



## CURRENCY AND PREMIUM PAYMENT

Please choose currency and premium payment by ticking the relevant boxes.

USD  EUR

Annual  Semi-annual

## REQUEST FOR PAYMENT FROM A BANK ADDRESS (if different from residential address)

Name(s)

Address

Account No. (if bank)

Address

Post Code

City

Country

## REQUEST FOR PAYMENT BY INTERNATIONAL CREDIT CARD

I / We wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

American Express  VISA  Eurocard / MasterCard  JCB  Diners

Card No.

CVC code (except American Express)

Expiry date (m/y)

Cardholder's data if cardholder and policyholder are not the same person:

Cardholder's name

Address

Address

Postal Code

City

Country

I, the undersigned, authorise International Health Insurance danmark a/s, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

**Please note that the Company will need the original, signed form to be able to charge the credit card.**

Cardholder's signature: \_\_\_\_\_

Date: \_\_\_\_\_

IHI *Superior*

by International Health Insurance danmark a/s · 8, Palaegade · DK-1261 Copenhagen K · Denmark

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1. Do you take or have you taken any kind of medicine on a regular basis?  Yes  No

If YES, please state type and daily dosage: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Expense per month: \_\_\_\_\_

2. Have you ever been hospitalised or received treatment for any illness?  Yes  No

If YES, please state name of clinic / doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date(s): \_\_\_\_\_

You can use "further remarks" (question 8) if you have more information.

3. Do you suffer from any side effects or consequences from the above conditions?  Yes  No

If YES, please enclose full details.

4. Do you use spectacles or contact lenses – if so please indicate strength: \_\_\_\_\_

5. For women only: Are you currently pregnant?  Yes  No

6. Name of family doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

7. Do you have additional medical information?  Yes  No

If YES, all relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. Further remarks, if any: \_\_\_\_\_

9. Applicant's signature:

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports.

I, the undersigned, solemnly declare that I and co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have not suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give International Health Insurance danmark a/s permission to seek such information from treating doctors and hospitals concerning my / our state of health as the Company deems necessary. Furthermore, I solemnly declare that I am / we are not under or about to undergo dental treatment, and hereby give the Company permission to seek information from treating dentists concerning my / our dental status or any dental treatment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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