EURO ACCIDENT
försäkring + hälsa

Claim form
Occupational pension and premium waiver

In order to process your case, please attach:

- a copy of all sick leave certificates
- a certified copy of an ID document (driving licence, passport or other approved ID document), see appendix

Insured

Name	Swedish Social Security Number
Postal address	Postcode and city
Telephone	E-mail

Occupational pension– payment

Payment to the insured is deposited at (name of the bank)		
Clearingnr	☐ Bank account number	☐ Personal account number

Premium waiver insurance

In which company du you have occupational pension insurance today?

Incident report (n/a if claim is due to illness)

Specify exact date of the incident, where and how the accident occurred and describe injuries sustained?

Name of the illness

Name of the illness		When was the illness first diagnosed?	When was yuor first medical visit?
Have you previously suffered from a similar illness? ☐ Yes ☐ No	When was the illness diagnosed?	Name of the illness	Date when were you cured from this illness?

Occupational tasks

Describe your occupational tasks below

Euro Accident Livförsäkring AB
Bäckgatan 16, 352 31 Växjö

www.euroaccident.se Tel 0771- 10 50 11

» Mandatory questions (in case of accident/illness)

Has the accident / illness caused incapacity at work/sick leave? ☐ Yes ☐ No			
If Yes, please indicate to what extent?	☐ 100 %	From	To
	☐ 75 %	From	To
	☐ 50 %	From	To
	☐ 25 %	From	To
Are you working full time? If Yes, from when? ☐ Yes ☐ No From		Do you have company sponsored health insurance from another company? ☐ Yes ☐ No	
If Yes, at which company?		Is the injury/illness reported to this company? ☐ Yes ☐ No	What is the compensation amount for full sick leave per month?
Were you fully or partially unemployed when you were on sick leave? If Yes, enter from when ☐ Yes ☐ No From		Enter your annual income (the one reported to Försäkringskassan).	

» Other compensation

Are you entitled to sickness or rehabilitation allowance or other rehabilitation compensation due to incapacity of work, from other insurances or other countries insurance funds? ☐ Yes ☐ No
If Yes, at which company or from which country?

» Additional information

Please provide any additional information that might be relevant to you claim:

» Processing of personal data

As a Controller, Euro Accident processes personal data to be able to offer and provide the insurance and services on which we have agreed and for other purposes such as, for example, compliance with laws and other rules. Further detailed information about the processing of personal data is available from Euro Accident's Integrity Policy (available at www.euroaccident.se) or by contacting Euro Accident. Our Integrity Policy not only includes information about how Euro Accident collects and uses your personal data, but also information about your rights in conjunction with the processing of personal data, such as the right to information, rectification, data portability, right to be forgotten and to object, etc.

» Signature

The information in this claim form creates the basis for the insurance agreement and its performance. I am aware that incorrect or incomplete information may render the insurance invalid and that any rights to insurance compensation may lapse. I certify that the information is accurate and complete to the best of my knowledge.

I agree that Euro Accident Life Insurance AB obtains information and documents from insurance companies, employers, the Swedish Social Insurance Agency, the Swedish Tax Agency and other authorities that may be necessary to assess the right to compensation. The consent does not apply to obtaining medical records, medical certificates and similar documents.

Place and date (YYMMDD)	Signature
Telephone	Print name

Certified copy of ID document

» Copy of valid identification (to be completed by customer)

Space below for copy of ID document (driving licence, passport or the bank´s or the postal service´s ID card).

PLACE YOUR ID DOCUMENT IN THIS BOX AND TAKE A COPY

» This photocopy of an ID document should be certified by two people (cannot be personally certified by the customer)

The above copy of the ID document is hereby certified

Place and date	Place and date

Signature

Signature

Print name	Print name
Street adress	Street adress
Postcode and district	Postcode and district
Daytime telephone number	Daytime telephone number

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The documents should be sent to:

Euro Accident Livförsäkring AB
Bäckgatan 16, 352 31 Växjö
www.euroaccident.se 077-440 00 10