sStarfstrygging Hagals, tjónskýrsla

Eyðublað þetta á að fylla út og senda hið fyrsta til Hagals, Árna Reynissonar ph.1166,121 Reykjavík

ÁRÍÐANDI: LESIÐ EFTIRFARANDI VEL

a) Vinsamlega svarið öllum spurningum og notið **blokkskrift, hástafi.** Ónákvæmni getur valdið töfum.

b) Tjónþoli svarar spurningum 1- 9 og skrifar undir neðst á síðu 1. Ef hann getur ekki gert það sjálfur má hann leita aðstoðar hjá öðrum.

c) Samþykki varðandi læknisvottorð verður tjónþoli að undirrita þega hann hefur lesið textann sem skýrir lagaleg réttindi hans. (Medical Reports Act 1988.)

d) Heimilislæknir tjónþola fyllir út læknisvottorðið á síðu 2 á kostnað tjónþola.

e) Vinsamlega sendið afrit af tryggingarskírteini með eyðublaðinu.

f) Ef sótt er um sjúkralaun er rétt að vera viðbúinn spurningum um launatekjur. Sjálfstætt starfndi folk gæti þurft að sýna ársreikning.

1. SKÍRTEINI

Númer____

Tryggingartaki___________________________________

____

2. TJÓNÞOLI

Fullt nafn_______________________________________

____

Starf____

Kennitala________________________ Sjálfstætt starfandi JÁ/NEI

Heimili ____

Póstfang____

____

______________________________ ____________

Símar____

Vinnuveitandi____________________________________

Staður póstfang__________________________________

____

____

____

Vinnusími____

3. SLYS EÐA SJÚKDÓMAR

Tímasetning tjónsatburðar, ______________________

____

Hvar átti hann sér stað?_________________________

Hvers kyns er ororka þín?________________________

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____

Hvernig vildi áfallið til?_______________________

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____

____

Hvaða dag varðst þú fyrst óvinnufær?_____________

____

Hvenær leitaðir þú fyrst læknishjálpar?__________

5. LÆKNIR

Nafn fyrsta læknis sem leitað var til, og staður:_______________

____

____

____

Ef hann er ekki heimilislæknir þinn, hversvegna leitað til hans?__________

____

____

6. SJÚKRASAGA

Hefur þú áður þjáðst af sama eða svipuðu einkenni? Sé svo, óskast nánari upplýsingar ?

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____

7. LOK SJÚKRALEYFIS

Er þú enn alls óvinnufær? JÁ/NEI

Hvenær býst þú við að fara til starfa á ný?______________________

Ef þú ert nú þegar starfandi, hvenær varðst þú

a) Fær til starfa að hluta?______________________________

b) Fullfrískur?_____________________________

8. FYRRI TJÓN

Hefur þú áður sótt bætur í þessa tryggingu? Sé svo, óskast nánari upplýsingar.

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9. AÐRAR TRYGGINGAR

Átt þú rétt á bótum úr annarri tryggingu vegna þessa tjóns? Sé svo, upplýstu nánar.

Tryggingafélag, nafn, útibú og staður:________________________

____

Skírteinisnúmer__________________________________

Bótafjárhæð______________________________________

Ég staðfesti að svör mín hér að ofan eru sönn og að ég skil að ef ég hef vitandi gefið ranga mynd, falla allar bætur úr þessarri tryggingu niður. Ég skil að hluti ofangreindra upplýsinga sem ég hef veitt verða afhentar öðrum tryggjendum til ákvörðunar bóta og tjónaumsýslu. Ég samþykki að upplýsinga megi leita til annarra tryggjenda til samanburðar á upplýsingum mínum og staðfesti að þær megi veita.

Undirritun______________________________________ Dags.______________Banki: _______-______-__________

Lækningatrygging – útlagður kostnaður sbr hjálögð fylgiskjöl: ______________ISK / EUR

ACCESS TO MEDICAL REPORTS ACT 1988

As part of your claim, a medical report may be required from your Doctor. However, before Underwriters can apply for a Medical Report your consent is required. Before signing the Consent Form you should read the following summary of your rights.

A) You can withhold your consent but if you should do so your Insurers may be unable to process your claim.

B) If you wish to see the Report, we will tell you at the same time we write to the Doctor and you will then have 21 days to contact the Doctor about arrangements for you to see the Report. Whether or not you wish to see the Report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied, if you ask.

C) You can ask your Doctor if he/she will amend any part of the Report which you consider to be incorrect or misleading. If the Doctor is not in agreement, you may append your comments to the Report.

D) Your Doctor can in certain circumstances withhold the Report or any part of it from you.

CONSENT TO OBTAIN A MEDICAL REPORT

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, as explained above, and in connection with my Insurance claim I hereby consent to the Insurers seeking medical information from any Doctor who at any time has attended me concerning anything which affects my physical or mental health in connection with this claim and I agree that a copy of this consent shall have the validity of the original.

Please ✓ the appropriate box

I wish to see the Report before it is sent to the Insurers

I do not wish to see the Report before it is sent to the Insurers

Signature____________________ Name (please print)____________________

Name and Address of Doctor____________________

____

MEDICAL REPORT: to be completed by Claimant's Doctor

The Claimant must arrange **at his/her own expense** for completion of the following certificate by a duly qualified and Registered Medical Practitioner.

1. Are you the usual Medical Attendant of the Claimant? YES/NO
2. If YES, how long have you known the Claimant?____________________
3. If NO, in what capacity are you treating the Claimant?____________________
4. On what date did you first attend the Claimant for his/her current disability?____________________
5. On what date did you first sign the Claimant as unfit for work?____________________
6. Please confirm the nature of the illness/injury sustained together with the precise diagnosis and treatment being given.____________________

   ____

   ____
7. Has the Claimant suffered from this or any associated complaint in the past? YES/NO

   If YES, please give details including the treatment given.____________________

   ____

   ____
8. At the time of the accident or onset of illness was the Claimant suffering from any other illness or injury? YES/NO

   If YES, please give details with medication prescribed and advise whether this will affect recovery from present disability____________________

   ____

   ____
9. Is the disability due to self inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, abortion, venereal disease or other sexually transmitted disease or HIV related illness including Acquired Immune Deficiency Syndrome (A.I.D.S.) or A.I.D.S. Related Complex (A.R.C.)? YES/NO

   If YES, please give details including the treatment given.____________________

   ____

   ____
10. Has the Claimant been confined to the house during the period of disability? YES/NO

    If Claimant has been confined, for how long?____________________
11. When do you expect the Claimant to a) return to partial duties____________________

    b) return to full time duties____________________
12. If the Claimant has already returned to work please give dates a) return to partial duties____________________

    b) return to full time duties____________________
13. Any other remarks____________________

    ____

DECLARATION BY DOCTOR

I confirm that the Claimant is/was under my medical supervision and is/was totally prevented from working for remuneration or profit from his/her usual occupation as stated above.

Official Surgery Stamp

Doctor's Signature____________________

Doctor's Name (please print)____________________

Qualifications____________________

Date____________________