SJÓVÁ

Þú tryggir ekki eftir á!

Sjóvá-Almennar tryggingar hf. | Sjóvá-Almennar líftryggingar hf.
Kringlunni 5, 103 Reykjavík | Telephone 440 2000 Fax: 440 2020 | sjova.is

☐ New policy
☐ Modification
☐ Short term policy

☐ 24 hour policy
☐ Spare time only
☐ Sports
☐ Work only
☐ Other

Policy no.	
Branch office	Agent

☐ AR ☐ BT ☐ IM

Accident Insurance

Name of insured | ID No. | Email

Home phone | Work phone | Mobile phone

Address | Postcode | Town

The policy holder (if other than the insured): | ID No. | Email

Work phone | Mobile phone

Address | Postcode | Town

I. Occupation and Special Risks

1. Principal occupation? _____

Other jobs? ☐ No ☐ Yes If yes, What are they? _____

Requesting Sjóvá for insurance for the other jobs?. . . . . ☐ No ☐ Yes

2. Any special risks connected with your work/leisure time, such as mountain climbing abroad, private aviation, glider flight, hang-gliding, skydiving, diving, motor sports or other such activities?. . . . . ☐ No ☐ Yes

If yes, what are they? (fill out a special form) _____ Request for insurance ☐ No ☐ Yes

3. Do you intend to reside abroad for a period longer than six months during the next three years ?. . . . . ☐ No ☐ Yes

If yes, please specify the country and length of stay: _____

Any changes in the insured person´s work/occupation or state of health that affects the risk of Sjóvá hf. must be reported to Sjóvá.

II. Insured Sum

1. **Death benefit** caused by accident ISK _____

☐ Lawful holder not nominated

This designation means that the spouse of the insured is the beneficiary of the insurance sum. If the spouse is not alive, the children of the insured are the beneficiaries; if the children are not alive, then the insured's legal heirs will be considered the beneficiaries. (Please note that the term "spouse" means that the individual is in a formal marriage and is not cohabiting).

☐ Registration of the designated beneficiaries

Name _____ ID No. _____

2. For 100% disability caused by accident ISK _____

3. Payment for accident per week ISK _____ Average wages the last 12 months? _____

3.1. Payment waiting period ☐ 4 ☐ 8 ☐ 12 ☐ 26 ☐ 52 weeks

3.2. For how many years do you want payments for accident (waiting period deducted) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 year

III. State of Health Report

1. Height_____ cm Weight _____kg
2. Have you suffered from any physical injuries, accidents or poisoning that have required or may require medical tests, operations or treatments. . . . . ☐ No ☐ Yes

   If yes, what are the injures and when did it happen?_____
3. Were there any permanent consequence´s /disability?. . . . . ☐ No ☐ Yes

   If yes, please provide full details _____ % disability _____
4. Do you have government classification as a disabled person or are you awaiting the result of a disability evaluation?. . . . . ☐ No ☐ Yes

   If yes, on what reason? _____ % disability _____
5. Do you currently suffer or have you ever suffered from discus prolapsus (slipped disk), lumbago, neck pain, fibrositis or other back problems, or symptoms. . . . . ☐ No ☐ Yes

   If yes, when? _____For how long? _____

   If there were permanent consequences, please provide full details _____
6. Do you suffer from any physical complications (including impaired hearing/sight)?. . . . . ☐ No ☐ Yes

   If yes, please clarify _____
7. Are you currently taking or have you taken prescription medicine/drugs?. . . . . ☐ No ☐ Yes

   If yes, what medicine? _____ At what dosage? _____

   Reason for intake? _____ when/period?_____
8. Are you currently, and have you been for the last years, in perfectly good health and able to work?. . . . . ☐ No ☐ Yes

   If not, why? _____
9. Have you visited a medical doctor or a medical facility during the last three years for reasons other than a brief illness? . . . . . ☐ No ☐ Yes

   If yes, explain why and when, and give the name and address of the doctor _____

   _____
10. Name and address of family doctor: _____

IV. Information Regarding Other Insurances

1. Do you presently have life, accident and/or health insurance, general accident insurance, disability income insurance or comparable insurance?. . . . . ☐ No ☐ Yes

   If yes, type of insurance and with what company or companies? _____

   _____
2. has any insurance company ever declined or postponed your application for personal insurance or demanded an extra premium?. . . . . ☐ No ☐ Yes

   If yes, please provide full details _____

   _____

   _____

VI. Insurance Period

Accident insurance effective date:

☐ Immediately – as soon as the application has been approved by Sjóvá

☐ Later – effective date. _____

☐ Resignation to _____ enclosed

If insurance is taken for short term, please state expires date _____

VII. Declaration and Signature of Applicant

The company's purpose in obtaining information on risks.

The information provided by the applicant in this application will be used for company risk assessment. Company employees will evaluate this information, assessing whether additional information on the applicant's previous health is needed from physicians, medical institutions, or others possessing such information, or whether a medical examination is required to allow for the possibility of arriving at a final decision on granting the policy to the applicant. Such information is provided to the company and its consulting physician. If additional information is needed on health, no position will be taken on the application until that information is available. The information may lead to the insurance being issued with a special surcharge on the premium or with a specified latency period before the insurance takes effect or to specified risks being excepted from the insurance or to the insurance being denied.

The provisions of Act No. 77/2000, on the Protection of Privacy as Regards the Processing of Personal Data, are observed during any processing of personal information. The consulting physician and company staff dealing with the information are bound to secrecy and lifelong confidentiality on anything contained in the information.

Statement by the applicant, and her/his consent to medical data being acquired from others.

I, the undersigned, hereby declare that I have myself answered all of the questions in this application, and I hereby confirm that my answers are, in accordance with the best of my knowledge, correct and in correspondence with the truth, and that no items have been left out which might matter for the company's risk assessment regarding this insurance. I have filled out this application in my own hand and realise that false or insufficient information about my health may cause a loss of compensation rights, in part or in whole, and that paid premiums will be unrecoverable. Moreover, the purpose of providing the information in this application or from others is clear to me, so that together with the insurance terms it becomes the basis of agreement between me and Sjóvá-Almennar tryggingar hf. It is clear to me that this insurance does not cover previous illnesses or accidents, or their effects.

I CONSENT TO INFORMATION PROCESSING BEING CONDUCTED IN THE MANNER DESCRIBED ABOVE, AND REALISE THE PURPOSE OF SUCH PROCESSING. IN ADDITION, I GRANT MY PERMISSION TO PHYSICIANS, MEDICAL INSTITUTIONS AND OTHERS POSSESSING INFORMATION ON MY HEALTH TO PROVIDE THE COMPANY AND ITS CONSULTING PHYSICIAN WITH ANY SUCH INFORMATION AS MAY BE NECESSARY FOR DECISIONS ABOUT ISSUING THIS INSURANCE AND FOR THE NECESSARY ASSESSMENT OF COMPENSATION CLAIMS. I have been informed of how privacy protection is guaranteed by the company and that I am allowed to revoke my consent to the processing of this information, if I do so in writing.

Any pledges and arrangements between the advisor and me are to appear on this application form.

I have noted the company terms that are in effect regarding the insurance for which I am herewith applying.

Date _____ Place _____

Signature of the insured _____

Attested by the consultant _____

VIII. To be Filled Out by the Company

Risk category: _____ Date of payment: _____

Special premium: _____ Why? _____

Comments by company/special terms:

_____

_____

_____

Acceptance _____ Date _____