Employer's declaration on change of provider

The completed form must be sent to Euro Accident via the contact form on Euro Accident's website www.euroaccident.dk, under Contact information.

Name of company	CVR No.
Commencement date	Previous provider

Euro Accident needs an employer's declaration in connection with change of provider. The employer's declaration is to help ensure that employees with reduced working capacity at the time of change of provider are taken care of with respect to:

1. maintaining insurance cover with previous provider, or
2. being transferred to Euro Accident.

As an employer, you must inform us of employees with reduced working capacity for one of the reasons stated below. You must do so based on the knowledge you have of the employees on the day of signing the declaration. Each employee should be stated only once, but with specification of all relevant reasons.

- On full or partial sick leave
- Working reduced hours for health reasons
- Employed under the flexjob scheme
- Employee for whom the former pension provider processes an application for benefits for loss of earning capacity
- Employee for whom either you or the employee receives benefits for loss of earning capacity

Please note that it may have financial consequences both for the employees and for you as the employer if the employer's declaration has not been completed correctly. You may incur liability for loss due to incorrect completion. Please do not hesitate to contact Euro Accident if you have any questions.
The employer's declaration should normally be signed before the new corporate insurance agreement takes effect. Euro Accident will contact you if you need to provide a new declaration either on or after the commencement date.

Information regarding employees on sick leave

Please state the name, civil reg. no., e-mail and telephone number of each employee. The date of the first sick day must be stated for employees who are on full or partial sick leave. Working hours must be stated as hours per week for employees on partial sick leave and employees working reduced hours for health reasons, respectively. If several items apply to an employee, they must all be stated.		On full-time sick leave (state the first sick day)	On partial sick leave (state the first sick day)	If on partial sick leave – what are the agreed working hours per week (state the number of hours)	Working reduced hours for health reasons (tick the box)	If working reduced hours for health reasons – what are the agreed working hours per week? (state the number of hours)	Employed under the flexjob scheme (tick the box)	Employee for whom the former pension provider processes an application for benefits for loss of earning capacity (tick the box)	Employee for whom either you or the employee receives benefits for loss of earning capacity (tick the box)
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐

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Information regarding employees on sick leave, continued

Please state the name, civil reg. no., e-mail and telephone number of each employee. The date of the first sick day must be stated for employees who are on full or partial sick leave. Working hours must be stated as hours per week for employees on partial sick leave and employees working reduced hours for health reasons, respectively. If several items apply to an employee, they must all be stated.		On full-time sick leave (state the first sick day)	On partial sick leave (state the first sick day)	If on partial sick leave – what are the agreed working hours per week (state the number of hours)	Working reduced hours for health reasons (tick the box)	If working reduced hours for health reasons – what are the agreed working hours per week? (state the number of hours)	Employed under the flexjob scheme (tick the box)	Employee for whom the former pension provider processes an application for benefits for loss of earning capacity (tick the box)	Employee for whom either you or the employee receives benefits for loss of earning capacity (tick the box)
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐
Name	Civil reg. no.	Date	Date	Number of hours/week	☐	Number of hours/week	☐	☐	☐

This employer's declaration is signed based on the company's knowledge of the employees on this date.

Date Signature on behalf of the company

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By my signature, I confirm that I am authorized by the company stated in this form, that I have read and understood the above and that all information stated in this proposal form and any related appendices is correct.

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