

DA1



Entitlement to Health care cover under insurance against Accidents at work and Occupational Diseases

EU Regulations 883/04 and 987/09 (*)

INFORMATION FOR THE HOLDER

This document is for insured persons who move to, reside or stay in a EU State other than the State of insurance against Accidents at Work and Occupational Diseases (AWOD). You must present this document to the healthcare/AWOD institution in the State of residence or stay to gain entitlement to health care benefits. You may be entitled to a supplementary reimbursement according to national reimbursement rates of the place of stay.

Your health care institution will advise you on this. For a list of health care institutions, see <http://ec.europa.eu/social-security-directory/>

1. PERSONAL DETAILS OF THE HOLDER

1.1 Personal Identification Number in the competent Member State		
1.2 Surname		
1.3 Forenames		
1.4 Surname at birth (**)		
1.5 Date of birth		
1.6 Status		
☐ 1.6.1 Employee	☐ 1.6.2 Self-employed person	☐ 1.6.3 Unemployed
1.7 Address in the State of residence/stay		
1.7.1 Street, N°	1.7.3 Post code	
1.7.2 Town	1.7.4 Country code	UK

2. THE HOLDER MAY RECEIVE BENEFITS IN KIND

☐ 2.1.1 for accident at work	☐ 2.1.2 for occupational disease
2.2 Expected period of treatment	
☐ 2.2.1 for a period laid down in the provisions of the legislation of his State of residence	
☐ 2.2.2 start date	end date
☐ 2.2.3 for a maximum of three months	☐ 2.2.4 for an unlimited period

(*) Regulations (EC) No 883/2004, article 36, and 987/2009, article 33.

(**) Information given to the institution by the holder when this is not known by the institution.

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3. THE HOLDER HAS A RIGHT TO HEALTH CARE ON GROUNDS OF

☐ 3.1 The accident at work sustained	3.1.1 on (date)
3.1.2 which had the following consequences	
☐ 3.2 The occupational disease diagnosed	3.2.1 on (date)
3.2.2 which had the following consequences	
☐ 3.3 The authorisation which we have granted to the person concerned to retain the rights to benefits	
in kind in UK	(State) where he is going
☐ 3.3.1 to take up residence	☐ 3.3.2 to receive medical treatment

4. THE REPORT OF OUR EXAMINING DOCTOR

☐ 4.1 is attached in a sealed envelope	☐ 4.2 may be obtained on request
☐ 4.3 was sent	
4.3.1 on	4.3.2 to
☐ 4.4 has not been drawn up	

5. INSTITUTION COMPLETING THE FORM

5.1 Name	
5.2 Street, N°	
5.3 Town	
5.4 Post code	5.5 Country code UK
5.6 Institution ID	
5.7 Office fax N°	
5.8 Office phone N°	
5.9 E-mail	
5.10 Date	
5.11 Signature	

STAMP