



Líftryggingafélag Íslands hf.

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Líftryggingarskírteini nr.
Sjúkdómategyggingarskírteini nr.

Insurance application

Life insurance

Critical illness insurance

Instructions

The insured must always fill out the insurance application himself or herself. Fill out the insurance application as accurately as possible. If you are in any doubt as to whether certain facts are relevant to our assessment of your application, please include them on the form. If you make a mistake when filling out the application, please cross it out, make corrections and put your initials next to the corrections. In section 7 is a field for additional information.

Líftryggingafélag Íslands hf. treats all documents as confidential.

1. Basic Information

1.1 The insured

Name: _____ Id. No: _____

Address: _____ Telephone: _____

Town / Postcode: _____ Email: _____

Occupation: _____ Other occupations: _____

1.2. Payer (if other than the insured)

Name: _____ Id. No: _____

Address: _____ Telephone: _____

Town / Postcode: _____ Email: _____

1.3. Premiums

I hereby wish that all my premiums with VÍS and Lífis will be charged from a credit card

Type of card: _____ Credit card No.

Valid thru Premiums charged: annual payment semi-annual payment

2. LIFE INSURANCE

2.1. Insurance sum being applied for, ISK: _____

2.2. Effective date: Immediately – when application has been approved
 Later – effective date: _____

DESIGNATION OF A BENEFICIARY OF THE SUM INSURED

Only tick one option

2.3. Spouse, in the event of no spouse then heirs according to laws or testamentary heirs

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. Note that the term "spouse" means that the individual is in a formal marriage, not only cohabiting.

2.4. Registration of the designated beneficiaries

e.g. cohabitant or other specified party that should be the designated of the beneficiaries.

Name _____ Id. No: _____ %

Name _____ Id. No: _____ %

Name _____ Id. No: _____ %

Name _____ Id. No: _____ %

2.5. Irrevocable designation of a beneficiary of the sum insured

Name _____ Id. No: _____ %

If the insured does not specify any designate of the beneficiaries then applies para. 2.- 6. of Art. 100 of Act. No 30 of 2004.

3. CRITICAL ILLNESS INSURANCE

3.1. Insurance sum being applied for, ISK: _____

- 3.2. Effective date Immediately – when application has been approved
 Later – effective date: _____
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4. INFORMATION ON OTHER LIFE AND HEALTH INSURANCE

- 4.1. Do you have or have you had a life insurance? Yes If yes, with what insurance company? _____
No Insurance sum, ISK: _____
- Should the old policy be cancelled? No Yes
- Was the policy taken out under normal terms and conditions? No Yes
-

- 4.2. Do you have or have you had a critical illness insurance? Yes If yes, with what insurance company? _____
No Insurance sum, ISK: _____
- Should the old policy be cancelled? No Yes
- Was the policy taken out under normal terms and conditions? No Yes
-

- 4.3. Have you ever applied for life and/or critical illness insurance but your application was postponed or denied? No Yes
- If yes, then why? _____
-

5. SPECIAL RISKS

- 5.1. Special risk is e.g. private aviation, glider flight, hang gliding (etc.), mountain climbing, skydiving, diving, motor sports, or other such activities?
Do you engage in any activities that involves special risks? No Yes If yes, what? _____
- Please specify further in segment 7 as relevant, your experience, where, how often, how high, how deep, etc.
-

6. PERSONAL HEALTH INFORMATION

6.1. Your height _____cm. Your weight _____kg.

- 6.2. Are you currently and have you been for the last three years in perfectly good health and able to work? No Yes
- If no, explain why? _____

-

- 6.3. Are you currently taking any medicine? No Yes
- If yes, what medicine? _____
- Are you in a regular medical attendance or on a special diet? No Yes
- If yes, explain why? _____
-

- 6.4. Do you use or have you used tranquilizing and/or stimulating drugs? No Yes
- If yes, at what dosage each day? _____
- If yes, have you ever sought medical advice because of your use of such drugs? No Yes
- If yes, where and when? _____
-

6.5. Do you smoke or have you ever smoked? No Yes

If yes, since when and what is your daily consumption? _____

If you have given up smoking, when did you quit? _____

Do you use alcohol? No Yes

If yes, at what dosage each month? Beer _____glass (0,5 l) Light wine _____glass Strong wine _____ (30 ml)

Have you ever sought medical advice because of use of alcohol or drugs/narcotics? No Yes

If yes, where and when? _____

Please explain further in section 7, such as about the consumption, rehabilitation, affects on work and any other relevant issues.

6.6. Do you currently suffer or have you ever suffered or sought medical advice because of any of the following disease or symptoms? (please tick "No" or "Yes" to all questions)

	No	Yes		No	Yes
a) Heart or vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	j) Sense organ disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	k) Diagnosis of AIDS following tests, or are you awaiting the results of such tests or do you have reason to believe that you are HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>
c) Stomach or intestinal disease?	<input type="checkbox"/>	<input type="checkbox"/>	l) Other diseases or medical problems?	<input type="checkbox"/>	<input type="checkbox"/>
d) Lung disease or any other symptoms in the respiratory organs, e.g. asthma?	<input type="checkbox"/>	<input type="checkbox"/>	m) Required operation?	<input type="checkbox"/>	<input type="checkbox"/>
e) Kidney or urinary system disease?	<input type="checkbox"/>	<input type="checkbox"/>	n) Had serious accident?	<input type="checkbox"/>	<input type="checkbox"/>
f) Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	o) Government classification as a disabled person? (disablement: %)	<input type="checkbox"/>	<input type="checkbox"/>
g) A disease of the bones, joints or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	p) Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
h) Depression, anxiety or any other mental illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	q) (For women) A disease in breasts or uterus?	<input type="checkbox"/>	<input type="checkbox"/>
i) A disease of the nervous system, e.g. paralysis, multiple sclerosis (MS), motor neurone disease (MND), epilepsy, migraines, spinal cord atrophy, dizziness or tremors?	<input type="checkbox"/>	<input type="checkbox"/>			

If you have answered any of the questions from (a) to (q) in the affirmative, please specify name of disease / description of accident, when you became aware of the disease / when did the accident occur, how long did the symptoms last, was your recovery total or partial, what were the consequences, what medical institution and what doctor attended you?

6.7. Are any of your parents or siblings deceased? No Yes

If yes, state for each the age at death and the cause of death. _____

6.8. Do your parents or siblings suffer or have they suffered from heart or vascular disease, mental illnesses or disease of the nervous system, tuberculosis, cancer, stroke, high blood pressure, kidney disease, diabetes I or II, MS, MND, Parkinson's disease or Alzheimer's? No Yes

If yes, explain further (give the exact medical term for the disease, the type of cancer (if any), and the person's age when the disease was diagnosed: _____

6.9. Name and address of your family doctor: _____
