

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 hospital / clinic / doctor.

Address _____

Telephone _____ Fax _____ E-mail _____

Diagnosis _____ Dates _____

(You can use "Further Remarks" (question 8) if you have more info.)

3. Do you suffer from any side effects or consequences of the above conditions? YES NO
If YES, please enclose complete information.

4. Do you use spectacles or contact lenses – if so, please indicate strength _____

5. For women only: Are you currently pregnant? YES NO

6. Family Doctor

Name _____

Address _____

Telephone _____ Fax _____ E-mail _____

7. Do you have additional medical information? YES NO
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 any co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have 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.

If insurance for dental treatment is required: 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 (day/month/year) _____ Signature _____