CLAIMS REPORT – ILLNESS

SJÓVÁ

To be filled out by the insured

GENERAL INFORMATION

Name of insured person _____ ID no. _____

Address _____ Postcode _____ Town/city _____

Phone (home) _____ Phone (work) _____ Mobile _____

e-mail _____

Employer _____ Job title _____ Work percentage _____

How many working hours per week? _____

Name of insurance policy holder (if not the injured) _____ ID no. _____

CLAIM INFORMATION

Name of the illness _____

When did first symptoms occur (date)? _____ First day of absence from work due to the illness? _____

Describe the symptoms and effects on physical and mental health (give details): _____

Is the illness connected to abuse of drug or alcohol? ☐ Yes ☐ No If yes, give details _____

Are you unable to work? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ Fully able to work

For how long do you expect to be unable to work? _____

TREATMENT

When did you first seek treatment for the illness? _____ ☐ Have not sought physician/treatment

Where did you first seek treatment for the illness? _____

Name of general practitioner _____

Address _____

Name of other physicians/treatment centres _____

Address _____

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FORMER HEALTH

Were you healthy and fully able to work before the illness? ☐ Yes ☐ No ☐ On disability pension

Have you suffered from the same or similar illness before? ☐ Yes ☐ No If yes, when last? _____

Have you previously been hospitalised due to any accident/illness? ☐ Yes ☐ No

If yes, when and why? _____

Any former disability evaluations? ☐ Yes ☐ No

If yes, when? _____ Percentage of disability _____%

Clarification _____

OTHER INFORMATION

_____

_____

_____

_____

_____

I, the undersigned, do hereby truthfully attest that the above answers and information I have provided herein are to the best of my knowledge correct and that I have not concealed any facts that might be of importance with respect to any decision Sjóvá may make regarding its liability, if any, and the amount of insurance benefits. I am aware that any false or insufficient information may affect my right to receive insurance benefits.

Bank account information: _____ – _____ – _____ **SSN (Kennitala):** _____

_____ _____

City and date Signature of insured person

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AUTHORISATION FOR RELEASE OF INFORMATION

I hereby authorise Sjóvá to gather any necessary information and documents from doctors, hospitals, clinics or other treatment centres regarding my state of health as well as prior/later accidents or illnesses the company considers relevant for assessing this claim.

This authorisation includes e.g. Sjóvá´s right to access information in my medical journals if concidered necessary. Furthermore, I authorise Sjóvá to obtain any necessary information and documents from The Icelandic Health Insurance and Social Insurance Administration, pension funds, tax authorities, trade union sick-pay funds, AOSH (Administration of Occupational Safety and Health), police and other insurance companies as necessary to determine liability and benefits.

I realise that this authorisation includes consent for processing sensitive personal data in accordance with law 77/2000, and that my concent can be revoked by writtent statement to the company.

All personal information is treated as confidential and access restricted to those who process the claim or have been granted clear permission/authority, I understand that incomplete information may affect my rights to receive benefits.

Date of illness	Signature of claimant
City and date	ID number