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)
ECG

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

110102 UK 240225

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

		NO	YES	
1	a. Are you the applicant's usual general practitioner?	☐	☐	If **yes**, since when? (month/year)
	b. Do you know the applicant?	☐	☐	If **NO**, how have you established the applicant's identity?

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).

1 **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.**

	NO	YES	
Is the applicant suffering from or has the applicant been suffering from:			
a. Infectious diseases (except for ordinary colds), such as meningitis, rheumatoid arthritis fever, tropical diseases, malaria and HIV/AIDS?	☐	☐	

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Name _____ Civil reg. (CPR) no. _____

1	b. Benign or malignant tumours, e.g. cancer, cancer precursors (dysplasia), blood and lymphatic cancer, polyps, cysts and/or other benign tumours?	NO ☐ YES ☐	
	c. Blood diseases, e.g. anaemia, bone marrow diseases, coagulation and immunological defects and diseases of the spleen?	NO ☐ YES ☐	
	d. Metabolic diseases, e.g. diabetes (including elevated blood sugar levels), struma or metabolic disorders and increased blood cholesterol? NB: In case of metabolic diseases (incl. dyslipidemia), please specify control values and treatment, if any.	NO ☐ YES ☐	
	e. Mental illness, e.g. depression, anxiety, stress, reaction to crisis etc.? Have there been any suicidal tendencies or cases of poisoning?	NO ☐ YES ☐ NO ☐ YES ☐	
	f. Diseases of the nervous system (including eye and ear diseases), e.g. headache or migraine, dizziness, epilepsy, cramps or fainting, paralysis or movement disturbances, stroke, thrombosis, sensory disturbances, including multiple sclerosis?	NO ☐ YES ☐	
	g. Heart or vascular diseases, 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? NB: In case of high blood pressure, please specify initial blood pressure level, current treatment and treatment period.	NO ☐ YES ☐	

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1	h. Lung or respiratory diseases such as asthma, hay fever or allergies, bronchitis, chronic obstructive lung disease (COLD), tuberculosis, lung thrombosis, lung infections, pneumoconiosis, emphysema and sarcoidosis?	NO ☐ YES ☐	
	i. Digestive diseases (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?	NO ☐ YES ☐	
	j. Skin diseases, e.g. eczema (including allergies), skin cancer, psoriasis, inflammations (including abscesses), blisters and venereal diseases?	NO ☐ YES ☐	
	k. Neck, back or lumbar diseases or problems, e.g. myalgia, sciatica, spinal disc herniation (slipped disc), lumbago, whiplash, spinal diseases and scoliosis?	NO ☐ YES ☐	
	l. Diseases of the joints, tendons, bones and connective tissue, e.g. tendon and ligament injuries, osteoarthritis, arthritis (rheumatoid diseases), fibromyalgia, osteoporosis, hypermobility and pelvic girdle pain?	NO ☐ YES ☐	

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1	m. Kidney and urinary tract diseases as well as gynaecological diseases, 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)?	**NO** ☐ **YES** ☐	
	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?	**NO** ☐ **YES** ☐	
2	**Has the applicant been injured within the last 10 years?** **If yes, are there any effects?** Please enclose supplementary patient records, including the results of paraclinical tests.	**NO** ☐ **YES** ☐ ☐ ☐	If **YES.** when? (month/year) What was the nature of the injury? If **YES**, please specify symptoms and degree of permanent injury, if any.
3	**Has the applicant within the last 10 years been on long-term sick leave/unfit to work (for more than one month)?**	**NO** ☐ **YES** ☐	If **YES.** If yes, during what periods? (month/year) For which reason?
4	**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?**	**NO** ☐ **YES** ☐	If **YES.** For which reason? During what periods? (month/year) At the present time? **NO** ☐ **YES** ☐

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5	**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?**	**NO** ☐ **YES** ☐	If **YES.** If yes, during what periods? (month/year) At the present time? **NO** ☐ **YES** ☐ Which drugs/substances? Are there any effects? **NO** ☐ **YES** ☐ Which?
6	a. Does the applicant ever drink beer, wine, fortified wine or spirits?	**NO** ☐ **YES** ☐	If **YES.** 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?	**NO** ☐ **YES** ☐	If **YES.** 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?	**NO** ☐ **YES** ☐	If **YES.** If yes, during what periods? (month/year) At the present time? **NO** ☐ **YES** ☐ Which treatment/counselling? To what effect?
7	a. Does the applicant smoke?	**NO** ☐ **YES** ☐	If **YES.** 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?	**NO** ☐ **YES** ☐	If **YES.** 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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Name _____ Civil reg. (CPR) no. _____

Section III: Doctor's examination

1 **Height and weight of the applicant:**

Height (without shoes): _____ cm Weight (without outerwear): _____ kg

Waist measurement (at navel): _____ cm

2 **Have any abnormalities been found in the:**

	NO	YES	If **YES**, please specify.
a. Head, mouth, throat, neck?	☐	☐	
b. Eyes, including eyesight with best correction?	☐	☐	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.	☐	☐	Hearing function (w/ corr.): _____
d. Chest, including deformities and mobility?	☐	☐	
e. Lungs, including stethoscopy? In case of lung disease, including symptoms of asthma and bronchitis, please provide three peak flow measurements (possibly a spirometry).	☐	☐	Peak flow measurements (LFT) in case of lung disease: Measurement 1: Measurement 2: Measurement 3:
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.	☐	☐	Pulse: Rhythm: / Frequency: Blood pressure: Systolic / Diastolic Measurement 1: Measurement 2: Measurement 3:
In case of recently discovered high blood pressure: Have further examinations/ treatment been initiated?	☐	☐	Which? _____
g. Abdomen, e.g. mass, organ tumour, soreness, scars? No gynaecological or rectal examination is required.	☐	☐	
h. Spine, including abnormal curvatures?	☐	☐	
i. Arms, legs and joints, e.g. varicose veins, oedemas, peripheral pulse conditions, signs of existing or past phlebitis, muscular atrophy?	☐	☐	
j. Skin and lymphatic glands (neck, armpit, groin)?	☐	☐	
k. External sexual organs, including palpation of breasts?	☐	☐	
l. Examination of the nervous system, e.g. paralysis, tremors, reflexes, sensory disturbances?	☐	☐	

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3	**Urine dipstick analysis** In case of recent positive test results: Have further examinations/treatment been initiated?	**NO** ☐ **YES** ☐	Result Protein ☐ Sugar ☐ Blood ☐ In case of a positive test result, the result of any immediately subsequent checks must be noted. Date of check _____ Result Protein ☐ Sugar ☐ Blood ☐ If **YES**, how? _____
4	**Does the applicant's appearance suggest any ill-health or infirmity, including mental disorders?**	**NO** ☐ **YES** ☐	If **YES.** how? _____
5	**Do you consider the applicant to be:** Healthy (showing no symptoms of illness or disease)? Fully fit to work?	**NO** **YES** ☐ ☐ ☐ ☐	If **NO.** Why not? _____ Why not? _____

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:

_____ _____
Date Doctor's signature

Exact address (stamp):

Payment can be made to NemKonto for the civil reg. (CPR)/CVR/SE no. specified

CPR no., CVR or SE no.

_____

Giro/bank reg. no. and account no.

_____

Please send the certificate in a closed envelope marked **MEDICAL CERTIFICATE** to:

Velliv
Lautrupvang 10
DK-2750 Ballerup

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.

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HIV ANTIBODY TEST

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 Seruminstitut 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, Seruminstituttet'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:

110102 UK 240225