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-17180903

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.

Date of birth . .

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 %

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 ATTACHED TO THIS AMENDMENT IS REQUIRED.

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

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-17180903 valid for the proposal for the conclusion of an insurance contract to which this amendment is concluded. The health questionnaire has been answered completely and truthfully.

I hereby declare with my signature and confirm that I took over in writing and received the document „Information for clients about the protection of personal data", created by NOVIS Poisťovňa a.s., in good time before writing this amendment to the proposal for conclusion of this insurance contract.

I declare that I have become familiar with all necessary information which the insured person must obtain before the insurance contract is concluded. 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.

CONSENT FOR THE PERSONAL DATA PROCESSING FOR MARKETING PURPOSES

I agree that company NOVIS Poisťovňa a.s., with its registered seat at Námestie Ľudovíta Štúra 2, 811 02 Bratislava, Slovakia, Company ID No.: 47 251 301 (hereinafter only „Insurer") itself or through its contractual partners, which the Insurer publishes on its website, will process my personal data to the extent provided in this document for the purposes of the Insurer's marketing activities and that is for the duration of this insurance contract and for one year after its termination. I allow the Insurer to contact me in the future by telephone and e-mail to advise and submit notices, suggestions and offers to me. At the same time, I am aware that I can withdraw this consent at any time.

◯ Yes ◯ No

Date | Signature of the insured person

CONSENT FOR THE PERSONAL DATA PROCESSING REGARDING HEALTH STATUS

I agree that the insurance company NOVIS Poisťovňa a.s., Námestie Ľudovíta Štúra 2, 811 02 Bratislava, Slovakia, Company ID No.: 47 251 301 (hereinafter as "Insurer"), as the Controller, will process my personal health data prior to the conclusion of the insurance contract with the number mentioned above for the purpose of the conclusion of this insurance contract, executing its subsequent administration, for the purpose of the settlement the claim and, if necessary, for the re-underwriting processed within the duration of the insurance contract with the above given number. I grant this consent for the duration of the contractual relationship with the Insurer and for a period of five years after the termination of the contractual relationship with the Insurer. I am aware that I can withdraw this consent at any time.

I note that the providing Insurer with the personal data is always voluntary, but in the event of failure to provide it, it is not possible to fulfill the contractual obligations to which this consent applies.

◯ Yes ◯ No

Date | Signature of the insured person

I confirm hereby in writing that I allow the Insurer to process my personal data which is submitted in this amendment to the insurance proposal and health questionnaire as well as its function in the future. I hereby give my consent that the Insurer is permitted to share this information with related parties as necessary such as Insurance Broker, Agents, Reinsurance Companies and fiduciary doctor, provided that these parties are bound by relevant legislation on Personal Data Protection or Special laws relating to absolute confidentiality. I realize I can revoke this consent in writing at any time and demand all my personal data to be handed back to me, however resulting in possible interruption in the normal proceedings of the insurance contract. I hereby authorize doctors, hospitals, Icelandic Health Insurance, Icelandic Social Security Administration and any other which have possession of my medical records, to send such to NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.) at their request, or to their fiduciary doctor, which are necessary for underwriting or claims settlement. This permission is fully valid after my death. I relieve all above mentioned institutions of the obligation for professional secrecy with regard to NOVIS Insurance Company Inc. (NOVIS Poisťovňa a.s.).

◯ Yes ◯ No

Date | Signature of the insured person

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 hereby confirm the receipt of the following documents: ◯ Supplementary sheet for the health questionnaire ◯ Information for clients about the personal data protection

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

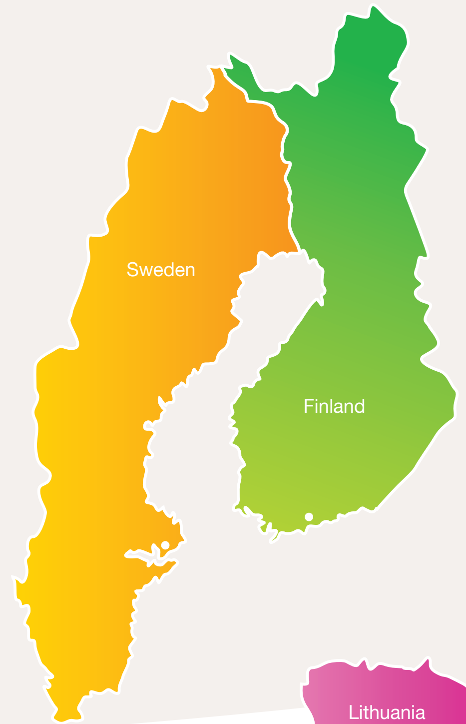
Identification No. | The insured person has provided identity with: ◯ Personal ID ◯ Passport

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.