Name _____ Date of birth/CPR no _____

Address _____ Postal code / City/Town _____

Occupation _____

To the applicant:

- Contact your doctor (GP) or medical specialist to have this certificate filled out. Remember to inform your doctor that the purpose of your appointment is to fill in a Health Certificate/FP100.
- Read the answers and sign the certificate to confirm that all health issues are included. You are responsible for making sure the certificate is answered correctly.
- According to the Danish Insurance Contract Act, the insurance may be cancelled or the coverage reduced if the information is incomplete or incorrect, or if information has been withheld.

To the doctor:

- Please answer the questions in the certificate's section II for a period of 10 years prior to this date.
- The certificate is a general health certificate, and all questions must be answered.
- When you complete the form, the insurance company would like you to focus specifically on _____

Part I: Doctor's information

		NO	YES	
1	a. Are you the doctor normally used by the applicant?	☐	☐	If **YES**, fill in the following _____
	b. Do you know the applicant?	☐	☐	If **YES**, since when? (month/year) _____
				If **NO**, how did you determine the identity of the applicant? _____

Part II: Doctor's questions to applicants with patient records

1. Question the patient about previous and current illnesses, examinations, treatments, use of drugs/medicine, alcohol, tobacco and stimulants. Please enclose relevant patient records such as doctor's notes, discharge letters and laboratory results.
2. Note that the following information may not be disclosed to the insurance company/pension fund:
   - Information on the health condition of other people, for example relatives.
   - Information on the result of genetic tests that have been carried out to clarify the patient's risk of developing certain dis-eases in the future (predictive genetic testing).
   - Information on participation in, and results of preventive examinations. However, the results of such examinations may be supplied, if they indicate current disease, or pertain to diseases that the patient has had, or which are in outbreak.
3. Please be aware of the consequences for the patient, if the information supplied is incomplete; cf. Danish In-surance Contract Act (see above).

		NO	YES	
1	**Does the applicant have - or has the applicant had within the past 10 years:** a. Infectious diseases, (except ordinary colds), e.g. meningitis, rheumatic fever, tropical diseases, malaria, HIV/AIDS? Please enclose supplementary patient records including results of paraclinical tests.	☐	☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.

Velliv / Lautrupvang 10 / 2750 Ballerup
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Name _____ Date of birth/CPR no. _____

	b. Tumors (benign and malignant tumors), e.g. cancer, including precancerous lesion, (dysplasia) leukemia and lymphoma, polyps, cysts and/or other benign tumors? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	c. Diseases of the blood, e.g. anemia, bone marrow diseases, coagulation and immunological diseases and diseases of the spleen? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	d. Metabolic disorders, e.g. diabetes (including hyperglycemia), goiter or metabolic irregularities and high blood cholesterol? NB: For endocrine disorders (including dyslipidemia), please state control values and treatment, if any. Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	e. Mental conditions, e.g. depression, nervousness, anxiety, stress, crisis reaction etc.? Has the patient had suicidal tendencies or been subject to poisoning incidents? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐ NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	f. Diseases of the nervous system (including eye or ear diseases), e.g. headache or migraine, vertigo/dizziness, epilepsy, fainting or cramps, paralyses or musculoskeletal disorders, cerebral hemorrhage, blood clots, sensory disturbances including multiple sclerosis (MS)? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.

Velliv / Lautrupvang 10 / 2750 Ballerup
Telefon: 70 33 99 99 / kontakt@velliv.dk / www.velliv.dk / Velliv, Pension & Livsforsikring A/S, CVR-nr. 24260577

Name

Date of birth/CPR no.

	g. Heart, circulatory or cardiovascular diseases, e.g. hypertension, chest pain (angina pectoris), palpitation or irregular heart rhythm, blood clot, heart or heart valve disease, varicose veins or phlebitis, blood clots in legs, claudicatio intermittens? NB: In case of hypertension, please state initial blood pressure, present treatment and duration of treatment. Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	h. Lung or respiratory diseases, e.g. asthma, hay fever or allergy, bronchitis, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, blood clot in the lungs, lung infections, silicosis, emphysema and sarcoidosis? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	i. Diseases of the digestive system (stomach, intestines, liver, gall bladder and pancreas), e.g. ulcer (ulcus) or hemorrhages, gastritis, esophagus discomfort or reflux, indigestion (irritable bowel syndrome, celiac disease or allergy), colitis, inflammation of the large or small intestine, intestinal malrotation, polyps, jaundice or hepatitis, gallstones, fatty liver (steatosis), abnormal liver count (in blood tests), pancreatitis? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	j. Skin diseases, e.g. eczema (including allergy), skin cancer, psoriasis, infections (including abscesses), blisters and venereal diseases? Please enclose supplementary patient records including results of paraclinical tests.	NO ☐ YES ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.

Velliv / Lautrupvang 10 / 2750 Ballerup
Telefon: 70 33 99 99 / kontakt@velliv.dk / www.velliv.dk / Velliv, Pension & Livsforsikring A/S, CVR-nr. 24260577

Name

Date of birth/CPR no.

	k. Diseases in, or discomfort from neck, back or lumbar area, e.g. infiltration, sciatica, herniated disc, lumbago, whiplash, diseases of the spine, scoliosis? Please enclose supplementary patient records including results of paraclinical tests.	**NO** ☐ **YES** ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	l. Diseases of the joints, sinews, bones or connective tissue, e.g. sinew or ligament injuries, osteoarthritis, arthritis/ rheumatism, fibromyalgia, osteoporosis, hypermobility or symphysis pubis dysfunction? Please enclose supplementary patient records including results of paraclinical tests.	**NO** ☐ **YES** ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	m. Kidney or urinary diseases and gynecological diseases, e.g. nephritis, cystitis, kidney or bladder stone; blood, protein or bacteria in the urine, removal of kidney, deformities or cysts, gynecological problems and male urinary problems (including enlarged prostate)? Please enclose supplementary patient records including results of paraclinical tests.	**NO** ☐ **YES** ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.
	n. Other diseases than the above mentioned, apart from uncomplicated childhood diseases, ordinary short-term and non-recurring infectious diseases and uncomplicated cosmetic treatments? Please enclose supplementary patient records including results of paraclinical tests.	**NO** ☐ **YES** ☐	**Please state:** Diagnosis, onset of symptoms, time of diagnosis, progress and current symptoms.

Velliv / Lautrupvang 10 / 2750 Ballerup
Telefon: 70 33 99 99 / kontakt@velliv.dk / www.velliv.dk / Velliv, Pension & Livsforsikring A/S, CVR-nr. 24260577

Name

Date of birth/CPR no.

2	**Has the applicant been injured within the past 10 years?** **If YES, are there complications?** Please enclose supplementary patient records, including results of paraclinical tests.	**NO** ☐ **YES** ☐ ☐ ☐	If **YES,** when? (month/year) What was the nature of the injury? If **YES**, which symptoms? Degree of permanent injury (if any)?
3	**Within the past 10 years, has the applicant been ill or unable to work for a longer period (more than a month?)**	**NO** **YES** ☐ ☐	If **YES.** For which periods? (month/year) For what reason?
4	**Apart from the above, has the applicant re-ceived long-term medical treatment (more than a month) or received recurring medical treatment, including tranquilizers and painkillers, within the past 10 years?**	**NO** **YES** ☐ ☐	If **YES.** For which periods? (month/year) For what reason? Currently? **NO** ☐ **YES** ☐
5	**Within the past 10 years, has the applicant used - or does the applicant use narcotic drugs (e.g. heroin, speed, cocaine, ecstasy, LSD), cannabis, organic solvents, anabolic drugs or other stimulating or tranquilizing substances?**	**NO** **YES** ☐ ☐	If **YES.** During which periods? (month/year) Currently? **NO** ☐ **YES** ☐ Which drugs/substances? Any complications? **NO** ☐ **YES** ☐ If, **YES** which?
6	**a. Does the applicant drink beer, wine, fortified wine or liquor?**	**NO** ☐ **YES** ☐	If **YES.** Average number of units per week?
	b. Within the past 10 years, has the applicant had a higher consumption of beer, wine, fortified wine or liquor?	**NO** **YES** ☐ ☐	If **YES.** Average number of units per week? During which periods? (month/year)

Velliv / Lautrupvang 10 / 2750 Ballerup
Telefon: 70 33 99 99 / kontakt@velliv.dk / www.velliv.dk / Velliv, Pension & Livsforsikring A/S, CVR-nr. 24260577

Name _____ Date of birth/CPR no. _____

	c. Within the past 10 years, has the applicant received treatment or counselling for excessive consumption of beer, wine, fortified wine or liquor?	**NO** ☐ **YES** ☐	If **YES.** During which periods? (month/year) _____ Currently? **NO** ☐ **YES** ☐ What kind of treatment/counselling? _____ What was the effect of the treatment/counselling? _____
7	**a. Does the applicant smoke?**	**NO** ☐ **YES** ☐	If **YES.** Daily consumption? (number of cigarettes, cigars, pibes) _____
	b. Has the applicant been smoking in the past 10 years?	**NO** ☐ **YES** ☐	If **YES.** During which periods? (month/year) _____ Daily consumption? (number of cigarettes, cigars, pibes). _____

I have reviewed the answers, and I hereby declare the above information to be true and accurate and with no information withheld. I am aware that the insurance may be cancelled or coverage reduced, if the information is incomplete, wrong or if information has been withheld.

Date _____ Signature of the applicant _____ Date of birth/CPR no. _____

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Name _____ Date of birth/CPR no. _____

Part III: Doctor's examination

1 **Applicant's height and weight.**

Height (without shoes): _____ cm

Weight (without outerwear): _____ kg

2

Any abnormality of:	**NO**	**YES**	If **YES**, complete the following:
a. Head, oral cavity, pharynx, throat?	☐	☐	_____
b. Eyes, including eyesight with best correction?	☐	☐	Visual acuity (w/correction) right. _____ left. _____
c. Ears, including hearing with best correction? Hearing can be measured by whispering and speaking at a distance of 4 m.	☐	☐	Hearing (w/correction): _____
d. Chest, including deformities and mobility?	☐	☐	
e. Lungs, including stethoscopy? For lung disease including asthma and bronchitis symptoms, please perform 3 peak flow measurements (possibly a spirometry).	☐	☐	Peak flow measurements by lung disease: Measurement 1: Measurement 2: Measurement 3:
f. Heart and blood vessels, including stethoscopy, pulse and blood pressure? Three different measurements are required at an interval of at least 1 minute, after the applicant has rested for at least 5 minutes.	☐	☐	Pulse: Rhythm: Frequency: Blood pressure: Systolic Diastolic Measurement 1: 2: 3:
In case of newly discovered hypertension: Has further diagnosing or treatment been initiated?	☐	☐	Which? _____
g. Abdomen, i.e. abdominal masses, organ tumor, soreness, scars? A gynecological or rectal examination is not required.	☐	☐	
h. Vertebral column, including abnormal curving?	☐	☐	_____
i. Arms, legs and joints, e.g. varicose veins, edemas, peripheral pulses, signs of current or past phlebitis, muscular dystrophy?	☐	☐	_____
j. Skin and lymph nodes (neck, armpit, groin)?	☐	☐	_____
k. External genitals, including palpation of the breasts?	☐	☐	_____
l. Examination of the nervous system, e.g. tremors, reflexes, sensory disturbances?	☐	☐	_____

Velliv / Lautrupvang 10 / 2750 Ballerup
Telefon: 70 33 99 99 / kontakt@velliv.dk / www.velliv.dk / Velliv, Pension & Livsforsikring A/S, CVR-nr. 24260577

Name _____ Date of birth/CPR no. _____

3	**Urine dipstick measurement** In case of newly discovered reactions: Has further diagnosing or treatment been initiated?	**NO** ☐ **YES** ☐	Protein ☐ Sugar ☐ Blood ☐ If positive reaction, please indicate below the result of any immediate follow-up examination. Follow-up date _____ Protein ☐ Sugar ☐ Blood ☐ If **YES**, which? _____
4	**Does anything in the appearance or behavior of the applicant indicate frailty or sickliness, including mental illness?**	**NO** ☐ **YES** ☐	If **YES,** how? _____
5	**Do you consider the applicant to be:** Healthy (with no signs of illness)? Fully able to work?	**NO** **YES** ☐ ☐ ☐ ☐	If **NO.** Why not? _____ Why not? _____
	I have completed this health certificate in accordance with present medical records, and based on my knowledge of the applicant, my questions to the applicant and my examination of the applicant: _____ _____ Date doctor's signature NExact address (stamp):		Please forward the certificate in a sealed envelope marked "**HEALTH CERTIFICATE**" to:

The doctor will be paid upon receipt of an invoice in accordance with the agreement between the Danish Insurance Association and the Danish Medical Association on medical certificates, health information etc.

90025 141123 UK