

Medical Questionnaire B

(Please use block letters)

A Medical Questionnaire must be completed for each person over the age of 10 applying for cover and also for any adopted children and any child under the age of 10 with a pre-existing condition or who is not in good health. A Medical Questionnaire B should be completed for each "paying" child. All the Medical Questionnaires B should be sent to the Company together with the Application Form A and the premium payment.

For administration use

Ref. _____	Policy Number _____	# _____
Date _____	_____ - 2001	

Applicant (Please underline the names you wish to be indicated on your insurance card, max. 29 fields)

First name(s) _____	Occupation _____
Family name(s) _____	
Date of birth (day/month/year) _____	Nationality _____
Age _____ Sex (M/F) _____	Height (cm) _____ Weight (kg) _____ / Height (inches) _____ Weight (pounds) _____

Other insurance

Do you have a health insurance with another company? NO YES

Company Name _____ Policy Number _____

Do you intend to continue being insured with the other company? NO YES

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? NO YES If yes, please enclose complete information.

Medical history

If you have or previously have had any of the following illnesses / disorders, please tick the appropriate box and provide details. If you have any additional comments, please state details under "Further Remarks" (question 8) or use the form Further Remarks C. All questions must be answered.

<p>a) Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>b) Migraine <input type="radio"/> Neurological Disorders <input type="radio"/> NO <input type="radio"/></p> <p>Epilepsy <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>c) Mental Illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>d) Eye Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>e) Asthma <input type="radio"/> Allergies <input type="radio"/> NO <input type="radio"/></p> <p>Pulmonary Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>f) Cardiovascular Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Arterial Hypertension <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>g) Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>h) Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p>	<p>i) Urinary Tract and Kidney Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>j) Rheumatism <input type="radio"/> NO <input type="radio"/></p> <p>Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>k) Back Problems <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>l) Skin Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>m) Cosmetic Operations <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>n) Any other diseases, disorders, illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>o) Have you ever had any fertility treatment? YES <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>p) Have you ever been tested for HIV-antibodies? YES <input type="radio"/> NO <input type="radio"/></p> <p>If YES, what was the result: HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/></p>
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20VEB-42/19.10.2007

_____ - 2 0 0 1

1. Do you take or have you taken any kind of medicine on a regular basis? YES NO

If YES, please state type and daily dosage _____

Diagnosis _____ Expense per month _____

2. Have you ever been hospitalised or received treatment for any illness? YES NO

If YES, please state name of hospital / clinic / doctor. (You can use Further Remarks (question 8) if you have more information)

Name _____

Address _____

Telephone _____ Fax _____

E-mail _____

Diagnosis _____ Dates _____

3. Do you suffer from any side effects or consequences of the above conditions? YES NO

If YES, please enclose complete information.

4. Do you use spectacles or contact lenses - if so please indicate strength _____

5. For women only: are you currently pregnant? YES NO

6. Family Doctor

Name _____

Address _____

Telephone _____ Fax _____

E-mail _____

7. Do you have additional medical information? YES NO

All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. Further remarks, if any: _____

9. Applicant's signature

I hereby accept that International Health Insurance danmark a/s (the Company) will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the application, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. I also accept that all correspondence concerning the insurance will be sent to the person registered as policyholder. The Company may choose to have data processed in or outside the EU.

I, the undersigned, solemnly declare that I and any applicants under the age of 10 are in excellent health and do not, except as disclosed on the application (Application Form A and Medical Questionnaire B), suffer from any recurring illness or physical debility. I hereby give the Company permission to seek any information from treating doctors and hospitals concerning our state of health as the Company deems necessary. I declare that if my or any person to be insured's state of health changes after the application has been signed and before the acceptance of cover by the Company, I will notify the Company of any change immediately.

I declare that I and any persons to be insured have received and read the Policy Conditions and accept that the Policy Conditions together with the policy schedule and the application will represent the insurance contract with the Company if the application is accepted. I also declare that I and any persons to be insured on this policy are not residents of the U.S.

I further declare that, to the best of my knowledge and belief, all information on the application is true. I acknowledge that any misrepresentation or nondisclosure of information requested may result in no coverage or modification of coverage under the policy.

I acknowledge and understand that acceptance of this application by the Company will be made in reliance on the accuracy of the information presented in the application.

A parent or person with legal custody of the child must sign on behalf of any applicant under 18 years of age.

Date (day/month/year)

Name in capital letters

Signature