EUROPEISKA ERV

# HEALTH DECLARATION - CHILD

Employees stationed abroad
Health declaration for CHILDREN (under 16 years) when applying for personal insurance

Please fill in the form digitally, then print it out and send to: Europeiska ERV, P.O.Box 1, S-172 13 SUNDBYBERG, SWEDEN. You can also send the form by e-mail to: hd@erv.se. Remember to sign the health declaration before sending it.

| The name of the company | Company registration no. | Insurance policy no. |
|---|---|---|
| E-mail address to company or contact person | City where the employee shall be stationed | |
| Duration of the contract (start and end date) | Country where the employee shall be stationed | |
| Name of the employee on contract | Date of birth (yy-mm-dd) of employee on contract | |

## Particulars concerning the person to be insured

| Surname and first name | | Date of birth |
|---|---|---|
| E-mail address to person who has custody of the child | | Citizenship |
| ☐ Girl<br>☐ Boy | Height in cm (without shoes) | Weight in kg (without clothes) |

## 1. The following questions must be answered

| | | |
|---|---|---|
| A) Has anything particular come to light during any medical examination at a child health care center or school health service during the past 5 years (including any referral for specialist medical examinitation)? | Yes ☐ | No ☐ |
| B) Has the applicant (the child) during the past 5 years, over and above check-up at a child health center or the school health service, received medical care, been treated or examined at a hospital or other medical institution, or otherwise by a doctor or other medical staff ? | Yes ☐ | No ☐ |
| C) Is the applicant (the child) being examined or treated for any disease or injury, slow development or any handicap ? | Yes ☐ | No ☐ |

## 2. The following questions to be answered only if the applicant (the child) is under the age of 4

| | | |
|---|---|---|
| A) Weight of the child at birth _____ gr | | |
| B) Were there any complications in connection with the pregnancy or the delivery, or during the child's first year? This also includes delivery by Caesarean section and other non-spontaneous delivery. | Yes ☐ | No ☐ |

## 3. The following questions to be answered only if the applicant (the child) is over the age of 4, but not yet 8

| | | |
|---|---|---|
| A) Weight of the child at birth _____ gr | | |
| B) Has the applicant (the child) undergone the standard age-4 medical examination at a child medical center, or similar all-round health examination by a paediatrician? | Yes ☐ | No ☐ |
| When? | Where? | Result? |

If your answer is "Yes" to any of the questions 1. A-C, provide additional information below. All diseases, injuries, handicaps and medical examinations shall be listed. Indicate the number of the question and provide answers to the follow-up questions and please enclose a copy of the medical records.

Illness/injury/handicap 1: .....

Illness/injury/handicap 2: .....

Illness/injury/handicap 3: .....

Illness/injury/handicap 4: .....

| | |
|---|---|
| During what periods of time was the applicant sick? | Diagnosis 1: .....<br>Diagnosis2: .....<br>Diagnosis 3: .....<br>Diagnosis 4: ..... |
| When was the applicant examined, checked up or treated? | Diagnosis 1: .....<br>Diagnosis 2: .....<br>Diagnosis 3: .....<br>Diagnosis 4: ..... |
| Which doctor, child care center or medical institution was consulted? | Diagnosis 1: .....<br>Diagnosis 2: .....<br>Diagnosis 3: .....<br>Diagnosis 4: ..... |
| What treatment did the applicant receive? | Diagnosis 1: .....<br>Diagnosis 2: .....<br>Diagnosis3: .....<br>Diagnosis 4: ..... |
| Does the applicant have any remaining problems? | Diagnosis 1: .....<br>Diagnosis 2: .....<br>Diagnosis 3: .....<br>Diagnosis 4: ..... |

D) Has any drug been prescribed for the applicant (the child)? Yes ☐ No ☐

State the name and the dosages .....

State the reason why the drug was prescribed .....

E) Does the applicant (the child) have, or is he/she suspected of having any defect to any internal organ, physical or mental handicap (including mental or development impairment), other physical defect or disease? Yes ☐ No ☐

State details .....

In the event of retarded speech development or impairment of sight or hearing, state details concerning type and degree of impairment and whether one-sided or doublesided.
In the event of myopia, state the value of diopters. If you are unsure, attach a copy of the latest prescription for spectacles.

F) Has the applicant (the child) received care allowance through the social insurance system, or have such benefits been applied for, or does the applicant (the child) receive sickness benefits, temporary disability Yes ☐ No ☐

If "Yes", for what reason and for what periods of time? .....

G) Is the applicant (the child) different in some manner, physically or mentally, from other children generally in the same age group? Yes ☐ No ☐

E.g. did the applicant receive special development support before school age, or specially adapted education during school years (e.g. attendance at a school for handicapped children), or was attendance at school postponed, or did the applicant, after school years, receive specially adjusted work (e.g. easier or protected work) or ork subject of salary allowances.

In what way? .....

## Signature of the person who has custody of the child

I hereby declare that the given information is true. I am aware that Europeiska ERV's coverage can be reduced or waived according to law, if I state untrue information. Europeiska ERV is data controller under the General Data Protection Regulation (GDPR). I give Europeiska ERV my consent to obtain and disclose my health information to collaborators and health care providers as part of the proceedings of my claim(s) or in relation to assistance. Furthermore, I give Europeiska ERV my consent to store my health information as long as it is necessary due to legitimate purposes.

| | |
|---|---|
| Date (yy, mm, dd) | Telephone number to person who has custody of child |
| Signature of the person who has custody of the child | The child's date of birth (yy-mm-dd) |

3317-0518