Read this before you fill in your health declaration!

Perhaps you are wondering why you need to complete all sections of the health declaration, and what we use the information for?
Briefly, this is to ensure you are given the right insurance protection - protection that gives you the right compensation at the right premium.
This information also applies when you want to change an insurance policy you have already taken out.

Make sure the information is complete

When you fill in the health declaration, it is very important that the information you provide is as complete as possible.

- Remember to answer all questions.
- Answer as accurately as you can and do not leave anything out. It is better to report too much than too little.
- You are responsible for ensuring that the health declaration is complete and filled in correctly.

How you get the right insurance protection

The information you provide when you apply for the insurance policy forms the basis of your policy, and for the compensation we pay in the event of a claim*. If you have given incomplete or inaccurate information in the health declaration, your compensation may be reduced or, in the worst scenario, you will receive no compensation at all from your insurance policy.

How you pay the right premium

In order to determine your premium, we assess the risk that you will require healthcare, be placed on sick leave or die. Part of our assessment is based on the information you provide in your health declaration. If you are in poor health, you may have to pay a slightly higher premium for your insurance.

Sometimes we make the assessment that illnesses/diseases or discomfort/complaints must be excluded from the insurance cover; these are called restrictions or clauses. In these cases, you do not need to pay a higher premium for your insurance, but you receive no compensation if you contract the illness/complaint to which the exclusion applies. Sometimes an exclusion may be combined with a higher premium.

What happens to your application

When you have completed the health declaration, please send it to us.

If you have reported anything that we feel may be significant for the insurance policy, we will decide whether we must request further information from you or from a doctor, hospital or social insurance office. In such a case we may ask you to sign an authorisation which gives SEB access to this type of information. This authorisation ceases to be valid once we have made a decision about your application. In certain cases, we will want you to consult a doctor for an examination. The health declaration and supplementary documents are handled confidentially.

When we have made our assessment, we will notify you about whether you will have an insurance policy without restrictions and without a higher premium, or a policy with restrictions and/or a higher premium. Unfortunately, in certain cases, we will be unable to offer any insurance at all.

If anything happens to you as the insured person

A claim of loss* is to be submitted to us as soon as possible. We need to know what has happened, so we obtain information from, for example, a doctor, hospital or social insurance office. The information is compared with the information you provided in your health declaration when you applied for the insurance cover. This is why it is very important that you submit accurate and complete information in the health declaration when you apply for insurance cover or wish to change an insurance policy that you have already taken out.

If you have any questions

If you have any questions about the health declaration, or you are wondering about anything to do with your insurance policy, contact your insurance broker, our sales agent or our Customer Services +46 77 11 11 800.

* Claim of loss, in this instance, means disease, accident or death.

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SEF Health Declaration

The health declaration can be sent in a sealed envelope to:
SEB, Riskbedömning, ST M5, SE-106 40 Stockholm, Sweden.

Insurance policy no.

Must be completed in ink.
Sign the health declaration on the next page.

Insured

Name	Personal identity no. (year, month, date and no.)
	–

It is very important that the information you provide is accurate

1 Are you covered by sickness and work injury benefits according to the Swedish Social Insurance Code (Socialförsäkringsbalken) (2010:110)? ☐ No ☐ Yes
This means that you are entitled to compensation from the Swedish Social Insurance Agency (Försäkringskassan) for e.g. sickness benefits and compensation for occupational injury.

2 Are you registered in Sweden? ☐ No ☐ Yes

3 To be answered by applicants who are not Swedish citizens.
Nationality
Do you live in Sweden? ☐ No ☐ Yes
If "Yes", since when? State year and month.

4 How tall are you and how much do you weigh?
State your height in cm
State your weight in kg

5 Do you smoke? ☐ No ☐ Yes
If "Yes", how many per day?
I used to smoke but gave up in (year):

6 Do you use any prescribed or over-the-counter medication? ☐ No ☐ Yes

Have you in the past 5 years:

7 Been checked, examined or treated at a healthcare institution or otherwise consulted a doctor, other health professional, psychologist, therapist, chiropractor, naprapath or similar? ☐ No ☐ Yes

8 Been on sick leave or unable to work, completely or partly, for more than 14 consecutive days? ☐ No ☐ Yes

9 Received sick pay, sickness benefit, short-term sickness allowance, sickness allowance, activity benefit, disability benefit, similar benefit, or do you have, for health reasons, adapted work or a position of subsidised employment? Any benefits as above that have been declared dormant to be stated. ☐ No ☐ Yes

If "Yes", which?	Since when?	Reason

Do you have or have you previously had (irrespective of when):

10 Discomfort/wear/injury or impaired function in joints or muscles? ☐ No ☐ Yes
☐ Neck ☐ Thoracic spine ☐ Lumbar region ☐ Hip ☐ Knee ☐ Other, please specify

11 Psychological problems, insomnia, mental illness, burnout or stress? Or symptoms that might indicate this? ☐ No ☐ Yes

12 Any disease, injury or physical defect? ☐ No ☐ Yes
Please note that vision defects of more than 8 diopters, hearing defects (including tinnitus) and alcohol problems or other substance abuse (drugs, doping preparations, medications, etc.) must be answered with "Yes" and be detailed on the next page.

13 Symptoms or complaints that can indicate disease, injury or physical defect? ☐ No ☐ Yes
Please note that discrepant results of the examination and sampling must be answered with "Yes" and be detailed on the next page.

You must sign the health declaration on page 4.
If you have answered "Yes" to any of questions 6-13, please also answer page 2.

Continued on next page

Insured

Name	Personal identity no. (year, month, date and no.)
	–

If you have answered "Yes" to any of questions 6-13, you must provide information below

My answer applies to question:	No.	No.	No.
State disease, injury, disability or symptoms.			
State which part of the body is affected, and whether it concerns the right or left side.			
When did the disease/complaint start?	State year: month:	State year: month:	State year: month:
Over which periods of time have you been completely or partly on sick leave?			
Which doctor or healthcare institution have you consulted?			
State doctor's name and address, hospital, clinic, department, etc.			
What care and treatment were you given? Indicate operation, radiotherapy, medication, etc.			
State the medication, dosage and prescribing doctor.			
Will you be going for another check-up? If "Yes", when?			
Are you completely recovered with no discomfort? Since when?	State year: month:	State year: month:	State year: month:
If you are not completely recovered and still have discomfort, what discomfort or symptoms remain?			
Other information.			

Continued on next page

SEF - supplementary questionnaire

Name	Personal identity number	Policy number
	–	

Supplementary questionnaire

14. Do you have or have you previously had (regardless of when):	Yes	No	If Yes, when? Year month	Where on your body?	Right/left	What treatment did you receive?	Symptom free? Yes	No	If Yes, when? Year month	If No, what symptoms persist?
skeletal fracture	☐	☐			☐ R ☐ L		☐	☐		
symptoms from joints or muscles	☐	☐			☐ R ☐ L		☐	☐		
hernia	☐	☐			☐ R ☐ L		☐	☐		

Do you have or have you previously had (regardless of when):	Yes	No	If Yes, when? Year month	Where?	What treatment did you receive?	Symptom free? Yes	No	If Yes, when? Year month	If No, what symptoms persist?
herniated disc	☐	☐		☐ back of neck ☐ thoracic spine ☐ lumbar region		☐	☐		
back injury/complaint	☐	☐		☐ back of neck ☐ thoracic spine ☐ lumbar region		☐	☐		

Do you have or have you previously had (regardless of when):	Yes	No	If Yes, when? Year month	How many?	What treatment did you receive?	Symptom free? Yes	No	If Yes, when? Year month	If No, what symptoms persist?
concussion/head injury	☐	☐				☐	☐		
cerebral hemorrhage	☐	☐				☐	☐		

	Yes	No	If Yes, when? Year month	What was the cause?	Right/left	When did you return to game? Year month day	Symptom free? Yes	No	If Yes, when? Year month	If No, what symptoms persist?
15. Have you been absent from games/training for more than seven consecutive days due to medical complaints?	☐	☐			☐ R ☐ L		☐	☐		
16. Have you ever undergone an operation/arthroscopy?	☐	☐			☐ R ☐ L		☐	☐		
17. Have you undergone an X-ray/ MR scan during the last 12 months?	☐	☐			☐ R ☐ L		☐	☐		

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Postal address: SE-106 40 Stockholm
Customer Centre private: +46 77 11 11 800, *Customer Centre corporate:* +46 771 43 10 00, *Switchboard:* +46 771 785 100
SEB Pension och Försäkring AB, Registered Office: Stockholm, Registration number: 516401-8243

Supplementary questionnaire continued

18. Have you ever suffered an injury to:	Yes	No	If Yes, when? Year month	Right/left	What treatment did you receive? Operation/X-ray/MR scan/other treatment?	Symptom free? Yes	No	If Yes, when? Year month	If No, what symptoms persist?
shoulder	☐	☐		☐ R ☐ L		☐	☐		
upper arm	☐	☐		☐ R ☐ L		☐	☐		
elbow	☐	☐		☐ R ☐ L		☐	☐		
lower arm	☐	☐		☐ R ☐ L		☐	☐		
wrist	☐	☐		☐ R ☐ L		☐	☐		
hand/finger	☐	☐		☐ R ☐ L		☐	☐		
hip	☐	☐		☐ R ☐ L		☐	☐		
groin	☐	☐		☐ R ☐ L		☐	☐		
thigh	☐	☐		☐ R ☐ L		☐	☐		
knee	☐	☐		☐ R ☐ L		☐	☐		
lower leg	☐	☐		☐ R ☐ L		☐	☐		
ankle	☐	☐		☐ R ☐ L		☐	☐		
foot/toe	☐	☐		☐ R ☐ L		☐	☐		

Please check that you have answered all questions.
The Health Declaration must be sent to SEB within one month of the date of signing.

Signature of insured

I understand the information about the importance of submitting complete and correct information in my Health Declaration with regard to purchase or change of insurance.

I understand that the information I have provided in this Health Declaration will form the basis of the insurance agreement, and that incorrect or incomplete information can render the insurance invalid.

I understand that my employer may be informed of any medical reservations / restrictions relating to insurance policies that my employer owns (does not apply to care insurance) and that the data SEB may receive regarding my health and risk assessment results may be communicated to the reinsurance company. SEB will store information submitted, regardless of whether the insurance application is approved or not.

Date	Signature	Name in block letters

Daytime telephone no. (incl. area code)	Mobile phone number	E-mail

Continued on next page

Supplementary information to the health declaration and questionnaire

Name	Personal identity number	Policy number
	–	

Supplementary information/notes

Signature of the insured person

Supplementary information to my health declaration and questionnaire is complete and correct.

Date	Signature	Name in block letters