TRYGGINGARFELAGIÐ LÍV
Postboks 206
Kopargøta 1
FO-110 Tórshavn
Tel. 31 11 11
liv@liv.fo
www.liv.fo

Application for Insurance Benefits Due to Incapacity for Work

Insured:			ID-No.: (P-tal)
Adress:			Insur.No:
Postal Code:	City/Town:		Tel.:

The undersigned hereby provides the following information regarding the illness or accident that is the reason for this application

1.	From what date has your ability to work or earn a living been reduced?	
2.	What illness or injury has caused the incapacity for work?	
3.a	When did the illness or injury begin or occur?	3.a
3.b	When did you seek medical attention?	3.b
3.c	Who was the doctor, hospital, etc?	3.c
4.a	Have you previously had the above-mentioned illness?	4.a
4.b	If so, when?	4.b
4.c	Have other impairments contributed to your current condition?	4.c
4.d	What impairments?	4.d
4.e	When did you have this/these impairments?	4.e
5.a	Are you currently receiving medical treatment?	5.a
5.b	If so, who is the doctor, hospital, etc.?	5.b
5.c	Are you hospitalised?	5.c
5.d	Where?	5.d
6.a	Are you bedridden?	6.a
6.b	Are you able to be up and about?	6.b
6.c	Are you performing any work? If so, what work?	6.c
6.d	When do you expect to be able to work again?	6.d

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7.	What was your occupation before the incapacity for work?	
8.a	Have you applied for public early retirement pension?	8.a
8.b	If so, when?	8.b
8.c	Was it approved?	8.c
8.d	Are you receiving any public benefits?	8.d
9.a	Have you applied for disability benefits or similar from another insurance company?	9.a
9.b	Was it approved?	9.b
10.	Do you have any additional information to provide?	

I hereby declare, on my honor, that all answers are true and complete, and that I have not withheld any information that may be relevant to the assessment of my situation.

For information regarding consent for the collection and sharing of information, please refer to the special declaration (FP 602).

(Date & Location)

(Signature)

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FP 602 - Consent for the Collection and Sharing of Information

Consent - Insurance Event

You are required to give consent

When you want to take out an insurance or make changes to the insurance agreement during the insurance period, LÍV requires information that may be important for assessing the insurance risk. If you provide false information, or fail to provide relevant information, the consequence may be that you will not receive the insurance amount, or only part of it, on the day you make a claim for reimbursement from LÍV. This is stated in the Insurance Agreement Act

Insurance Payout

You are entitled to claim compensation, in accordance with the law, no sooner than 14 days after LÍV has received the necessary information to process the case and decide on the insurance payout. This is pursuant to the Insurance Contracts Act.

Your Doctor and Others May Share Information

Your doctor may, with your consent, provide further information regarding your health conditions, other private matters, and any confidential details. Public authorities, insurance companies, and other relevant parties may also, with your consent, share information about you. These rights are in accordance with current legislation.

You can always withdraw your consent

Your consent is valid for one year after it is given. A copy of this consent will be provided to anyone LÍV requests information from. If you change your mind, you can always withdraw your consent.

You will receive a notification every time LÍV collects information

Each time LÍV collects specific information, you will receive a notification explaining the purpose of the request, the type of information being requested, the time period it covers, and from whom LÍV intends to collect the information.

Consent

I hereby give my consent for LÍV to collect all relevant information. This includes medical information, details regarding my health conditions, contact with healthcare providers, and information on social matters, among others.

Information may be collected from doctors, hospitals, and other relevant parties within the healthcare sector, public authorities, including social services/municipalities, the Accident Insurance Council, the police, as well as other insurance companies and pension funds. The collected information may be shared with other insurance companies, public institutions, and certified healthcare professionals who are involved in handling my case.

This consent covers the information required until LÍV has reached a final decision regarding the claim for compensation. A copy of this consent will be provided to doctors and others from whom LÍV requests information.

_____ _____

(Date & Location) **(Signature)**

The Medical Association has approved that this consent form may be used when requesting health information, etc., from doctors. When information is requested from doctors, this agreed form will be used and supplemented with copies or extracts of relevant medical records if requested by LÍV.