

» In order to process your case, please attach:

- a copy of all medical certificates.
- a certified copy of an ID document (driving license, passport or other approved ID document), see appendix.

» Insured

Name	Swedish Social Security Number
Postal address	Postcode and city
Telephone	Mobile number
E-mail address	
Employer	Enter your annual income
Describe your occupational tasks below	

» Statement/declaration/report of the accident (n/a if claim is due to illness)

When did the accident happen? Specify date	Was a physician consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, specify date
Describe the bodily injuries you have sustained		
How did it happen?		

» Statement/declaration/report of the illness

Name of the illness	When were the first symptoms noticed?	When was your first medical visit?
Have you previously suffered from a similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	When was the illness diagnosed?	Name of the illness
		Date when were you cured from this illness?

» Mandatory questions (in case of accident/illness)

When was your first day of sick leave, i.e qualifying day?	Has the accident/illness caused incapacity at work/sick leave for more than 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please indicate to what extent?	<input type="checkbox"/> 100 %	From	To
	<input type="checkbox"/> 75 %	From	To
	<input type="checkbox"/> 50 %	From	To
	<input type="checkbox"/> 25 %	From	To
Are you working full time? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, enter from when. From		
Were you fully or partially unemployed when you went on sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, enter from when. From		

The documents should be sent to:

Euro Accident Livförsäkring AB
Bäckgatan 16, 352 31 Växjö
www.euroaccident.se Tel 0771- 10 50 11

» Other compensation

Are you entitled to sickness or rehabilitation allowance or other rehabilitation compensation due to incapacity of work, from other insurances or other insurance funds?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, at which company or from which country?	
Is the injury reported there?	What is the monthly amount being paid in the case of full compensation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	

» Additional information

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

» Account for payments

Our payments are made via Swedbank's payment system (SUS). Details of the bank account into which the compensation should be paid should therefore be provided via swedbank.se/kontoregister. The bank account may be with a different bank, and it is not required to be a customer of Swedbank. If no bank account details are provided, we will send an advice notice which can be exchanged via Swedbank's website or in certain shops.

» Premium waiver insurance - payment

In which company do you have occupational pension insurance today?

» 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 from the Swedish Social Insurance Agency 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 (insured)
Mobile number	Name

» Copy of valid identification

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 one person (cannot be personally certified by the holder of the ID document)

The above copy of the ID document is hereby certified

Place and date	Signature
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Name	Postal address
Postcode and city	Mobile number

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