Futur

Declaration of Health

☐ New policy	☐ Change	Policy number

Name			Personal ID number
Address		Zip code	City
Telephone	E-mail		
Profession/Occupation	Company name*		CIN

* State the name of the employer if the insurance is owned by the company

Important!

The information forming the basis for the insurance agreement shall be provided by the person who will be insured. All of the questions must be answered. No self-evaluations about the significance of the information may be made. All care, treatment, examinations, check-ups or sick leave lasting more than 14 consecutive days, including psychological or nervous disorders and alcohol or narcotics, shall be reported. This also applies to suspected HIV infection.
Please note that any false or incomplete statement may result in the insurance being rendered invalid in whole or in part.

No.	Question		
1	Are you a resident of or registered in Sweden?		☐ Yes ☐ No
	If you have answered "No", you may not take out insurance. Contact your insurance adviser or Futur if you have any questions.		
2	Do you have full capacity to work?*		☐ Yes ☐ No
	If "No": You might be able to take out life insurance. You are **not** able to take out premium exemption insurance or health insurance. Contact your insurance adviser or Futur for more information.		
	* You have full capacity to work if you, without limitations, can perform your regular tasks at work or at home. You do **not have full capacity to work** if you, either full-time or part-time, receive sick pay, sickness benefits, activity or sickness compensation (dormant or time-restricted), non-life annuities, rehabilitation compensation, disability or similar compensation or if you for health reasons have specially adapted assignments (e.g. simpler or protected work) or wage-subsidized employment.		
	If "No", how?		
	Cause?	Since when?	
3	Height in cm	Weight in kg	
4	Do you smoke?		☐ Yes ☐ No
	Have you smoked previously?	☐ Yes, I stoped smoking (year):	☐ No
5	Have you submitted blood for an HIV test?		☐ Yes ☐ No
	If "Yes", when?	Results? ☐ Negative (no HIV infection) ☐ Positive (HIV infection)	
6	Are you suffering from any symptoms/pains but have not visited a doctor or other care provider?		☐ Yes ☐ No
	If "Yes", which symptoms/pains?		
7A	Have you undergone a health examination in the past five years?		☐ Yes ☐ No
7B	Was the health examination due to an underlying disorder or injury?		☐ Yes ☐ No
	If "Yes", which underlying disorder or injury?		
7C	Were the results of the examination normal?		☐ Yes ☐ No
	If "No", what was the result? Describe.		

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If you answer "Yes" to any of Questions 8–33, additional information should be provided under A–I.

8	Are you taking any medication? (prescription or over-the-counter)	☐ Yes ☐ No
9	Are you being examined or treated by a doctor or other health care professional?	☐ Yes ☐ No

Have you ever (now or previously) had any of the following conditions (10–30)?
NOTE: Do not forget to fill in the additional information (A–I) if you answered "Yes"!

10	Impaired vision, eye disorder or eye injury?	☐ Yes ☐ No
	If "Yes", check which applies:	☐ Right eye ☐ Left eye
	☐ Near-sighted: More than 8 diopters? ☐ Yes ☐ No **A–I do not need to be answered!**	☐ Eye disorder **Answer A–I!**
	☐ Visual impairment other than near-sightedness and that is not caused by a disorder or an injury. **A–I do not need to be answered!**	☐ Eye injury **Answer A–I!**
11	Ear disorder? Loss of hearing? Tinnitus?	☐ Yes ☐ No
	If "Yes", check which applies:	☐ Right ear ☐ Left ear
	☐ Ear disorder **Answer A–I!** ☐ Loss of hearing **Answer A–I!** ☐ Tinnitus **Answer A–I!**	
12	Heart disease? Tightness of or pain to the chest? Swollen legs? Heart palpitations, irregular heartbeats or shortness of breath?	☐ Yes ☐ No
13	Blood clots? Stroke? Vascular disorder? Varicose veins?	☐ Yes ☐ No
14	High blood pressure?	☐ Yes ☐ No
15	Asthma, respiratory disorders, lung disease?	☐ Yes ☐ No
16	Allergies?	☐ Yes ☐ No
17	Stomach, intestinal, liver, pancreatic or other abdominal disorder? Hepatitis (jaundice)?	☐ Yes ☐ No
18	Kidney or urinary tract disorder?	☐ Yes ☐ No
19	Genital/lower abdominal disorder/pain? Prostate disorder?	☐ Yes ☐ No
20	Egg whites, blood or sugar in your urine?	☐ Yes ☐ No
21	Elevated glucose? Diabetes?	☐ Yes ☐ No
22	Elevated lipoproteins?	☐ Yes ☐ No
23	Skin disease or eczema? Psoriasis?	☐ Yes ☐ No
24	Deterioration/pain or decreased function in ligaments and muscles? Rheumatic or another type of joint disorder? Collagen disorder?	☐ Yes ☐ No
25	Symptoms/pain from your back, neck, shoulders, arms, legs, hips, gluteal area, sciatic nerve or a slipped disc?	☐ Yes ☐ No
26	Tumors? Lymphatic gland disorder? Blood disease?	☐ Yes ☐ No
27	Nervous disorder, MS, epilepsy, convulsive fit, paralysis? Dizziness, fainting? Migraine?	☐ Yes ☐ No
28	Psychological disorders, sleep disorders, psychological illness, stress-related symptoms, burnout or similar problems?	☐ Yes ☐ No

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29	Metabolism, hormone or thyroid disorder?	☐ Yes	☐ No
30	Alcoholism or any other type of addiction (narcotics, doping or similar substance, or overconsumption of medication)?	☐ Yes	☐ No
31	Do you have any other disorders or physical/psychological disabilities than those stated above?	☐ Yes	☐ No
32	In the past five years, have you been examined, treated or admitted to a hospital or other health care facility, or for any other reason paid for the services of a doctor or other health care professional (e.g. physical therapist, naprapath, chiropractor) for something other than what you have already stated?	☐ Yes	☐ No
33	In the past five years, have you been on sick leave or incapable of working (part-time or full-time) more than 14 consecutive days for something other than what you have already stated?	☐ Yes	☐ No

If you answered "Yes" to any of Questions 8–33, provide additional information below.
State only one injury/disorder/pain per section.

Additional information – Section 1

A	What was the reason for the examination, check-up or treatment? State disorder (diagnosis), if applicable.				
B	When did you first suffer from the pain, injury or disorder?				
C	Are you symptom-free?	☐ Yes	Since when?	☐ No	What symptoms did you display?
D	What type of examination have you undergone (X-ray, EKG, scope, etc.)?				
E	What type of treatment are you receiving or have you received (medication – specify which medication, operation, therapy, physical therapy, radiation, etc.)?				
F	When was your last check-up, examination or treatment?				
G	What was the result of the check-up, examination or treatment? ("Normal"? If "Abnormal", describe.)				
H	Which doctor(s) or caregiver(s) did you go to? State name, address, hospital, clinic, department.				
I	If you have been on sick leave, state start/end dates (year-month) both full-time and part-time.				

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Additional information – Section 2

A	VWhat was the reason for the examination, check-up or treatment? State disorder (diagnosis), if applicable.				
B	When did you first suffer from the pain, injury or disorder?				
C	Are you symptom-free?	☐ Yes	Since when?	☐ No	What symptoms did you display?
D	What type of examination have you undergone (X-ray, EKG, scope, etc.)?				
E	What type of treatment are you receiving or have you received (medication – specify which medication, operation, therapy, physical therapy, radiation, etc.)?				
F	When was your last check-up, examination or treatment?				
G	What was the result of the check-up, examination or treatment? ("Normal"? If "Abnormal", describe.)				
H	Which doctor(s) or caregiver(s) did you go to? State name, address, hospital, clinic, department.				
I	If you have been on sick leave, state start/end dates (year-month) both full-time and part-time.				

Additional information – Section 3

A	What was the reason for the examination, check-up or treatment? State disorder (diagnosis), if applicable.				
B	When did you first suffer from the pain, injury or disorder?				
C	Are you symptom-free?	☐ Yes	Since when?	☐ No	What symptoms did you display?
D	What type of examination have you undergone (X-ray, EKG, scope, etc.)?				
E	What type of treatment are you receiving or have you received (medication – specify which medication, operation, therapy, physical therapy, radiation, etc.)?				
F	When was your last check-up, examination or treatment?				
G	What was the result of the check-up, examination or treatment? ("Normal"? If "Abnormal", describe.)				
H	Which doctor(s) or caregiver(s) did you go to? State name, address, hospital, clinic, department.				
I	If you have been on sick leave, state start/end dates (year-month) both full-time and part-time.				

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Covid-19

34	Have you had a confirmed COVID-19 infection?	☐ Yes ☐ No
	If "Yes", when did you last have symptoms?	
	If "Yes", have you been hospitalized?	☐ Yes ☐ No
	Please state complete address to the care giver.	
	If "Yes", are you still suffering from any symptoms or reduced capacity or have you been diagnosed with post-COVID?	☐ Yes ☐ No
	Please state complete address to the care giver.	

Questions about genetic testing and family information (refer also to the information sheet, point D)

These questions should only be answered if you are over the age of 18 years and the total amount insured when paid as a lump sum (e.g. life insurance) exceeds 30 price base amounts or as a periodic indemnity (e.g. survivor's pension, premium exemption insurance, sickness insurance) exceeds 4 price base amounts/year.

35	Have you undergone any type of genetic investigation?	☐ Yes ☐ No
	If "Yes", describe the results	
36	Have any of your parents or siblings died from a disease before the age of 65?	☐ Yes ☐ No
	If "Yes", state relation, age and cause of death	

Other information (or continuation of additional information)

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Attestation, consent and signature

Attestation: I certify that the information in this declaration of health is complete and true and that I am aware that false or incomplete information can invalidate the insurance.

☐ I hereby give my consent as the person insured that Futur can process information concerning my health in order to provide this product in accordance with the information stated above. You are entitled to withdraw your consent at any time by contacting Futur. See more detailed information and contact details at www.futur.se/gdpr.

Location	Date	Signature	Name

Why is it important for you to submit correct information about your health?

In order for us to calculate a fair premium for our insurances, you, as the insurance applicant, may need to submit a declaration of health. Examples of such insurances include premium exemption insurance and sickness insurance in which it is your potential future incapacity to work that the insurance will compensate. Another type of insurance is survivor's pension or family pension that in the event of your death pays compensation to your survivors.

It is important that you, the insurance applicant, submit as carefully detailed information about your health as possible, both when you are applying for an insurance for the first time and when you are making amendments to your insurance that require a health declaration.

When you apply for insurance, or in some cases when amending your insurance, and when you apply for compensation from your insurance, we will check that you have submitted accurate health information in your declaration. If you have not provided accurate information, there is a risk that the insurance, either in part or in full, will become invalid. Providing false information jeopardizes future compensation to you or your survivors.

Therefore, it is important that you:

- fill in the form yourself
- answer all questions
- do not forget to state earlier conditions
- do not exclude information you think is sensitive
- do not make your own evaluation about the importance of the information
- give too much information rather than too little
- contact us if you afterwards realize you have forgotten information that should have been included
- are aware that you are responsible for ensuring the accuracy of the information
- are aware that inaccurate or incomplete information can result in the invalidity of the insurance, either in part or in full

Think very carefully when you are filling in your declaration of health!

Information about questions concerning genetic testing and family information

A. Genetic Integrity Act
The purpose of this act, which entered into force on 1 July 2006, is to safeguard the integrity of the individual by providing improved protection against discrimination due to genetics. The Act applies to the use of genetic investigations and genetic information, but only for family information prepared in health and medical care. The Act does not include investigations for the purpose of diagnosing an illness.

B. Definitions
Genetic investigation: An investigation in health and medical care or medical research for the purpose of providing data concerning an individual's genetic inheritance via various methods of analysis or through collecting data on his/her biological relatives.

Genetic information: Information concerning the result of a genetic investigation. However, this does not include information that only includes data on the current state of health of the person investigated.

C. Prohibition
Unless by virtue of provisions laid down by law, no party may stipulate as terms of an agreement that the other party must undergo a genetic investigation or provide genetic information about himself/herself. Unless by virtue of provisions laid down by law, no party may inquire or use genetic information about the other party in connection with an agreement. No person may effect access to genetic information about another person without authority.

D. Limitation of the prohibition in insurance
An insurance company may inquire into or use genetic information in connection with entering into, amendment or renewal of risk-assessed private insurance provided that

1. the person is over the age of 18 years and the amount insured that becomes payable in the event of an insurance event will be a lump sum in excess of 30 price base amounts.
2. the person is over the age of 18 years and the amount insured that becomes payable in the event of an insurance event will be a periodic indemnity in excess of four price base amounts per year.

E. Comments
The term "amount insured" refers to the total risk-assessed amount of the insurance applications and previously written policies with a single company. "Insurance applications" also refers to increases to the insurance.

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