Health declaration Adult

Folksam

To be filled in by the person to be insured
It is important to answer all of the questions.

Group agreement number

Member's/employee's (group member's) name	Personal identity number
Co-insured, spouse or partner's surname, first name	Personal identity number

Are you fully fit to work? **Member** ☐Yes ☐No **Co-insured** ☐Yes ☐No

If you are not fully fit for work at present, you can apply for insurance when you become fully fit

Being fully fit for work means that the person to be insured:
- Can perform normal work without restrictions
- Does not receive nor is entitled to compensation in relation to their own illness, accident and/or disability nor has such compensation pending.

Special qualifications apply to persons receiving subsidised employment ,persons who have been granted leave due to illness in order to seek new work, and persons granted health-related occupation modifications(although this point does not apply to medical care insurance) – see Terms and Conditions.
In student insurance, fully fit to study replaces fully fit to work.

* **Used any health care services** = e.g. received a prescription, been granted sick leave, received medical care, treatment, or been examined at a hospital, health care centre, treatment centre or other care institution, or in any other way contacted a doctor or e.g. a nurse, physiotherapist, chiropractor, naprapath, psychologist or any of the conditions/symptoms/illnesses/disabilities regarding any of the following body parts/organs and/or any of the following conditions.

Have you used any of the above* health care services during the past three years	Group member		Co-insured	
1. Allergy, asthma and/or other respiratory disease?	☐ Yes	☐ No	☐ Yes	☐ No
2. Skin condition/skin disease?	☐ Yes	☐ No	☐ Yes	☐ No
3. Thyroid disorder and/or other metabolic disorder?	☐ Yes	☐ No	☐ Yes	☐ No
4. Eye disease, ear disease, tinnitus?	☐ Yes	☐ No	☐ Yes	☐ No
5. Condition/disease of the back, neck, shoulders, shoulder blades, arms, hips, legs, knees, feet and/or hands?	☐ Yes	☐ No	☐ Yes	☐ No
6. Condition/disease of the muscles and/or joints?	☐ Yes	☐ No	☐ Yes	☐ No
7. Nervous conditions, sleeplessness, stress, burn-out, acute stress reaction and/or mental illness?	☐ Yes	☐ No	☐ Yes	☐ No
8. Condition/disease of the stomach, intestines, gallbladder, pancreas and/or liver?	☐ Yes	☐ No	☐ Yes	☐ No
9. Condition/disease of the urinary tract, kidneys, genital organs and/or prostate?	☐ Yes	☐ No	☐ Yes	☐ No
10. Dietary, tablet or insulin treated diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
11. High blood pressure and/or high lipoprotein levels?	☐ Yes	☐ No	☐ Yes	☐ No
12. Condition/disease of the heart ,coronary vessel or any other part of the body	☐ Yes	☐ No	☐ Yes	☐ No
13. Blood clot/haemorrhage in the brain and/or other blood vessel?	☐ Yes	☐ No	☐ Yes	☐ No
14. Epilepsy, dementia, headache or other neurological symptom or disease?	☐ Yes	☐ No	☐ Yes	☐ No
15. Tumour, lymph node or blood diseases?	☐ Yes	☐ No	☐ Yes	☐ No
16. Any condition, symptom, illness, injury or disability other than those mentioned	☐ Yes	☐ No	☐ Yes	☐ No
17. Have you been on full or partial sick leave for more than 14 consecutive days during the last three years?	☐ Yes	☐ No	☐ Yes	☐ No
If you answered "yes" to any of the questions in 1-17, you will need to provide supplementary information on the back of the form.				
18. Do you smoke?	☐ Yes	☐ No	☐ Yes	☐ No
19. Provide your height and current weight	cm	kg	cm	kg

I confirm that the provided information is complete and truthful. I am aware that incorrect or incomplete in- formation could render the insurance invalid. I am aware that the insurance will only enter into force if the application is complete and the insurance can be granted by Folksam.

Date	Day time telephone (including area code)	Date	Day time telephone (including area code)
Group member's signature		Co-insured's signature	

FL 6010 (FLG-660) 18-06

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Supplementary information to question No.________in the health declaration.

It is important to answer all of the questions.

Refers to ☐ Group member
☐ Co-insured

Please make a copy of this form if you have answered Yes to more than one question

Name	Personal identity number	Group agreement No.
What is your trade or profession and what are your working duties?		

What is the name of the illness/condition? Diagnosis?
Describe the condition/symptoms in your own words:
How often do you have/have you had the condition?
Reason for the condition/symptom (e.g. accident, illness, work-related)?

When did the symptom, illness, injury or handicap first occur? Year: Month:

Have you had a similar condition before? ☐ Yes ☐ No — If the answer is "Yes", when did you have the condition? Year: Month:

What examination(s)/treatment have you had?

Provide the name and complete surgery address, department/clinic of health care services that you used during the past three years.	Cause/diagnosis?	When was the last time you used this health care service? Year Month

Have you had sick leave for the above condition? ☐ Yes ☐ No

If "Yes" provide the dates of sick leave and the diagnosis, as fully as possible.

From	to	Diagnosis:
From	to	Diagnosis:
From	to	Diagnosis:

Do you take or have you taken any medicines for any of the above? ☐ Yes ☐ No

If "Yes" state which. When?

Will there be further check-ups or treatment? ☐ Yes ☐ No

If the answer is" Yes", what kind?

Are you symptom free? ☐ Yes Since when? Year: Month:

☐ No What disability/problems do you still have?

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Date	Signature