AMENDMENT TO THE PROPOSAL FOR THE CONCLUSION OF AN INSURANCE CONTRACT

Wealth Insuring

powered by

AMENDMENT TO THE PROPOSAL FOR THE CONCLUSION OF AN INSURANCE CONTRACT

Amendment for insurance contract No. 1718

Social Security No. of the Insured Person

GTC-17180202

Icelandic Master Broker: Tryggingar og ráðgjöf ehf

Agent Name

Name of the Sub-broker

Social Security No. of the Agent

Agent Email

Agent Mobile

INSURED PERSON

◯ Mr. ◯ Mrs.

Name

Place of Birth

Street

Nationality

Place

Email

Zip Code

Mobile

Please fill in in case the country tax residence is not Iceland. The jurisdiction(s) of tax residence (country):

REQUESTED INSURANCE COVERAGE

		Start of insured risks:
Insurance sum for death	. . €	01. .2018
Insurance sum for illnesses, operations and long term care	. . €	01. .2018
Insurance sum for accident, extended accident coverage and accidental death	. . €	01. .2018

The minimum insured sum for individual risks is at least 10 000 €. The minimum limit of the cumulative insurance sum is 20 000 €.

NOTES

BENEFICIARIES IN CASE OF DEATH OF THE INSURED PERSON

Name	Relationship to the policyholder	Social Security No.	Share
			%
			%
			%

Total 100 %

Original for Insurance Company; 1. copy for agent; 2. copy for client

SIMPLIFIED MEDICAL EXAMINATION

Simplified medical examination is available in case following conditions are met: maximum insured sum for death insurance 20 000 €, maximum age at entry is 64 years no additional insured risks.

Can you truthfully make the following declaration?

I hereby declare that at the moment I am fully able to work and I do not receive and have not applied for any benefits because of reduction in earning capacity, occupational disability or invalidity or long-term care.

In addition, **I confirm** that I was not in inpatient treatment in the last five years and that I did not have treatment or that I was not on medication longer than three weeks uniterrupted because of the same diseases, appeals or health problems.

I declare that following diseases did not occur or do not occur: Malignant tumor diseases, diseases of the nervous system, mental diseases, HIV infection, heart attack or stroke.

◯ Yes ◯ No

If the insured person does not truthfully declare the requested information, he might lose his insurance benefits partially or in whole.

Date, signature of the insured person

IF THE DECLARATIONS WAS ANSWERED "NO" A COMPLETE ANSWERING OF THE MEDICAL QUESTIONS ON THIS PAGE IS REQUIRED.

HEALTH QUESTIONS

Current occupation

Are you a mother or a father? ◯ Yes ◯ No

Height and weight cm kg

Do you smoke? ◯ Yes number of cigarettes/cigars per day: ◯ **No** (I have not smoked in the last 12 months)

I do the following sports Leisure sport

Semi professional sport

Professional sport

		Yes	No
1.	Do you have any contract for life, accident or health insurance in other insurance company? If yes, please specify the type and scope of the contract as well as the name of the company.	◯	◯
2.	Have any insurance company declined, postponed or accepted with a risk loading your application for life, accident or health insurance in the last five years? Did you have any exclusion of some part of the insurance? If yes, please specify the type, scope of the contract as well as the name of the company and reason.	◯	◯
3.	Are you exposed at work or in your spare time to any special risks? (e.g. dangerous and flammable substances, hazardous sports such as parachuting, paragliding, private motor airplane or glider flying, diving, mountain sports, martial arts, motosports, etc.). Do you practise other sport disciplines regularly? Are you planning a longer stay in countries out of Europe for more than 6 months? If yes, please specify (if necessary, additional questionnaire will be provided).	◯	◯
4.	Did you have any surgeries, were you hospitalized or treated during the last 5 years? Are any surgeries, hospitalisation or treatment planned or recommended? If yes, please specify when and for what reason.	◯	◯
5.	Are you suffering of chronic illness or physical / mental disability, birth defects, results of surgery, infections or injury? If yes, please specify from when, treatment and complications.	◯	◯
6.	Did you take medication regularly or for a longer period during the last five years because of health problems, pain, illness or injury? In this content „longer „means a period of more than two weeks. If yes, provide the name, dosage and the length of taking the medication.	◯	◯
7.	Have you been suggested a treatment or were you treated due to alcohol, drugs or other addiction (e. g. gambling and others)? If yes, please specify when, how long, the reason and type of addiction.	◯	◯
8.	Do you or did you receive annuity due to disability or invalidity or did you apply for such annuity? If yes, please specify the reason and the length.	◯	◯
9.	Have you been unable to work for more than 21 days in the last 5 years or are you actually unable to work? If yes, please specify when, for how long and the reason.	◯	◯
10.	Illnesses and diseases listed in parentheses are not final and serve as examples of possible diseases of specific organs. Are you or have you ever been treated or hospitalized in the last 5 years for the following diseases, health disorders or do you have symptoms of these diseases?		
a)	Hearth, vascular system and blood circulation (e.g. high or fluctuating blood pressure, heart rhythm disorders, palpitation, heart murmur, coronary heart disease, chest pain, myocardial infarction, angina pectoris, varicose veins, thrombosis etc.)	◯	◯
b)	Nervous system and mental disorders (e.g. common headache, migraine, vertigo, seizure disorders, epilepsy, multiple sclerosis, paralysis, Parkinson's, Alzheimer's, psychiatric disorders, anxiety, depression, psychosis, eating disorders, etc.)	◯	◯
c)	Blood, lymphatic system and spleen (e.g. anaemia, blood coagulation disorders, haemophilia, leukaemia, changes in the blood, spleen disease, etc.)	◯	◯
d)	Respiratory system (e.g. dyspnoea, embolism, asthma, tuberculosis, hay fever, chronic bronchitis etc.)	◯	◯
e)	Eye and ear (e.g. blurred vision, vision impairment, cataracts, blindness, tinnitus, hearing loss, deafness etc.). If you wear glasses or contact lenses, please provide the dioptre of lenses for each eye separately.	◯	◯
f)	Musculoskeletal system (e.g. spinal disorders, spinal discs, joints, muscles, tendons and ligaments, arthrosis, shortening of the leg, the absence of the limbs. Orthopaedic defects limiting normal movements and requiring continuous use of orthopaedic appliances (e.g. wheelchair, crutches, orthosis, spinal fixator etc.).	◯	◯
g)	Gastrointestinal tract: oesophagus – e.g. reflux disease, varicose veins and other, stomach - e.g. peptic ulcer disease, gastritis and other, bowel disease – e.g. Crohn's disease, ulcerative colitis, ulcer disease and other.	◯	◯
h)	Kidney, genitourinary system and prostate (e.g. inflammation, stones, cysts, prostate disease etc.)	◯	◯
i)	Gynaecological disorders or breast disease (eg. cysts, fibroids, adenomas, polyps, dysplasia, menstrual disorders, infertility treatment, caesarean section, risk pregnancy, ectopic pregnancy, etc.)	◯	◯
j)	Skin (e.g. eczema, itching, redness, allergy etc.)	◯	◯
k)	Liver, glands or metabolism (e.g. diabetes, higher values of cholesterol, higher values of liver enzymes, gout, thyroid gland or other diseases of endocrine glands) or rheumatoid illnesses	◯	◯
l)	Immune system, chronic infectious or viral diseases (e.g. inherited immunity disorder, hepatitis, tropical diseases, fever of unknown cause, etc.)	◯	◯
11.	Do you have or did you have oncological diseases or other cancer diseases (e.g. benign and malignant, cysts, myomas, etc.)	◯	◯
12.	Have you been or are you undergoing a HIV / AIDS screening? If yes, please explain, since when, the results or treatment.	◯	◯
13.	Have you undergone radiotherapy, chemotherapy, or you were found abnormal results of specialized tests (e.g. CT, MRI, X-ray, ultrasound, EKG, EEG, measuring blood pressure, laboratory values etc.)? If yes, please provide details the following illnesses before the age of 60: diabetes, malignant tumors in the large intestine, rectum, chest or ovaries, cardiovascular diseases, polycystic kidney illnesses, multiple sclerosis, Alzheimer's, Parkinson's, Huntington's disease, hypertrophic cardiomyopathy)?	◯	◯

For detailed information on health questions answered with YES:

Question	Type of disease, complaint, change	When? How long?	Name and address of the physician / hospital

DECLARATION OF THE INSURED PERSON

I hereby declare that I have familiarized myself with the general insurance terms and conditions of NOVIS „Wealth Insuring" GTC-17180202 and have received it in written form. The health questionnaire has been answered completely and truthfully.

I consent that the NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.), may transfer my protected data to the places cooperating with the insurance company and relieve the coworkers of NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.), to the extent of its professional secrecy obligation.

I consent that NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.), is entitled to obtain information on my health condition from doctors and medical institutions that have treated me or will treat me. I am authorizing the doctors and medical institutions to provide or give reports or extracts from medical documents to NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.), to verify proposals or benefits, changes to the insurance coverage or the cancellation of an insurance contract also for the period after my death.

I relieve all treating doctors and medical institutions of the obligation for professional secrecy with regard to NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.).

I declare that I have become familiar with the General Terms and Conditions of the insurance contract and the Statutes of the Insurance Funds (these are the data that the insured person-must obtain before the insurance contract is concluded) and the data in the document about the important contractual terms of the insurance contract. At the same time, I confirm that I have received them in written form.

The insured person declares: I am not involved in financing terrorism in terms of valid money laundering laws; I am, in the sense of the money laundering regulations not a politically exposed person (PEP).

Signature of the insured person

The insured person also undertakes that if he becomes a politically exposed person during the contractual relationship with the insurance company, he shall notify this fact without any delay to the insurance company and complete the Statement of the politically exposed person.

The insured person with his signature confirms and claims that he is not a US resident, he is not a US citizen, nor is his place of birth in the United States of America.

Signature of the insured person

With my signature I confirm that all the information in this amendment is truthful and complete. If the contact details, especially email or telephone number of the insured person included in this amendment to the proposal for the conclusion of an insurance contract changes, the insured person is obliged to notify NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.) without any delay.

FINAL CLAUSE

This amendment is filed by the policyholder together with the insured person. The Insurance Company is obliged to process this amendment of the insurance contract in 8 weeks after it has been delivered to the Insurance Company's office.

The insurance coverage requested by this amendment is not valid before this amendment of the insurance contract has been confirmed by the Insurance Company.

In order to do so the Insurance Company needs to receive within the period for acceptance of this amendment completely, truthfully and correctly filled and signed amendment and other documents requested by the Insurance Company. Also all the potential additional medical examinations needs to be done and its findings needs to be delivered in the same period.

SIGNATURES

○ I allow the Insurance Company to contact me in the future by telephone, and E-Mail to advise and submit, notices, suggestions and offers to me. I can revoke this consent at any time, without indication of reasons, in writing to the NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.).

I hereby confirm the receipt of the following documents: ○ General Terms and Conditions ○ Supplementary sheet for the health questionnaire

Icelandic law applies to this amendment as well as to the insurance contract.

Place and date

Place and date

Signature of the INSURED PERSON

Signature of the POLICYHOLDER

INDENTIFICATION OF THE INSURED PERSON AND SIGNATURE OF AGENT

Identification of the insured person according to Anti Money Laundering legislation

Identification No.

The insured person has provided identity with: ○ Personal ID ○ Passport

Issuing Location

Issuing Authority:

Valid until __ __ . __ __ . __ __ __ __

Issuing Country:

I, the agent, confirm the information of the insured person for the determination of identification has been provided with this person present. I have examined the correctness of the data and signature(s) on the basis of the identification document submitted to me. The information obtained is confirmed by me as applicable. Furthermore, there are no other risk-increasing circumstances known, if such are not attached in a separate report.

Place, Date

Agent Signature

International fundamentally

NOVIS is an exceptional insurance company with a large number of real innovations and with clients in ten European countries. In 2017 the company started very successfully in Italy and in the beginning of 2018 it has launched its operations in Sweden and Iceland.

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