EURO ACCIDENT forsikring+sundhed

Notification of claim and Consent form
Loss of earning capacity and Waiver of premium

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

Your full name	Civil reg. no.
Address	Postal code/city
Tel./mobile	E-mail
Employer	
Agreement number	

Guide

All questions must be answered. You may use a blank page if there is not enough space in the fields to the right.
When we have received your application, we will ask for a copy of medical or medical record information and results of relevant tests and scans concerning your notified diagnosis. In case of a cancer diagnosis, we ask for a copy of tissue test results (histology results). In case of a coronary thrombosis, we ask for a copy of blood test results (cardiac biomarkers). In case of cerebral haemorrhage/cerebral thrombosis, we ask for results of CT or MRI scan.

If you have the above information, please enclose a copy. We can assist you in obtaining the information. In that case, the processing of the claim will take an additional 2-3 weeks.

1.	Were you completely well and fit for work when the incapacity for work arose?	No ☐	Yes ☐	If no, please state the reason:
2.	Which illnesses du you suffer from / What kind of accident have you had?			
3.	When did you notice the first symptoms of the illness / consequences of the accident?			
4.	Have you previously had the same or similar illness / symptoms?	No ☐	Yes ☐	If yes, please state why:
5.	Are you on sick leave?	No ☐	Yes ☐	If yes, please state the first sick day and any periods of illness: _______________ When do you expect to resume work completely or partially? Date: ____________ Number of weekly hours: __________
6.	Do you receive sickness benefit?	No ☐	Yes ☐	If yes, please state the date of payment: ______________ If no, why not?
7.	Have you been treated for your illness?	No ☐	Yes ☐	If yes, please state the following: Hospital: ____________ Department: ____________ Specialist/physician: ____________ Date: ____________

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Notification of claim, continued

8.	What is your position/occupation?		
9.	Have you been given notice of termination from your job?	No ☐ Yes ☐	If yes, please state the date of resignation:__________________
10.	How does the illness affect your earning capacity?		Please provide a description:
11.	Are you able to work reduced hours?	No ☐ Yes ☐	
12.	Are there any plans for a work ability test?	No ☐ Yes ☐	If yes, please state when:
13.	Are there any plans for employment rehabilitation?	No ☐ Yes ☐	If yes, please state when:
14.	A. Have you been recommended for public disability pension? B: Was it granted?	No ☐ Yes ☐ No ☐ Yes ☐	If A is yes, please state the date: If B is yes, please enclose a copy of the decision
15.	Which municipality do you belong to?		Please state name and address of municipality: ____ ____
16.	Please state name and address of your family physician		Name: ____ Address: ____ Postal code: ___________ City:_________________________
17.	Do you have insurance with another company?	No ☐ Yes ☐	If yes, please state where: ____

Salaried employee

18.	What is your current monthly income?		Please state the monthly amount before tax:
19.	What was your monthly income before your incapacity for work?		Please state the monthly amount before tax:

Self-employed

20.	If you are applying for payment and/or waiver of premium for the first time, please enclose a copy of your tax assessment notice for the last 3 years

Tax information

21.	Euro Accident Liv receives information about your tax card directly from SKAT (the Danish tax authorities).

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Payment information

22.	Name and address of your bank: Reg. Number: Account number:

Questions

All questions must be answered. If there is not enough space, please enclose an appendix.

Signature

I declare that my answers and information are truthful and that I have not concealed any information. I am aware that the insurance may be reduced or terminated if the answers are not completely truthful or if information has been concealed.

Date   Signature

_______________ ____

Consent form on the next page must also be completed and signed in order for Euro Accident to process the application.

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Consent form
Loss of earning capacity and Waiver of premium

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

Consent giver's name: ____

By my signature, I consent to Euro Accident, in connection with my claim, obtaining, using and disclosing any information necessary for the company's assessment of my claim and to Euro Accident disclosing information in this connection for the identification of me and my insurance claim to those from whom the company obtains the relevant information. The company will notify the party from whom information is obtained of the relevant information.

From whom can information be obtained?

With this consent, Euro Accident may obtain relevant information from the following parties, with whom I have been, are or will be in contact in the period stated below:

- My present and former physician
- Public and private hospitals and laboratories, outpatient facilities and clinics
- Specialists, physiotherapists, chiropractors and psychologists
- Alternative therapists
- My present and former municipality of residence
- Other insurance companies and pension funds
- My present and former employer
- Other parties of whom I have notified Euro Accident in connection with my application

With this consent, the mentioned parties may disclose the relevant information to Euro Accident.

To whom may the obtained information be disclosed?

With this consent, Euro Accident may disclose the obtained information to the following parties, who are affiliated with Euro Accident:

- Physicians, specialists and psychologists
- Reinsurance company
- Sygeforsikring Danmark ("danmark" health insurance)
- Hospital/clinic where my case is examined and treated.

In addition, with this consent, Euro Accident may disclose the obtained information to the following parties:

- Public authorities such as municipalities and the National Board of Industrial Injuries
- Insurance companies and pension funds

Which information may be processed?

The consent includes obtaining, using and disclosing the following categories of information:

- Health information, including disease information and information on contacts with the health service
- Information on social and financial matters
- To my employer: Name, civil reg. no. and that this is an insurance case
- From my employer: Working hours, absence due to illness, salary and special working conditions

For which period may information be obtained?

The consent comprises information for a period of 10 years prior to the time of my signing of this consent and until the time when Euro Accident has decided on my insurance claim. If justified by the information for this period, Euro Accident may, for a specific reason, obtain information prior to this period.

Time restriction, notification etc.

The consent applies for one year. I may at any time withdraw my consent and/or have any incorrect or misleading information rectified or erased. Those who are involved in my case are informed of my consent.

I receive notification each time Euro Accident obtains information. I am informed why the information is obtained, which information is obtained and disclosed and for which period and from whom the information is obtained and to whom it is disclosed.

Date	Signature by the insured	Civil reg. no.
___________	____	_______________-_________

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