Gouda
En del af Gjensidige

Health declaration - expatriate insurance

To the insurance applicant:

As an insurance applicant, you must fill in and sign this declaration. It is necessary that you answer each question.

Our assessment is undertaken on the basis of the information submitted by you, so it is important that the information is precise and correct. If information is withheld, or incorrect answers are given which could have an influence on Gouda's assessment in connection with the taking out of insurance, the compensation may be reduced or cancelled entirely in accordance with the Danish Insurance Contracts Act. At the same time, the insurance coverage may be reviewed.

Please complete this form in block letters.

1. Insurance applicant

Name:	Nationality:
E-mail:	CPR no. / Date of birth:
Country of expatriation:	Company name:

2. Medical history

Do you suffer from, or have you ever suffered from, had symptoms of, been examined for or been treated for any of the following ailments, or anything related to them? Consider the examples as help – they do not cover all conditions. Any other symptoms or ailments must also be stated, and a clarification and further details should be written on the last page.

If your state of health changes after you have submitted your health information and before the insurance takes effect, you are required to notify Gouda of this immediately for an assessment of the new information.

A. Diseases of the digestive system and metabolism
Peptic ulcers or stomach catarrh, stomach acid-related disorders, bleeding (blood in vomit or faeces). Inflammatory intestinal diseases, diarrhoea or constipation. Hepatic, biliary or pancreatic diseases, jaundice, haemorrhoids or anal fissures, obesity (BMI>30), hernia, diabetes. Functional bowel disorders. Other disorders of the stomach or intestines.

☐ Yes ☐ No

B. Cardiac and circulatory diseases
Blood clots, pain/tightness in the chest, high blood pressure, varicose veins, phlebitis, swollen ankles, heart rhythm disorders, pacemaker, elevated cholesterol. Other cardiovascular disorders.

☐ Yes ☐ No

C. Respiratory diseases, allergies and hay fever
COPD, bronchitis, asthma, shortness of breath, emphysema, pneumonia or other respiratory problems. Allergies, hay fever, urticaria. Tuberculosis, malaria, HIV, AIDS or other infectious or parasitic diseases. Other disorders.

☐ Yes ☐ No

D. Skin diseases
Psoriasis, acne, bothersome blemishes, moles, or the like, eczema or rashes. Disorders of the scalp and face. Infections. Other skin disorders.

☐ Yes ☐ No

E. Blood and lymphoid diseases, diseases of the endocrine glands
Anaemia, diseases of the blood-forming organs, spleen or lymphatic system. Endocrine disorders. Other disorders.

☐ Yes ☐ No

F. Urinary tract diseases and gynaecological disorders
Prostate disorders, urinary stones, incontinence or urinary retention, infections, other diseases of the urinary tract or genitals. Menstrual disorders, symptoms due to menopause. Diseases of the female genitals/endocrine disorders or hormonal therapy. Problems with previous pregnancies/ childbirth. Also state if you are pregnant or have reason to believe you might be, for example because of missed periods.

☐ Yes ☐ No

2. Medical history (continued)

G. Cancer, other tumours/growths, immune system-related disorders
Any type of cancer or cancer precursor/suspected cancer. Polyps in the bowel, benign tumours/growths.

☐ Yes ☐ No

H. Diseases of the muscles, bones, joints or connective tissues
All rheumatic diseases, including incipient osteoarthritis. Injuries to the bones, muscles, joints or ligaments. Artificial joints and ligaments, osteoporosis. Slipped disc, degeneration or inflammation. Other disorders of the muscles/bones/joints or connective tissues.

☐ Yes ☐ No

I. Eye, ear, nose, throat and dental diseases
Visual impairment, myopia greater than -6, retinal detachment, glaucoma, cataracts or other eye disorders. Long-lasting or repeated ear infections, fluid in the middle ear, sinusitis, or other disorders of the ear/nose/throat. Ear tube insertion. Dental infections, gingivitis, problems with wisdom teeth or tooth misalignment requiring treatment. Dental diseases.

☐ Yes ☐ No

J. Neurological disorders
Epilepsy, migraine and headache disorders, multiple sclerosis, stroke, alcohol-related disorders, dementia, brain injury, infections and genetic diseases, Parkinson's disease, chronic pain and other neurological disorders.

☐ Yes ☐ No

K. Psychiatric and behavioural disorders
Nervousness, anxiety, psychosis, depression, mania, insomnia, or disorders related to addiction to alcohol or drugs, or other addictions. Dementia. Developmental and behavioural disorders, compulsive behaviours (ADHD, OCD, etc.). Eating disorders. Other psychiatric disorders and symptoms.

☐ Yes ☐ No

L. Other diseases and symptoms that do not fall under the above

☐ Yes ☐ No

M. Your current state of health
Have you within the past six months experienced signs or symptoms of illnesses or health conditions, irrespective of whether you have consulted a doctor or other health professional in this connection?

☐ Yes ☐ No

N. Medicine
Do you use, or have you used, prescribed medicine/alternative medicine? This includes sedatives, blood pressure medications, etc.

☐ Yes ☐ No

O. Other support/compensation
Have you applied for or received public benefits or compensation, pension or the like, due to illness or injury?

☐ Yes ☐ No

If yes: What benefits?	When?	Why?

P. Alcohol
Do you currently, or have you at any time for a period of more than six months, consumed more than 21 units of alcohol (men)/14 units of alcohol (women) per week?

☐ Yes ☐ No

If yes: When?

Q. What is your height and weight?	Height:	Weight:

R. Pregnancy
Are you pregnant?

☐ Yes ☐ No Yes, due date:

3. Consent and signature

If Gouda Rejseforsikring requires additional information in the form of copies of or excerpts from relevant records, the insurance applicant must provide this on request. If you are already in possession of this material, it may be enclosed.

I hereby consent to Gouda Rejseforsikring obtaining all relevant information, including disease information and information about my health, including contact with the health care system, information on social conditions, etc.

The information may be obtained from GPs, hospitals or other relevant parts of the health system, public authorities, including municipal bodies, the National Board of Industrial Injuries, the police, and other insurance companies and pension funds. The information obtained may be disclosed to other insurance companies, pension funds, the National Board of Industrial Injuries and other authorised healthcare professionals who are involved in my case.

This consent applies only to information that exists prior to the time at which Gouda Rejseforsikring grants the requested insurance cover, if it does so.

A copy of this consent must be given to the doctor, municipality, etc., from whom Gouda Rejseforsikring requests information.

Signature of insurance applicant:	Date:

4. Additional information

If you have answered 'yes' to any of the questions on your state of health, this part must also be completed.
Point: Please specify as precisely as possible the name of the disease or health problem. If there is insufficient space, please use a separate description or enclose relevant records.
When did the symptoms commence, and when was the treatment completed?
What treatment did you receive, and when did you receive it? (Specify dates and the name and type of any medications)
What was the outcome of the therapy (e.g. ongoing treatment, complete recovery, recurrent disease or a likelihood of relapse)?
Point: Please specify as precisely as possible the name of the disease or health problem. If there is insufficient space, please use a separate description or enclose relevant records.
When did the symptoms commence, and when was the treatment completed?
What treatment did you receive, and when did you receive it? (Specify dates and the name and type of any medications)
What was the outcome of the therapy (e.g. ongoing treatment, complete recovery, recurrent disease or a likelihood of relapse)?
Point: Please specify as precisely as possible the name of the disease or health problem. If there is insufficient space, please use a separate description or enclose relevant records.
When did the symptoms commence, and when was the treatment completed?
What treatment did you receive, and when did you receive it? (Specify dates and the name and type of any medications)
What was the outcome of the therapy (e.g. ongoing treatment, complete recovery, recurrent disease or a likelihood of relapse)?

5. Own doctor/doctor providing treatment

Name:	
Address:	
Telephone:	E-mail:

A.C. Meyers Vænge 9 • DK-2450 Copenhagen SV • CVR no. DK 33 25 92 47 • Tel.: (+45) 88 20 88 20 • Fax: (+45) 88 20 88 21
E-mail: gouda@gouda.dk • web: gouda.dk • CVR no. DK 33 25 92 47
Part of the Gjensidige Group • Danish branch of Gjensidige Forsikring ASA, Norway • org. no. 995 568 217