

PLEASE ALSO ANSWER THE QUESTIONS BELOW IF YOUR ANSWERS IS "YES" TO ANY OF THE QUESTIONS 1-5. ALL FOLLOW-UP QUESTIONS MUST BE ANSWERED.

Question No.	What disease, injury or disability does it concern?	When was the examination, check-up or treatment carried out?	Which doctors/child care centres/school health services have been involved?	What kind of treatment/medication has been carried out?	Which after effects or problems are there? If free from all symptoms, since when?

TO BE ANSWERED IF THE CHILD IS FROM 0 TO 6 YEARS OLD

The birth weight of the child?	In which week of pregnancy was the child born?
<p>Has the child in the last 5 years been treated or examined at a hospital or other health care facility or otherwise by a doctor or other health professional, other than regular check-ups at the child health centre or school health service? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

OTHER OR ADDITIONAL INFORMATION

Please use a separate sheet of paper if you need to add something from the other questions on the form. Write the number of the question, the child's name and social security number at the top of the paper and then sign it and write the date.

SIGNATURE

I am aware that the information I have submitted in this health declaration will constitute the basis of my insurance policy. I am aware that incorrect or incomplete information may render the insurance invalid.

Date and place	Telephone
Guardian's signature	Name in block letters

The information obtained in this application will kept on file at If. If the application is not approved, the information will kept on file at If for 6 months. Personal data will be handled in observance of the provisions of the Personal Data Act (Personuppgiftslagen, PUL).

PLEASE SEND THIS HEALTH DECLARATION TO:

If
Personförsäkring
Foretag/Industri
SE-106 80 Stockholm

After answering all questions and signing, you may also send it by e-mail to:
foretagscenter@if.se

