:
a. Within the past 10 years, have you – apart from what you have already informed - been treated or examined in or admitted to a hospital (including private hospitals)? *NB: Do not include hospitalization in connection with the hospitallization of a child or uncomplicated child births.*	☐	☐	Where? ……..…… Cause: ……..……..…….. When? ……..……..……..…… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?...……..……..……
b. Within the past 10 years, have you been referred to any laboratory, ambulatory or any other place for treatment, including X-ray clinics or physiotherapeutic clinics?	☐	☐	Where? ……..…… Cause: ……..……..…….. When? ……..……..……..…… month/year Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?...……..……..……

5

	NO	YES	If **YES**, fill in the following:
Are you referred to - or on the waiting list for examination, treatment or hospitalization?	☐	☐	Where/who? ……..……..……... hospital/name of doctor Cause: ……..……..……

6

	NO	YES	If **YES**, fill in the following:
a. Do you have **congenital** bodily defects or any complications/discomforts (permanent injury) after injuries?	☐	☐	Which? ……..……..…… Have you received compensation for the disability? ☐ No ☐ Yes When? ……..……..……..…… month/year Which symptoms as well as percentage of permanent injury (if any)? ……..……..……..……
b. Do you have reduced hearing?	☐	☐	Cause: ……..……..……..…… Are you able to effortlessly hear ordinary speech (you may use your hearing aid) at a distance of **more than 2 metres**? ☐ No ☐Yes

HEALTH DECLARATION HE

		NO	YES	
	c. Do you have reduced sight?	☐	☐	If **YES**, fill in the following: Cause: …… Power of glasses/contact lenses: Right: +/÷ ……..…. Left: +/÷ ……..… Are you able to effortlessly read this form? ☐ No ☐ Yes (glasses/contact lenses may be used)
7	**a.** Do you use drugs/medicine (prescription or non-prescription drugs/medicine) prescribed by a doctor or other therapists?	☐	☐	If **YES**, fill in the following: What preparations? …… Cause: ……
	b. Within the past 10 years, have you received medical treatment for more than one month, including tranquillizers or painkillers?	☐	☐	What preparations? …… When? …… month/year Cause: ……
8	**a.** Do you drink beer, wine, dessert/ fortified wine or liquor?	☐	☐	If **YES**, fill in the following: Number: ……. of drinks per week (on average)
	b. Have you previously had a larger consumption of beer, wine, dessert/fortified wine or liquor?	☐	☐	Number: ……. of drinks per week (on average) When? …… month/year
	c. Are you receiving or have you – within the past 10 years received treatment or counselling for this?	☐	☐	Which treatment? …… When? …… month/year
9	**a.** Do you smoke?	☐	☐	If **YES**, fill in the following: Daily consumption: …… number of cigarettes, cigars, pipes
	b. If not, have you been smoking during the past 10 years?	☐	☐	When did you give up smoking? …… month/year Daily consumption: …… number of cigarettes, cigars, pipes
	c. Do you use or have you within the past 10 years used ”hard drugs” (e.g. heroin, speed, cocaine, ecstasy, LSD), cannabis, anabolic drugs, organic solvents or other stimulants?	☐	☐	Which drugs? …… When? …… month/year Have you received treatment or counselling for this? ☐ No ☐ Yes
10	**a.** Within the past 10 years, have you been ill or unable to work for a consecutive period of two weeks or more?	☐	☐	If **YES**, fill in the following: Cause: …… When? …… month/year Duration: …… Any following complications/discomforts? ☐ No ☐ Yes If **YES**, which?……
	b. How many sick days have you had within the past 12 months?			Number of workdays: ☐ 0-5 ☐ 6-10 ☐ 11 or more, please state the cause: ……
11	Are you fully capable of working?	☐	☐	If **NO**, why not? ……
12	**a.** Have you been recommended for/referred to, or are you or have you been in a flexible job, a resource or job clarification process or rehabilitation/work ability assessment?	☐	☐	If **YES,** which? ☐ Flexible job ☐ Job clarification process ☐ Resource process ☐ Rehabilitation ☐ Work ability assessment Since when? …… month/year

HEALTH DECLARATION HE

		NO	YES	
	b. Have you been granted, or are you or have you been recommended for/referred to early retirement pension with disability or disability benefit (flexible allowance)?	☐	☐	☐ Early retirement pension with disability ☐ Disability benefit ☐ Flexible allowance Since when? ..... month/year
	c. Are you working reduced hours due to health issues, or has a special agreement been signed with your employer regarding his duty to pay sickness benefit (e.g. section 20-56 of the Sickness Benefits Act)?	☐	☐	☐ Working reduced hours due to health issues ☐ Special agreement with employer regarding his duty to pay sickness benefit (e.g. section 20-56) Since when? ..... month/year Reason? .....
13	What is your height and weight?			Height: ..... cm Weight: ..... kg
14	Who is your doctor (private practitioner)?			Name: ..... Address: ..... Postal code: ..... Town/city: .....

If you wish to add any comments, you may do so here. Please refer to the relevant question in the health declaration.

If you need any more space, please use a blank sheet and add as annex. Please remember to date and sign the sheet.

I have answered all questions to the best of my knowledge and have not concealed or omitted anything. I am aware that in the case of incorrect or inadequate information, the insurance may not cover if I need to claim payment from [the company].

When [the company] handles your insurance application or wish to change insurance, [the company] often needs to obtain relevant information from others than yourself to get the most complete information about your health situation – so we can determine the price and the terms of the insurance. We need your consent for this.

Consent to [the company]'s obtaining, processing and recording your information
With my signature, I agree that [the company] may process and record all relevant information [the company] receives from me or obtains through my consent from third parties, including doctors, hospitals, ambulances, clinics, physiotherapists, etc. with whom I have been in contact, as well as the Danish Centre of Health & Insurance. In relation to this, [the company] may pass on information for identification to those from whom [the company] retrieves the relevant information. The collected information may be used for the effecting, administration and payment of any insurance or pension in [the company].

The Danish Centre of Health & Insurance
In some cases, [the company] may transfer your health information to the Danish Centre of Health & Insurance (Health & Insurance) for a medical assessment before [the company] determines your insurance terms. In other cases, the insurance company may retrieve information from Health & Insurance about previous medical assessments for insurance purposes.

Health & Insurance is an association advising insurance companies on health and insurance medicine. The Centre helps ensure that as many applicants as possible with health issues may be offered insurance at reasonable terms. Read more at www.helbredogforsikring.dk.

Consent to the processing of your information at Health & Insurance
With my signature, I agree that, at receiving my application for insurance, [the company] may obtain relevant information about me from - and pass on my information to - Health & Insurance (including CPR number, health information, sickness reports, information about treatments and contacts with the health service as well as social services), and that the Centre may carry out a medical assessment for insurance purposes.

HEALTH DECLARATION HE

In addition, I agree that Health & Insurance may process my information and record it and the medical assessment in the Centre's Health Register at the assumption of increased health risk. The main purpose of the information in the Health Register is to constitute the statistical basis to ensure adequate medical assessments. Furthermore, life insurance companies and pension funds, which are members of Health & Insurance, may seek information about potential policyholders in the Health Register for use at subsequent insurance applications (see separate consent below).

Consent to transfer of information to life insurance companies and pension funds
I also agree that Health & Insurance may transfer my information and the medical assessment to the life insurance companies and pension funds that are members of the Centre (see www.helbredogforsikring.dk/da/organisation/medlemmer) if, at a later stage, I should request insurance coverage in a member company or member fund. At that time, however, the member company or member fund concerned must obtain your consent for this.

Your health information is only registered in the Health Register if the assessment indicates an increased health risk (see www.helbredogforsikring.dk/da/register). You will be notified by [the company] if your information is registered in the Health Register. The information is deleted from the Health Register when you reach the age of 70 or earlier if Health & Insurance estimates that there is no longer any increased health risk.

The Centre stores the personal data and medical assessment for up to 10 years for documentation purposes and fulfilment of obligations in accordance with personal data regulations, etc. The information, however, will continue to be used for statistical purposes.

For your information
All collected personal data is treated confidentially and in accordance with the rules of the Data Protection Regulations, by selected employees who are bound by professional secrecy. See [the company's] Personal data Policy: link. You can also find more information about Health & Insurance's IT and Security Policy and Privacy Policy at www.helbredogforsikring.dk/da under "IT- og sikkerhedspolitik".

Withdrawal of consent and consequences hereof
At any time, you may withdraw your consent to 1) [the company's] collection and processing of your information; 2) retrieval and transfer to Health & Insurance for medical assessment; and 3) registration in the Health Register and potential transfer to member companies at a later application to another insurance company.

If you withdraw your consent that [the company] may retrieve and process your information or retrieve information from, or transfer the information for assessment to Health & Insurance, [the company] may refuse to consider your application for insurance.

If you withdraw your consent to registration in the Health Register and to possible transfer to member companies at a later application, a consequence might be that your health information cannot be reused, but must be retrieved anew.

If you withdraw your consent, this does not affect the legality of any processing or transfer prior to the withdrawal.

Learn more about the process, etc.
If you would like to know more about the processing of your information and your rights as a registered person, you can read more in the information letter, which you will receive, when [the company] collects your information – or if your information is forwarded to Health & Insurance.

Date: _____ E-mail: _____ Telephone: _____

CPR-no. __ __ __ __ __ __ - __ __ __ __ Signature: _____