



Health Declaration

Life Insurance, Certain Critical Illnesses and Disability Insurance

Full name:		Personal ID:
Address:		Telephone:
Postal Code:	City/Town:	
Occupation:	Email:	

When writing the health certificate, it is important that:

- you answer all questions carefully without omitting anything – e.g., issues such as back problems, psychological issues, and use of drugs and alcohol – even if it does not seem relevant for the insurance.
- you are responsible for ensuring that the description is correct.
- incomplete or inaccurate information may result in no compensation in the event of an insurance claim.
- you are not obligated to provide information about genetic tests, i.e., tests that describe your genes (hereditary factors) and future disease risks.

1 In the 10 years, have you had:

If yes:

Which illness, where/who treated you, and what treatment was provided?

Heart illness/blood vessels?	No ☐ Yes ☐	_____
High blood pressure?	No ☐ Yes ☐	_____
Stroke (apoplexy)	No ☐ Yes ☐	_____
Nervous system diseases, including epilepsy, memory problems, paralysis?	No ☐ Yes ☐	_____
Cancer, tumors, or other malignant diseases?	No ☐ Yes ☐	_____
Diabetes?	No ☐ Yes ☐	_____
Kidney disease or urinary tract disease?	No ☐ Yes ☐	_____
Liver disease?	No ☐ Yes ☐	_____
Asthma/bronchitis or other respiratory diseases?	No ☐ Yes ☐	_____
Mental illness?	No ☐ Yes ☐	_____



2 Have you now or in the last 10 years had illnesses or problems (pain or discomfort) from the neck, back, or lower back, including disc herniation, lumbago, whiplash, muscle tension, etc.? No ☐ Yes ☐ If yes: Which? _____

When last?(month/year) _____

Who treated you? _____
Name and address _____

3 Have you now or in the last 10 years had illnesses or problems (pain or discomfort) from shoulders, arms, elbows, hands, hips, knees, or feet, including joint and rheumatic diseases? No ☐ Yes ☐ If yes: Which? _____

When last?(month/year) _____

Who treated you? _____
Name and address _____

4 In the last 3 years, have you been examined or treated by a doctor, chiropractor, physiotherapist, had tests done in a lab, or been hospitalized or admitted to a day clinic? No ☐ Yes ☐ If yes: For what: _____

When? _____

Where? _____

For how long? _____

(Including overuse of alcohol and drugs, etc.) Possible consequences? _____

5 Are you currently on a waiting list for examinations, treatment, or hospitalization? No ☐ Yes ☐ If yes: Where/which facility? _____

For what? _____

6 a. Have you had congenital physical defects or consequences (injuries) after an accident? No ☐ Yes ☐ If yes: What/Which? _____

b. Hevur tú niðursetta hoyrn? No ☐ Yes ☐ What is the cause? _____

c. Sært tú illa? No ☐ Yes ☐ What is the cause? _____

Glasses/contact lens strength: Right: +/- _____ Left: +/- _____

7 a. Are you using any medication prescribed by a doctor or other practitioner? No ☐ Yes ☐ If yes: Which meds? _____

For what? _____

b. In the last 10 years, have you undergone medical treatment for more than 1 month, including sedatives or painkillers? No ☐ Yes ☐ Which meds? _____

When? _____

For what? _____



8 a. Do you drink wine, spirits, or alcohol?

No ☐ Yes ☐

If yes:

Average _____ units per week

b. In the last 10 years, have you had increased consumption of beer, wine, spirits, or alcohol?

No ☐ Yes ☐

Average _____ units per week

Which time period?(month/year) _____

c. Do you or have you received treatment for this?

No ☐ Yes ☐

If yes:

Which treatment and where? _____

Which time period?(month/year) _____

d. Smoking?

No ☐ Yes ☐

How much every day? _____

number of cigarettes/cigars/pipes

e. d. Do you or have you used "hard drugs" (e.g. heroin, speed, cocaine, ecstasy, LSD), cannabis, anabolic steroids, organic solvents, or other stimulants?

No ☐ Yes ☐

Which drugs? _____

In which periods?(month/year) _____

f. Have you received treatment or counselling?

No ☐ Yes ☐

What treatment and where? _____

In which periods?(month/year) _____

9 In the last 10 years, have you been sick or incapacitated for more than 1 month?

No ☐ Yes ☐

If yes:

What was the reason? _____

When?(month/year) _____

For how long? _____

Are there any consequences? _____

10 a. Are you completely healthy? Yes ☐ No ☐

If no:

What is the reason? _____

b. Are you fully capable of working?

Yes ☐ No ☐

What is the reason? _____

11 a. Are you undergoing vocational training or in an adapted job?

No ☐ Yes ☐

If yes:

What is the reason? _____

When?(month/year) _____

b. Are you receiving or applying for disability or retirement benefits from the public due to your health?

No ☐ Yes ☐

What is the reason? _____

When?(month/year) _____

12 How tall are you and what do you weigh?

Height _____ cm

Weight _____ kg



Who is your doctor? (write the name and address of the doctor)

If you have additional comments, you can write them here. Remember to specify which question (number) they relate to.

If you need more space, you can write on an extra sheet. Remember to date and sign the supplement.

I understand that the insurance may be reduced or voided according to the provisions of the insurance contract law if the health information provided is not true or if any information has been omitted.

Regarding the collection and disclosure of information, please refer to the specific consent form (FP 601)

(Date&Place)

(Signature)

To be filled out by LÍV:

Lív-útekning:

☐

Góðkend

☐

Ikki góðkend

Viðgj. á læknafund

Dagfesting:

Forbókstavir
+stempul:

Treytir: