

**To the doctor****Pension scheme**

Due to the size of the overall risk relating to the pension scheme that the customer wants to establish with us, we kindly ask you to fill in the enclosed certificates.

**Please also send us the results of the following tests:**

Chest x-ray (alternatively pulmonary function test)

**Blood tests:**

Cholesterol (HDL, LDL, Total-cholesterol and Triglyceride)

GGT

ALAT

S – Creatinine

HbA1c

CRP (C – reactive protein)

HIV antibody test (HIV – Antibody test declaration enclosed)

All tests must be new and include reference values, and we kindly ask you to send them to us within three weeks of performing the tests. We will pay the test fees.

Kind regards,

Health Department  
Velliv  
Tel. +45 70 33 30 03

## Your personal details

Your full name	Civil reg. (CPR) no.
Address	Postcode and town/city
Position	

### To the applicant:

- You must contact your general practitioner or attending medical specialist and ask him/her to fill in this certificate. Please remember to tell your doctor that he/she must fill in FP 100.
- You must read the answers and sign the certificate to confirm that all health information has been covered. You are responsible for ensuring that the certificate is filled in correctly.
- Please note that if the answers are not truthful, or information has been withheld, the insurance cover may be reduced or cancelled pursuant to the Danish Insurance Contracts Act (Forsikringsaftaleloven).

### To the doctor:

- In Section II of this document, please answer the questions having the latest 10 years from today in mind.
- The certificate is a general certificate, and you should therefore answer all questions.
- When you complete this document, the company wants you to pay special attention to:

### Section I: Information to be provided by the doctor

<b>1</b>	a. Are you the applicant's usual general practitioner?	NO	YES	If <b>yes</b> , since when? (month/year) <hr/> If <b>NO</b> , how have you established the applicant's identity? <hr/>
		<input type="checkbox"/>	<input type="checkbox"/>	
	b. Do you know the applicant?	<input type="checkbox"/>	<input type="checkbox"/>	

### Section II: Doctor's questions to the applicant with patient records

1. Ask the patient about previous and existing illnesses, tests, treatments, consumption of medicine, alcohol, tobacco and stimulants. Please enclose relevant patient records, such as doctor's certificates, discharge summaries and laboratory test results.
2. Please note that the following information cannot be submitted to the company:
  - Information about other persons' (for example relatives') present or former states of health.
  - Information about the result of genetic tests carried out to clarify the insurance applicant's future risk of contracting certain diseases (predictive genetic tests).
  - Information about participation in and the result of preventive examinations. However, the result of such examination is to be stated if they reveal present signs of disease, or if they concern diseases earlier contracted by the insurance applicant, or if the outbreak of disease has already taken place.
3. Please be aware of the consequences for the patient if you fail to provide adequate information as stated in the Danish Insurance Contracts Act (see above).

<b>For questions 1A-1N, please specify the diagnosis, symptom start, time and date of diagnosis, progress and current symptoms within the last 10 years. Please enclose supplementary patient records, including the results of paraclinical tests.</b>				
<b>1</b>	Is the applicant suffering from or has the applicant been suffering from:	NO	YES	<hr/> <hr/> <hr/> <hr/>
	a. Infectious diseases (except for ordinary colds), such as meningitis, rheumatoid arthritis fever, tropical diseases, malaria and HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>1</b>	<p><b>b. Benign or malignant tumours,</b> e.g. cancer, cancer precursors (dysplasia), blood and lymphatic cancer, polyps, cysts and/or other benign tumours?</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>c. Blood diseases,</b> e.g. anaemia, bone marrow diseases, coagulation and immunological defects and diseases of the spleen?</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>d. Metabolic diseases,</b> e.g. diabetes (including elevated blood sugar levels), struma or metabolic disorders and increased blood cholesterol?</p> <p>NB: In case of metabolic diseases (incl. dyslipidemia), please specify control values and treatment, if any.</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>e. Mental illness,</b> e.g. depression, anxiety, stress, reaction to crisis etc.?</p> <p>Have there been any suicidal tendencies or cases of poisoning?</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>f. Diseases of the nervous system (including eye and ear diseases),</b> e.g. headache or migraine, dizziness, epilepsy, cramps or fainting, paralysis or movement disturbances, stroke, thrombosis, sensory disturbances, including multiple sclerosis?</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>g. Heart or vascular diseases,</b> e.g. high blood pressure, angina pectoris, heart palpitations or irregular heartbeat, thrombosis, heart or heart valve defect, varicose veins or phlebitis, leg thrombosis and intermittent claudication?</p> <p>NB: In case of high blood pressure, please specify initial blood pressure level, current treatment and treatment period.</p> <p style="text-align: center;">NO      YES</p> <p style="text-align: center;"><input type="checkbox"/>      <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>

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<b>1</b>	<p><b>h. Lung or respiratory diseases</b> such as asthma, hay fever or allergies, bronchitis, chronic obstructive lung disease (COLD), tuberculosis, lung thrombosis, lung infections, pneumoconiosis, emphysema and sarcoidosis?</p>	<p><b>NO</b></p> <input type="checkbox"/>	<p><b>YES</b></p> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>
	<p><b>i. Digestive diseases</b> (stomach, intestines, liver, bile and pancreas), e.g. ulcers or haemorrhages, gastritis, oesophagus problems or reflux, digestive problems (irritable bowel syndrome, celiac disease or allergies), colitis or enteritis, ileus, polyps, jaundice or hepatitis, gallstones, fatty liver (steatosis), affected liver transaminase levels (blood tests) and pancreatitis?</p>	<p><b>NO</b></p> <input type="checkbox"/>	<p><b>YES</b></p> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>
	<p><b>j. Skin diseases,</b> e.g. eczema (including allergies), skin cancer, psoriasis, inflammations (including abscesses), blisters and venereal diseases?</p>	<p><b>NO</b></p> <input type="checkbox"/>	<p><b>YES</b></p> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>
	<p><b>k. Neck, back or lumbar diseases or problems,</b> e.g. myalgia, sciatica, spinal disc herniation (slipped disc), lumbago, whiplash, spinal diseases and scoliosis?</p>	<p><b>NO</b></p> <input type="checkbox"/>	<p><b>YES</b></p> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>
	<p><b>l. Diseases of the joints, tendons, bones and connective tissue,</b> e.g. tendon and ligament injuries, osteoarthritis, arthritis (rheumatoid diseases), fibromyalgia, osteoporosis, hypermobility and pelvic girdle pain?</p>	<p><b>NO</b></p> <input type="checkbox"/>	<p><b>YES</b></p> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>

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<b>1</b>	<p><b>m. Kidney and urinary tract diseases as well as gynaecological diseases,</b> e.g. kidney or bladder infection, kidney or bladder stones, blood, protein or bacteria in the urine, kidney removal, deformations or cysts, female gynaecological problems and male urinary tract problems (including prostate problems)?</p> <p style="text-align: right;">NO YES <input type="checkbox"/> <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
	<p><b>n. Diseases other than those mentioned above, except for uncomplicated children's diseases, common and non-recurring infectious diseases as well as complications relating to cosmetic treatments?</b></p> <p style="text-align: right;">NO YES <input type="checkbox"/> <input type="checkbox"/></p>	<p>_____</p> <p>_____</p> <p>_____</p>
<b>2</b>	<p><b>Has the applicant been injured within the last 10 years?</b></p> <p style="text-align: right;">NO YES <input type="checkbox"/> <input type="checkbox"/></p> <p><b>If yes, are there any effects?</b></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>Please enclose supplementary patient records, including the results of paraclinical tests.</p>	<p>If YES. when? (month/year)</p> <p>_____</p> <p>What was the nature of the injury?</p> <p>_____</p> <p>If YES, please specify symptoms and degree of permanent injury, if any.</p> <p>_____</p> <p>_____</p>
<b>3</b>	<p><b>Has the applicant within the last 10 years been on long-term sick leave/unfit to work (for more than one month)?</b></p> <p style="text-align: right;">NO YES <input type="checkbox"/> <input type="checkbox"/></p>	<p>If YES. If yes, during what periods? (month/year)</p> <p>_____</p> <p>_____</p> <p>For which reason?</p> <p>_____</p>
<b>4</b>	<p><b>Has the applicant within the last 10 years undergone long-term (for more than one month) or recurring medical treatment, including treatment involving sedatives or pain relievers, other than that specified above?</b></p> <p style="text-align: right;">NO YES <input type="checkbox"/> <input type="checkbox"/></p>	<p>If YES. For which reason?</p> <p>_____</p> <p>_____</p> <p>During what periods? (month/year)</p> <p>_____</p> <p>At the present time? NO <input type="checkbox"/> YES <input type="checkbox"/></p>

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<b>5</b>	Is the applicant an existing or former user of controlled substances within the last 10 years (e.g. heroin, speed, cocaine, ecstasy and LSD), cannabis, organic solvents, anabolic substances or other stimulants or sedatives?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . If yes, during what periods? (month/year) _____ At the present time? <b>NO</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> Which drugs/substances? _____ Are there any effects? <b>NO</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> Which? _____
<b>6</b>	a. Does the applicant ever drink beer, wine, fortified wine or spirits?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . How many units per week on average? _____
	b. Has the applicant had a high consumption of beer, wine, fortified wine or spirits within the last 10 years?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . How many units per week on average? _____ During what periods? (month/year) _____
	c. Has the applicant received treatment for or sought counselling to deal with excessive consumption of beer, wine, fortified wine or spirits within the last 10 years?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . If yes, during what periods? (month/year) _____ At the present time? <b>NO</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> Which treatment/counselling? _____ To what effect? _____
<b>7</b>	a. Does the applicant smoke?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . If yes, what is his/her daily consumption? (number of cigarettes, cigars, pipe fillings) _____
	b. Has the applicant been a smoker within the last 10 years?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	If <b>YES</b> . If yes, during what periods? (month/year) _____ What was his/her daily consumption? (number of cigarettes, cigars, pipe fillings) _____

I have read the answers and hereby declare that the above information is true, and that no information has been withheld. I am aware that the insurance may be cancelled or the cover may be reduced if the information is incomplete, false, or if information has been withheld.

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant's signature

\_\_\_\_\_ Civil reg. (CPR) no.

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Section III: Doctor's examination																					
<b>1</b>	<b>Height and weight of the applicant:</b>		Height (without shoes): _____ cm Weight (without outerwear): _____ kg																		
<b>2</b>	<b>Have any abnormalities been found in the:</b>	<b>NO</b> <b>YES</b>	If <b>YES</b> , please specify.																		
	a. Head, mouth, throat, neck?	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	b. Eyes, including eyesight with best correction?	<input type="checkbox"/> <input type="checkbox"/>	Eyesight (w/ corr.) Right: _____ Left: _____																		
	c. Ears, including hearing function with best correction? The hearing function can be measured by whispering and talking from a distance of 4 metres.	<input type="checkbox"/> <input type="checkbox"/>	Hearing function (w/ corr.): _____																		
	d. Chest, including deformities and mobility?	<input type="checkbox"/> <input type="checkbox"/>																			
	e. Lungs, including stethoscopy? In case of lung disease, including symptoms of asthma and bronchitis, please provide three peak flow measurements (possibly a spirometry).	<input type="checkbox"/> <input type="checkbox"/>	Peak flow measurements (LFT) in case of lung disease: Measurement 1: <input style="width: 50px; height: 20px;" type="text"/> Measurement 2: <input style="width: 50px; height: 20px;" type="text"/> Measurement 3: <input style="width: 50px; height: 20px;" type="text"/>																		
	f. Cardiovascular system, including stethoscopy, pulse and blood pressure? Three blood pressure measurements should be carried out at at least one-minute intervals after the applicant has had at least five minutes of rest.  In case of recently discovered high blood pressure: Have further examinations/ treatment been initiated?	<input type="checkbox"/> <input type="checkbox"/>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;">Pulse</td> <td style="width: 15%; text-align: center;">Blood pressure</td> <td style="width: 15%; text-align: center;">Measurement 1:</td> <td style="width: 15%; text-align: center;">Measurement 2:</td> <td style="width: 15%; text-align: center;">Measurement 3:</td> </tr> <tr> <td></td> <td style="text-align: center;">Rhythm: <input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;">Systolic <input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> </tr> <tr> <td></td> <td style="text-align: center;">Frequency: <input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;">Diastolic <input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 50px; height: 20px;" type="text"/></td> </tr> </table> Which? _____		Pulse	Blood pressure	Measurement 1:	Measurement 2:	Measurement 3:		Rhythm: <input style="width: 50px; height: 20px;" type="text"/>	Systolic <input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>		Frequency: <input style="width: 50px; height: 20px;" type="text"/>	Diastolic <input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
	Pulse	Blood pressure	Measurement 1:	Measurement 2:	Measurement 3:																
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	g. Abdomen, e.g. mass, organ tumour, soreness, scars? No gynaecological or rectal examination is required.	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	h. Spine, including abnormal curvatures?	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	i. Arms, legs and joints, e.g. varicose veins, oedemas, peripheral pulse conditions, signs of existing or past phlebitis, muscular atrophy?	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	j. Skin and lymphatic glands (neck, armpit, groin)?	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	k. External sexual organs, including palpation of breasts?	<input type="checkbox"/> <input type="checkbox"/>	_____																		
	l. Examination of the nervous system, e.g. paralysis, tremors, reflexes, sensory disturbances?	<input type="checkbox"/> <input type="checkbox"/>	_____																		

Name \_\_\_\_\_ Civil reg. (CPR) no. \_\_\_\_\_

<b>3</b>	<p><b>Urine dipstick analysis</b></p>       <p>In case of recent positive test results: Have further examinations/treatment been initiated?</p>	<p><b>NO YES</b></p>           <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: none;">Protein</td> <td style="border: none;">Result Sugar</td> <td style="border: none;">Blood</td> </tr> </table> <p>In case of a positive test result, the result of any immediately subsequent checks must be noted.</p> <p>Date of check _____</p> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> <td style="width: 33%; border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: none;">Protein</td> <td style="border: none;">Result Sugar</td> <td style="border: none;">Blood</td> </tr> </table> <p>If YES, how? _____</p>				Protein	Result Sugar	Blood				Protein	Result Sugar	Blood
Protein	Result Sugar	Blood													
Protein	Result Sugar	Blood													
<b>4</b>	<p><b>Does the applicant's appearance suggest any ill-health or infirmity, including mental disorders?</b></p>	<p><b>NO YES</b></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>If YES, how? _____</p>												
<b>5</b>	<p><b>Do you consider the applicant to be:</b></p> <p>Healthy (showing no symptoms of illness or disease)?</p> <p>Fully fit to work?</p>	<p><b>NO YES</b></p>  <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>If NO.</p> <p>Why not? _____</p> <p>Why not? _____</p>												
<p>This certificate has been issued by me in accordance with my records and my knowledge of the applicant as well as my questions and my examination carried out on the date indicated below:</p>  <p>_____</p> <p style="text-align: center;">Date                                  Doctor's signature</p> <p style="text-align: center;">Exact address (stamp):</p>   <p>Payment can be made to NemKonto for the civil reg. (CPR)/CVR/SE no. specified</p> <p>CPR no., CVR or SE no.</p> <p>_____</p> <p>Giro/bank reg. no. and account no.</p> <p>_____</p>		<p>Please send the certificate in a closed envelope marked <b>MEDICAL CERTIFICATE</b> to:</p>   <p style="text-align: center;"><b>Velliv</b> Lautrupvang 10 DK-2750 Ballerup</p>													

The certificate has been approved by the Danish Medical Association's certificate committee and will be remunerated by the insurance company after prompt submission of an invoice for the amount corresponding to the current rate according to the collective agreement with the Danish Medical Association.

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



This certificate forms part of the agreement between the Danish Insurance Association and the Danish Medical Association regarding certificates, health details etc.

It has been agreed between the Danish Insurance Association and the Danish Medical Association that this certificate can be completed by anyone with a medical background.

**To the applicant**

In connection with your application for personal insurance, we require supplementary health information from you. Please contact a doctor with a view to performing blood tests and filling in this certificate.

**To the examining doctor**

In connection with the above insurance application, we require an HIV antibody test to be performed. This is done by taking a blood sample and sending it to Statens Serum Institut or another laboratory along with the form 'ANTIBODIES IN CASE OF INFECTIOUS DISEASES'. Please write the name of the insurance company in the box 'Sender' under the certificate-issuing doctor's name and address.

The insurance company will reimburse the cost of the HIV test according to forwarded invoice - please remember to state the name and civil registration number of the person tested. Upon receipt of the test results, Serum Institut's reply must be indicated below. If a new sample is required, the doctor should perform a new blood test and write the test result on the certificate. The certificate may not be forwarded to the insurance company without the applicant's acceptance (see declaration 4 below).

**HIV antibody test**

Test conclusion:

No HIV antibody detected

Blood test performed on: \_\_\_\_\_

HIV antibody detected

Test result dated: \_\_\_\_\_

The blood test has been performed on the above-mentioned person under my supervision, and this certificate has been filled in by me in strict compliance with the actual result.

\_\_\_\_\_  
Place and date

\_\_\_\_\_  
Civil reg. (CPR) no./SE no.

\_\_\_\_\_  
Doctor's signature and stamp

**Acceptance given by the applicant in the doctor's presence**

I hereby give permission for the certificate to be forwarded to the insurance company where I am applying for insurance.

\_\_\_\_\_  
Place and date

\_\_\_\_\_  
Applicant's signature

Please send the certificate in a closed envelope marked Certificate to the doctor by:

\_\_\_\_\_