

IHI SUPERIOR APPLICATION FORM A (Please use block letters) # 2102-000-00

FOR ADMINISTRATION USE

COMMENCEMENT

Ref.: _____ Policy Number: _____ #

I / We request that the policy commences from

Date: _____ - _____

____ day ____ month _____ year

POLICYHOLDER

First name(s)

Date of Birth (day/month/year)

____/____/____

Family name(s)

Sex (M/F)

Address

Postal Code

City

Country

Telephone

Fax

e-mail

DEPENDANT 1

First name(s)

Date of Birth (day/month/year)

____/____/____

Family name(s)

Sex (M/F)

DEPENDANT 2

First name(s)

Date of Birth (day/month/year)

____/____/____

Family name(s)

Sex (M/F)

DEPENDANT 3

First name(s)

Date of Birth (day/month/year)

____/____/____

Family name(s)

Sex (M/F)

CURRENCY AND PREMIUM PAYMENT

Please choose currency and premium payment by ticking the relevant boxes.

USD EUR

Annual Semi-annual

REQUEST FOR PAYMENT FROM A BANK ADDRESS (if different from residential address)

Name(s)

Address

Account No. (if bank)

Address

Post Code

City

Country

REQUEST FOR PAYMENT BY INTERNATIONAL CREDIT CARD

I / We wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

American Express VISA Eurocard / MasterCard JCB Diners

Card No.

Expiry date (m/y)

CVC code (except American Express)

Cardholder's data if cardholder and policyholder are not the same person:

Cardholder's name

Address

Address

Postal Code

City

Country

I, the undersigned, authorise International Health Insurance danmark a/s, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

Please note that the Company will need the original, signed form to be able to charge the credit card.

Cardholder's signature:

Date:

IHI *Superior*

by International Health Insurance danmark a/s · 8, Palaegade · DK-1261 Copenhagen K · Denmark
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IHI SUPERIOR MEDICAL QUESTIONNAIRE B

#2102-000-00

(Please use block letters)

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

FOR ADMINISTRATION USE

Ref.: _____ Policy Number: _____ #

Date: _____ - _____

APPLICANT

First name(s) _____

Date of Birth (day/month/year) _____

Sex (M/F) _____

Family name(s) _____

Height (cm) _____

Weight (kg) _____

Occupation _____

Nationality _____

OTHER HEALTH INSURANCE

Please complete the following if you will continue to have a health insurance with another company:

Company Name _____

Policy Number _____

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?

Yes No If yes, please give details: _____

MEDICAL HISTORY - If you have or previously had any of the following illnesses/disorders, please tick the appropriate box.

If you have any additional comments, please state details under "Further Remarks" (question 8). All questions must be answered.

a) Tumours: <input type="radio"/> Benign <input type="radio"/> Malignant <input type="radio"/> No
b) <input type="radio"/> Migraine <input type="radio"/> Epilepsy <input type="radio"/> Neurological Disorders <input type="radio"/> No
c) <input type="radio"/> Mental Illness <input type="radio"/> No
d) <input type="radio"/> Eye Diseases <input type="radio"/> No
e) <input type="radio"/> Asthma <input type="radio"/> Allergies <input type="radio"/> Pulmonary Diseases <input type="radio"/> No
f) <input type="radio"/> Cardiovascular Diseases <input type="radio"/> Arterial Hypertension <input type="radio"/> No

g) <input type="radio"/> Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/> Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> No
h) <input type="radio"/> Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> No
i) <input type="radio"/> Urinary Tract and Kidney Diseases <input type="radio"/> Diseases of the Sexual Organs <input type="radio"/> No
j) <input type="radio"/> Rheumatism <input type="radio"/> Muscle, Joint or Bone Diseases <input type="radio"/> No
k) <input type="radio"/> Back Problems <input type="radio"/> No
l) <input type="radio"/> Skin Diseases <input type="radio"/> No

m) <input type="radio"/> Cosmetic Operation <input type="radio"/> No
n) Any other: <input type="radio"/> Diseases <input type="radio"/> Disorders <input type="radio"/> Illness <input type="radio"/> No
o) Have you ever had any fertility treatment? <input type="radio"/> Yes <input type="radio"/> No
p) Have you been tested for HIV-antibodies? <input type="radio"/> Yes <input type="radio"/> No If YES, what was the result: <input type="radio"/> HIV-Positive <input type="radio"/> HIV-Negative

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 clinic / doctor: _____

Address: _____

Telephone: _____ Fax: _____ e-mail: _____

Diagnosis: _____ Dates: _____

You can use "further remarks" (question 8) if you have more information.

3. Do you suffer from any side effects or consequences from the above conditions? Yes No

If, YES, please enclose full details.

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's name: _____

Address: _____

Telephone: _____ Fax: _____ e-mail: _____

7. Do you have additional medical information? Yes No

If yes, 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:

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports. I, the undersigned, solemnly declare that I and co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have not suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give International Health Insurance danmark a/s permission to seek such information from treating doctors and hospitals concerning my / our state of health as the Company deems necessary. Furthermore, I solemnly declare that I am / we are not under or about to undergo dental treatment, and hereby give the Company permission to seek information from treating dentists concerning my / our dental status or any dental treatment.

Date: _____ Signature: _____

IHI *Superior*

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