# FP 004 Consent: When I become injured or ill

# Insurance against loss of earning capacity

With my signature, I consent to [name of company], *collecting, using and disclosing*, in connection with my application for payment, the information relevant for the company's consideration of my application.

[Name of company] collects information to be able to assess whether my loss of earning capacity is covered by the insurance. In this connection, [name of company] 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. [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:

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

* Medical specialist who is to fill in or prepare a medical specialist’s certificate.
* *My current and former employer.*
* 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.
* 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 [insert] years prior to the date of occurrence or the time of onset of the disease and until the time when [name of company] 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, [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.: \_ \_ \_ \_ \_ \_ - \_ \_ \_ \_