

IHI GLOBAL 1 • APPLICATION FORM A

(PLEASE USE BLOCK LETTERS)



FOR ADMINISTRATION USE

Ref. _____ Policy Number _____ # _____
 Date _____ - _____

COMMENCEMENT DATE

I / We request that the policy commences from 01 day _____ month _____ year

POLICYHOLDER

First name(s) _____ Date of Birth (day/month/year) _____
 Family name(s) _____ Sex (M/F) _____
 Address _____
 Address _____ Postal Code _____
 City _____ Telephone _____
 Country _____ Fax _____
 e-mail _____ Occupation _____

IBAN NUMBER

If you would like us to transfer future reimbursements to your bank account, please state your IBAN number

DEPENDANT 1

First name(s) _____ Date of Birth (day/month/year) _____
 Family name(s) _____ Sex (M/F) _____

DEPENDANT 2

First name(s) _____ Date of Birth (day/month/year) _____
 Family name(s) _____ Sex (M/F) _____

DEPENDANT 3

First name(s) _____ Date of Birth (day/month/year) _____
 Family name(s) _____ Sex (M/F) _____

DEPENDANT 4

First name(s) _____ Date of Birth (day/month/year) _____
 Family name(s) _____ Sex (M/F) _____

IHI GLOBAL 1 • APPLICATION FORM B

(PLEASE USE BLOCKLETTERS)



A Medical Questionnaire B must be completed for each person. All the Medical Questionnaires should be sent together with the Application Form.

FOR ADMINISTRATION USE

Ref. _____ Policy Number _____ # _____
 Date _____ - _____

APPLICANT (PLEASE UNDERLINE THE NAMES YOU WISH TO BE INDICATED ON YOUR INSURANCE CARD, MAX. 29 FIELDS)

First name(s) _____ Occupation _____

 Family name(s) _____

 Date of birth (day/month/year) _____ Nationality _____ Sex (M/F) _____ Height (cm) _____ Weight (kg) _____

OTHER INSURANCE

Please complete the following if you will continue to have a health insurance with another company:

Company Name _____ Policy Number _____

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? YES NO

If yes, please give details:

MEDICAL HISTORY

If you have or previously had any of the following illnesses / disorders, please tick the appropriate box and provide details. If you have any additional comments, please state details under "Further Remarks" (question 8). All questions must be answered.

- | | |
|---|--|
| a) Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/>
Details _____ | i) Urinary Tract and Kidney Diseases <input type="radio"/>
Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/>
Details _____ |
| b) Migraine <input type="radio"/> Neurological Disorders <input type="radio"/>
Epilepsy <input type="radio"/> NO <input type="radio"/>
Details _____ | j) Rheumatism <input type="radio"/>
Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ |
| c) Mental Illness <input type="radio"/> NO <input type="radio"/>
Details _____ | k) Back Problems <input type="radio"/> NO <input type="radio"/>
Details _____ |
| d) Eye Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ | l) Skin Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ |
| e) Asthma <input type="radio"/> Allergies <input type="radio"/>
Pulmonary Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ | m) Cosmetic Operation <input type="radio"/> NO <input type="radio"/>
Details _____ |
| f) Cardiovascular Diseases <input type="radio"/>
Arterial Hypertension <input type="radio"/> NO <input type="radio"/>
Details _____ | n) Any other diseases, disorders, illness <input type="radio"/> NO <input type="radio"/>
Details _____ |
| g) Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/>
Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ | o) Have you ever had any fertility treatment? <input type="radio"/> NO <input type="radio"/>
Details _____ |
| h) Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/>
Details _____ | p) Have you been tested for HIV-antibodies?
YES <input type="radio"/> NO <input type="radio"/>
If YES, what was the result:
HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/> |

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 information).

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 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 _____