Pdf instructions | Reset

LOCALTAPIOLA

Claim

Working capacity insurance

- ☐ Treatment expenses cover
- ☐ Pharmaceutical expenses cover
- ☐ Therapy cover
- ☐ Surgical expenses cover

	Insurance number	Claim reference	
Policyholder	Name		Business ID
	Street address	Postal code	City or town
	Telephone number of the company's contact person		
Insured	Last name and first names		Personal ID code
	Street address	Postal code	City or town
	Phone number	Profession	
	E-mail	☐ Information relating to the claim can be sent by email.	
Claimant	☐ Policyholder ☐ Insured		
	Account number		
Information on illness	Date the illness or symptoms occurred	First day of treatment by physician	
	Period of hospitalisation	Name of hospital	
	Name of clinic and treating physician		
	Have you suffered from the same illness or symptoms relating to the illness before? ☐ No ☐ Yes, first day of treatment by physician, name of clinic and treatment periods		
	Description of illness and occurred symptoms		

Information on accident

Date and time of accident | First day of treatment by physician and name of clinic | Place of accident

The accident occurred

☐ During gainful employment, travel relating to gainful employment or travel between the home and place of work

☐ During entrepreneurial activity or other corresponding work, travel relating to such work or travel between the home and the place of work

☐ Traffic accident ☐ Leisure time ☐ Professional sports

☐ Other. Please specify:

Injured body part

☐ Left ☐ Right

Has the same body part been injured or showed symptoms before?

☐ No ☐ Yes. Please specify when:

Was the injured under the influence of alcohol or any other narcotic substance?

☐ No ☐ Yes. Please specify how much he/she had consumed:

Police investigation

☐ Has not been performed ☐ Has been performed

Name of police department

Description of accident and causes

Other insurance policies

Have you applied for or received compensation on the basis of statutory or voluntary insurance or by virtue of law? ☐ No ☐ Yes

Please specify from which party:

Appendices

— Original expenses receipts or original decision by Kela and copies of related documents.

— Copy of prescription or pharmaceutical calculation issued by a pharmacy as well as the original receipt from pharmacy.

— Original invoices for daily hospital charges and outpatient clinic charges and related receipts.

— Pre-trial record if a police investigation has been made.

The information and documents required for claims handling are usually specified in connection with the claims process. Eventual additional information or documents required for the claims handling will be requested separately.

Claims handling

Information on claims filed to LocalTapiola is saved in the insurance companies' mutual claims register. At the same time, we shall examine the losses reported to other insurance companies. The information is only used in connection with the claims handling in order to prevent crime against the insurance companies.

Power of attorney

I hereby consent that physicians, hospitals, health centres, welfare clinics, occupational health care units, mental health offices and private hospitals that have examined and treated the insured, as well as other insurance companies and insurance and pension institutions, may provide LocalTapiola Group with information on the insured's state of health as required to handle the claim. In order to gain the required information, the aforementioned companies may provide the parties mentioned above with detailed information on the insured's state of health and the insurance.

I hereby give my consent as above and assure that the information given is true and correct.

Signature

Place and date

Insured's signature

Policyholder's signature (only if the beneficiary is the policyholder)

Claim

To local Kela office/employee sickness fund

The application shall always be filled in if the claimant wants the insurance company to pay compensation for medical treatment expenses as stipulated in the Health Insurance Act.

Personal data

Last name and first names of insured

Personal ID code | Permanent domicile

Address | Phone number

Information on claim

Do the expenses relate to a traffic accident, occupational accident or occupational disease?

☐ No ☐ Yes

Please pay the compensation to LocalTapiola's account number

Has the insured received compensation from elsewhere?

☐ No ☐ Yes

Please specify from which party:

Signature

I hereby declare that the information given in this application is true and correct

Place and date

Signature of insured or his/her representative

Print | To the first page