# FP 013 Consent: Deceased

**Non-life insurance**

With my signature, I consent to [name of company], collecting, using and disclosing, in connection with my application for payment after *[name and civil reg. no. of the deceased]*, the information about [name and civil reg. no. of the deceased] which is relevant for the company's consideration of my application.

In this connection, [name of company] may disclose information that identifies [name of the deceased] (such as civil registration number) and relevant information about [name of the deceased]'s insurance case and health to the parties from which the company collects information. [Name of company] will specify to the parties from which information is collected what information is relevant.

***From whom can information be collected?***

With this consent, [name of company] may for one year from the date of my signature collect relevant information from the following parties:

* The deceased's general practitioner.
* Public and private hospitals, clinics, centres and laboratories.
* Medical specialists, physiotherapists, chiropractors and psychologists.
* Labour Market Insurance (<https://aes.dk/>).
* Municipality of residence of the deceased.
* Other insurance companies.
* The police.
* The state administration.
* Statens Serum Institut and the Danish Health Data Board, including information from the Cause of Death Register.
* The administrator.
* Others (state the name and other relevant contact information).

With this consent, the specified parties may for one year from the date of my signature disclose the relevant information to [name of company].

***To whom may relevant case information be disclosed?***

With this consent, [name of company] may disclose relevant case information to the following parties in connection with the consideration of my application for payment:

* Others (state the name and other relevant contact information).

***What types of information may be collected, used and disclosed?***

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

* Medical information, including information about illnesses, symptoms and contacts to the health services.
* Death certificate, inquest and autopsy reports.
* Police reports.

***For what period of time may information be collected?***

The consent covers information for a period of [insert] years prior to the date of occurrence and until the time when [name of company] has considered my application for payment.

If the information for that period so warrants, [name of company] 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 [name of company] to consider my application for payment.

Date: ………………… Signature: ……………………………………… Civil reg. no.: \_ \_ \_ \_ \_ \_ - \_ \_ \_ \_