

NOTIFICATION OF CLAIM - LOSS OF EARNING CAPACITY



Danica Pension • Parallevej 17 • 2800 Kgs. Lyngby • Denmark
Telephone +45 70 11 25 25

Policy No. (please state the numbers of all relevant policies)		
Name of the insured		CPR No.
Address		
Email	Tel.	Mobile

To be completed by the insured.
You must answer all the questions. Use a blank sheet of paper if there is not enough room for your answer next to each question.

1.

First sick day:	Date: _____
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2.

What illness or condition are you suffering from? Or please describe how it affects your overall health.	_____

3.

Have you lost your earning capacity as the result of an accident?	No	Yes	If no, please answer questions 3a → 3b: If yes, please answer questions 3c → 3f:
	<input type="checkbox"/>	<input type="checkbox"/>	
If no:			
a. When did you notice the first symptoms of your illness or condition?			_____
b. Have you had these symptoms before? If yes:	<input type="checkbox"/>	<input type="checkbox"/>	If yes: When? _____
If yes:			
c. When did the accident occur?			Date: _____ Time: _____
d. How did the accident occur and what was the direct cause of the accident?			_____

Please answer these questions as precisely and thoroughly as possible so Danica Pension has a clear understanding of what happened.			
e. Was a police report filed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes: At which police station? _____
f. Were you or anyone else involved in the accident tested for alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____

4.

Have any other illnesses or conditions affected your current condition?	No	Yes	If yes:
	<input type="checkbox"/>	<input type="checkbox"/>	Which illness(es) or condition(s)? _____

			When did you first suffer from it or them? _____

5.

What job (position) did you hold before losing your earning capacity?	_____
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6.

What were your working hours before losing your earning capacity?	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	Number of hours per week _____
	<input type="checkbox"/> Incl. lunch break	<input type="checkbox"/> Excl. lunch break	

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7.

What type of work did you do?	<input type="checkbox"/> Manual labour or skilled tradesman	Number of hours per week _____
	<input type="checkbox"/> Office work	_____
	<input type="checkbox"/> Management	_____
	<input type="checkbox"/> Sales	_____
	<input type="checkbox"/> Security	_____
	<input type="checkbox"/> Driving	_____
	<input type="checkbox"/> Other - please specify _____	_____

8.

What was your gross income (from all sources of income) before losing your earning capacity?	DKK _____
<input type="checkbox"/> Weekly	<input type="checkbox"/> Every two weeks
<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly

9.

Your gross income comes from:	<input type="checkbox"/> Your salary	DKK _____
	<input type="checkbox"/> An independent business or enterprise	DKK _____

10.

Have you lost your earning capacity completely, and have you been fully unable to work since your first sick day?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If no, please answer questions 10a → 10d:
a. When did you fully return to work?	Date _____	
b. When did you partially return to work?	Date _____	Number of hours per week _____
c. Which of your usual job functions are you currently not able to perform?	_____	

d. Which of your usual job functions are you currently able to perform?	_____	

11.

When do you believe that your health will have improved enough for you to fully or partially regain your earning capacity?	<input type="checkbox"/> Fully	Date _____
	<input type="checkbox"/> Partially	Date _____
	<input type="checkbox"/> Never	Number of hours per week _____

12.

Do you receive or have you received statutory sickness benefit? (please enclose documentation)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes: From which date? _____
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13.

Are you receiving full salary from your employer during your sick leave?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes: Until when? _____	Date _____
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14.

Who is your usual doctor?	Name _____
	Address _____

15.

Place of treatment:	<input type="checkbox"/> No treatment	<input type="checkbox"/> At home	<input type="checkbox"/> At the doctor's
	<input type="checkbox"/> At an outpatient clinic	<input type="checkbox"/> At a hospital	
	Please state the details of the attending doctor, specialist, hospital, treatment centre or the like:		
	Name _____		
	Address _____ _____		
	First treatment	Date	_____
	Latest treatment	Date	_____

16.

Have you been recommended for or been granted:	No	Yes	If yes:
	<input type="checkbox"/>	<input type="checkbox"/>	When? _____
	<input type="checkbox"/>	<input type="checkbox"/>	Municipality/Business _____
	<input type="checkbox"/>	<input type="checkbox"/>	Address _____ _____
	Officer _____		

17.

a. Have you filed a claim for public anticipatory pension?	No	Yes	If no:
	<input type="checkbox"/>	<input type="checkbox"/>	Please state why, if relevant _____
			If yes:
			When? _____
		Municipality _____	
		Address _____	
		Officer _____	
b. Has a final decision been made about your claim for anticipatory pension?	<input type="checkbox"/>	<input type="checkbox"/>	To be answered only if Yes to question 17a
c. Have you been granted anticipatory pension?	<input type="checkbox"/>	<input type="checkbox"/>	To be answered only if Yes to question 17b
d. Did you appeal the decision?	<input type="checkbox"/>	<input type="checkbox"/>	To be answered only if No to question 17c

18.

Have you notified or do you intend to notify the claim to other insurance companies?	No	Yes	If yes:
	<input type="checkbox"/>	<input type="checkbox"/>	Which company? _____
			Policy No. _____
			Type of insurance _____

19.

Tax information	
Which tax card should we use when disbursing taxable benefits to you?	<input type="checkbox"/> Primary tax card
If you do not have a tax card with the Danish tax authorities, we are under an obligation to withhold 55 % in taxes at source pursuant to the Danish Act on tax at source. This also affects those who are generally not taxed at source.	<input type="checkbox"/> Secondary tax card
	<input type="checkbox"/> Tax exemption card
	<input type="checkbox"/> Other - please specify: _____

Declaration

The undersigned declares that all questions have been answered to the best of his or her knowledge, and that the undersigned has not concealed any information which might be relevant to a decision on whether the conditions laid out in the insurance policy have been fulfilled.

Date _____ CPR No. _____ Signature _____

We need your consent – this is why

To be able to assess your request for insurance benefits, we need information about your accident, your illness or any other event substantiating your insurance claim. We will typically need information about your illness and treatment, if any, and information about your financial situation and other matters may also be relevant. We may also need information from before the accident/illness in order to assess whether your current condition may have causes that are irrelevant to the insurance.

The information stated in the request for insurance benefits or the claims notification is thus in many cases not sufficient. Remembering information dating back a while can be difficult. This may be particularly true when the information is of a medical or financial nature, for example. We therefore need to be able to obtain such information from sources that are also familiar with the circumstances and have documentation of the events in medical records, files and the like.

When you make a request for benefits from Danica Pension, you are required under the Danish Insurance Contracts Act to provide us with all available information relevant to the assessment of your claim.

Your doctor and others may disclose health information with your consent

Pursuant to the Danish Health Act, your doctor may disclose information about your health, information about other personal matters and other confidential information if you give your consent.

Pursuant to other legislation, public authorities and insurance companies and others may also disclose information about you if you give your consent.

You will be notified each time Danica Pension obtains information

Each time we obtain information, you will be notified about why we requested the information, the type of information we requested, the precise period for which we requested it and from whom.

You can withdraw your consent at any time

A copy of this consent will be given to anyone from whom Danica Pension wishes to obtain information. If you change your mind about having given your consent, you can withdraw it at any time. You can do so by calling us on +45 45 13 22 98 or by contacting us via danicapension.dk.

If you choose to withdraw your consent, this will only apply from the date of your withdrawal. This means that, up to the date of withdrawal, the registration and use of your personal data will be based on the consent you have previously given.

Please note that withdrawing your consent could mean that we will not be able to process your request for benefits, as we will not be able to obtain all relevant information that we need to assess your claim.

Processing of personal data

We protect your personal data by taking all relevant measures in accordance with the legislation.

Read more about how Danica Pension looks after your personal data and the privacy rights you are granted by law at [\[\[danica.dk/personoplysninger\]\]](http://danica.dk/personoplysninger).

CONSENT

FP 004 CONSENT: WHEN I BECOME INJURED OR ILL
INSURANCE AGAINST LOSS OF EARNING CAPACITY

Danica Pension • Parallevej 17 • 2800 Kgs. Lyngby • Danmark
Telefon 70 25 02 03

Consenter's name:	Consenter's civil reg. no
Case No.:	

With my signature, I consent to Danica Pension, collecting and disclosing, in connection with my application for payment, the information relevant for the company's consideration of my application.

Danica Pension collects information to be able to assess whether my loss of earning capacity is covered by the insurance. In this connection, Danica Pension may disclose information that identifies me (such as my civil registration number) and relevant information about my insurance case and my health to the parties from which the company collects information. Danica Pension will specify to the parties from which information is collected what information is relevant.

From whom can information be collected?

With this consent, Danica Pension may for one year from the date of my signature collect relevant information from the following parties:

- My current and former general practitioner.
- Public and private hospitals, clinics, centres and laboratories.
- Medical specialists, physiotherapists, chiropractors and psychologists.
- My current and former municipality of residence.
- Other insurance companies and pension funds from which I have applied for payment.
- AS3 Work&Care (www.as3workcare.dk)
- My current and former employer.

With this consent, the specified parties may for one year from the date of my signature disclose the relevant information to Danica Pension.

To whom may relevant case information be disclosed?

With this consent, Danica Pension may disclose relevant case information to the following parties in connection with the consideration of my application for payment:

- Medical specialist who is to fill in or prepare a medical specialist's certificate.
- My current and former employer.
- AS3 Work&Care (www.as3workcare.dk)

What types of information may be collected and disclosed?

The consent covers collection and disclosure of the following categories of information:

- Medical information, including information about illnesses, symptoms and contacts to the health services.
- Municipal information about sickness benefits, test of capacity for work, resource clarification, decision on flexjob and incapacity benefits or other social security benefits.
- To my employer: Name, civil reg. no. and the fact that it is an insurance case.
- From my employer: Working hours, sickness absence, salary and special working conditions.

For what period of time may information be collected?

The consent covers information for a period of 10 years prior to the date of occurrence or the time of onset of the disease and until the time when Danica Pension has considered my application for payment.

In connection with an assessment of whether the current payment should be maintained, the period is calculated from the time of assessment.

If the information for that period so warrants, Danica Pension may, providing a specific reason, also collect information relating to the time before that period.

Withdrawal of consent

I can withdraw my consent at any time with effect for the future. The withdrawal may affect the ability of Danica Pension to consider my application for payment.

Date

Signature

Consenter's civil reg. no