TRYGGINGARFELAGIÐ LÍV
Postboks 206
Kopargøta 1
FO-110 Tórshavn
Tel. 31 11 11
liv@liv.fo
www.liv.fo

Health Declaration

Life Insurance

Full name: | Personal ID:
Adress: | 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 Have you had any serious illness in the last 3 years?

No ☐ Yes ☐

If yes:
What illness? ____________

When? ____________

For how long? ____________

2 Have you been examined or treated by a doctor, psychologist, psychiatrist, chiropractor, physiotherapist, had tests done in a lab, or been hospitalized or admitted to a day clinic in the last 3 years?

(Including overuse of alcohol and drugs, etc.)

No ☐ Yes ☐

If yes:
For what: ____________

When? ____________

Where? ____________

For how long? ____________

Possible consequences? ____________

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3 **a. Are you going undergoing vocational training or in an adapted job?** No ☐ Yes ☐

If yes:
What was the cause? ______________________

When?(month/year) ______________________

b. Are you receiving public or applying for disability or retirement benefits due to your health? No ☐ Yes ☐

What is the cause? ______________________

When?(month/year) ______________________

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4 **Have you been sick or incapacitated for more than 1 month in the last 10 years?** No ☐ Yes ☐

If yes:
What is the cause? ______________________

When?(month/year) ______________________

For how long? ______________________

Any consequences/aftereffects? ______________________

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5 **a. Are you completely healty?** Yes ☐ No ☐

If no:
What is the cause? ______________________

____

b. Are you fully capable of working? Yes ☐ No ☐

What is the cause? ______________________

____

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

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.

______________________ ______________________

(Date & Place) (Signature)

To be filled out by LÍV:

Lív-átekning:	☐ Góðkend	☐ Ikki góðkend	Viðgj. á læknafundi
Dagfesting:	Forbókstavir +stempul:	Treytir:	