INSURANCE CLAIM

Medication-related injury

Svenska Läkemedelsförsäkringen AB
ETT BOLAG INOM LFF SERVICE AB, LÄKEMEDELSFÖRSÄKRINGEN

1. CLAIMANT (INJURED PERSON)

Surname, first name (please underline given name)		Swedish personal identification no. (yyyymmdd-nnnn)
Street name and number		Tel. home (incl. area code)
Post code	Town	Tel. work (incl. area code)
Profession / Occupation		

2. PRIMARY COMPLAINT

For which primary complaint were you treated? Diagnosis?

☐ Road traffic accident ☐ Workplace injury

Name of the doctor/s that has/have treated you?	Hospital/Clinic

Has your primary complaint resulted in your taking sick leave from work? ☐ No ☐ Yes	Completely from	to	Partially from	to

Have you been admitted to hospital for your primary complaint? ☐ No ☐ Yes	Hospital	Department

3. MEDICATION

Medication presumed to have caused the injury

Name of the doctor who prescribed this medication?	Hospital/Clinic

When was the medication prescribed?	For whom was the medication prescribed? ☐ The claimant ☐ Another person	From which pharmacy or hospital was the medication purchased or administered?

When did the medication first start to be used?	When was usage of the medication stopped?

Dosage. Please copy from the label (or attach the packaging with the label)

Has the doctor provided additional instruction for how to take the medication?

☐ No ☐ Yes, including:

Have you followed these dosage and other instructions? ☐ No ☐ Yes	Deviated as follows:

Have any other medications been used at the same time as the above?

☐ No ☐ Yes, the following:

Have naturopathic medicines been used at the same time as the above?

☐ No ☐ Yes, the following:

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Box 17608, 118 92 Stockholm

VISITING ADDRESS
Sveavägen 63, Stockholm

TELEPHONE
08-462 37 00

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08-462 02 92

E-MAIL
info@lakemedelsforsakringen.se

WEBSITE
www.lakemedelsforsakringen.se

4. MEDICATION-RELATED INJURY

Has a claim for this injury been made to the Swedish Patient Insurance (LÖF or other)?

☐ No ☐ Yes

How would you describe your medication-related injury?

Any other comments on the origin of the injury?

When was the injury first noticed?

When was a doctor first consulted regarding the injury?

Name of the doctor who first examined the injury?

Hospital / Clinic

Which other doctors, care professionals or pharmacists have provided information?

5. CONSEQUENCES OF THE MEDICATION-RELATED INJURY

Has the medication-related injury resulted in sick leave from work? ☐ No ☐ Yes

From

To

Date recovered from medication-related injury

Additional comments

Has the medication-related injury resulted in admission to hospital? ☐ No ☐ Yes

From

Date of discharge from hospital

Additional comments

6. SIGNATURE

INFORMATION ABOUT THE SWEDISH PERSONAL DATA ACT (PUL)

By signing this form you agree that SLF can use your personal data. All data will be treated confidentially. All data, including personal data, must be registered, stored and processed so that SLF can handle your claim. Data is provided partially by you, but also during the processing of your claim SLF may need to obtain information from other sources, such as healthcare agencies, your employer, Försäkringskassan (Social Insurance Agency) and the Swedish Tax Authority.

You have the right to access information that SLF has registered about you, once a year, free of charge. If you would like to find out what personal data is held, or would like to request an amendment to incorrect information, please send a written notification to Svenska Läkemedelsförsäkringen AB, Box 17608, 118 92 Stockholm. The request should be signed by the applicant and contain the insurance number or Swedish personal identification number.

Appointed personal data representatives registered with the Swedish Data Protection Authority are responsible for ensuring that Svenska Läkemedelsförsäkringen AB complies with all applicable regulations regarding the handling of personal data.

The responsible body for personal data management is Svenska Läkemedelsförsäkringen AB.

Place and date

Signature of claimant / legal guardian

Signature of proxy, if relevant (attach consent document or document with decision of the court)

If the person for whom the claim applies is under curatorship or legal guardianship, please contact Svenska Läkemedelsförsäkringen AB in conjunction with the insurance claim.

PLEASE SEND THIS INSURANCE CLAIM TO

Svenska Läkemedelsförsäkringen AB, Box 17608, 118 92 Stockholm

ANY ADDITIONAL INFORMATION

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