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

Application for Payout Due to Specified Critical Illness

Name (tinsurec+possibly insured child)	ID-No.: (FO+possibly DK)
Adress:	Insur.No.: + possible union

Postal Code:	City/Town	General Practitioner:

Only the illness-related decisions listed below may be applied for:

I (or my child) have been diagnosed with one of the following illnesses:

	A. Cancer		O. Kindey failure
	B. Blood clot in heart(myocardial infraction)		P. Organ transplantation
	C. Conoary bypass surgery or angioplasty for coronary artery disease		Q. Parkinsons disease-Paralysis agitans
	D. Heart valve surgery		R. Loss of vision
	E. Life-threatening arrhythmia with ICD implantation (pacemaker)		S. Loss of hearing
	F. Aortic disease (main artery disease)		T. Alzheimer disease
	G. Stroke(brain haemorrhage or clot in brain)		U. Creutzfeldt-Jacobs disease
	H. Intracranial aneurysm, AV malformation, or cavernous angioma in the brain		V. Meningitis-only applicable for insured children
	I. Specific benign tumors in the brain or spinal cord		W. Consequences of Brain or Meningeal Inflammation
	J. Multiple sclerosis		X. Significant Burn Injuries (ambustio)
	K. Motor neuron disease (MND)		Y. Permanent heart failure associated with the implantation of an ICD/CRT device or durable mechanical heart pump, e.g., Heartmate
	L. Muscular dystrophy		Z. Heart disease requiring surgery – only applicable for insured children
	M.HIV infection resulting from blood donation or occupational exposure		Æ. Histiocytoses and fibromatoses – only applicable for insured children
	N. AIDS		Ø. Consequences of Borrelia infection or Tick-Borne Encephalitis (TBE)

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The diagnosis and the date of confirmation:
(Date)

Regarding the illness, please state:
(name of the municipal doctor, which hospital and department treated it, and when and for how long the hospitalization occurred, etc.)

If surgery is involved, specify which surgery and the date it was performed or is planned:

Have you (or the child) previously had any of the specified critical illnesses?
Check: No ___ Yes ___

If yes, which one and when?

At which hospital was the diagnosis made:

I hereby confirm that the above information is true and complete. For information regarding the collection and sharing of information, please refer to the special declaration (FP 602).

Date

Signature

If this concerns incapacity for work, you are asked to answer the questions below:

Occupation:

First sick day:
(Date)

When do you expect to return to work:

	I have not been on sick leave
	I returned to work on:
	I expect to return to work on:
	I do not expect to be able to work again
	I don't know

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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.