Patient Insurance centre

Incapacity to work and loss of income

Only fill this form if the patient injury has caused you additional incapacity to work and loss of income. More information on loss of income compensable under patient insurance can be found at https://www.pvk.fi/en/claimant/compensations/

Claim reference number

_____

Claimant

Last name _____ First name _____

Personal identity code

_____

Incapacity for work

The patient injury resulted in an incapacity to work, verified by a physician. Please specify the dates in the format dd.mm.yyy–dd.mm.yyyy.

_____

The incapacity for work ☐ has ended ☐ is on-going ☐ is permanent

Work

When the patient injury incurred I was ☐ Employed ☐ Self-employed*

☐ A student** ☐ Unemployed** ☐ Retired**

☐ Other**, please specify. _____

* If you are self-employed (including those in agriculture or forestry) and the patient injury has caused your business to lose income, please provide the information requested from self-

employed persons in the Additional information section or submit a separate appendix. At your discretion, you may also attach a free-form application.

**If you are a student, an unemployed, retired or other, please report how the loss of income occurred in the Additional information section.

If you are self-employed, please give the following information

a) Name of company, contact details and business ID

b) Form and field of your business and number of employees

c) Your share of the company

d) The share of your work input in the company's overall operations

e) Content of your work, and working environment

f) How the patient injury has affected your work?

g) Impact of the incapacity to work on the operations of your business

h) How your duties have been covered during your incapacity to work?

i) Statement on the caused loss of income and grounds for the losses (e.g. what tasks were left undone)

j) If the incapacity to work and the loss of income resulting from it apply to a calendar year for which the tax assessment process is still on-going, submit a copy of your income statement for the financial year and of your tax returns.

Occupation and education

My occupation at the time of occurrence of the patient injury was

---

My educational background is

Pay during a sick leave

My employer paid my salary/wages during the sick leave until (Please, specify the date in format dd.mm.yyyy)

Employment and payroll information

Employer's name

Postal address

Postal code and city

Phone number and email

Contact details for payroll administrator, if applicable

Name of the payroll administrator

Postal address

Postal code and city

Phone number and email

Places of treatment

Specify the places of treatment where you were examined or treated due to the patient injury. If the place of treatment is a private practice, also indicate the name of the doctor or other professional who provided the treatment.

☐ Public health care

Names of the public health care units

☐ Private health care

Names of private healthcare clinics and responsible physicians

Occupational healthcare

I have access to occupational healthcare ☐ Yes ☐ No

Name of occupational healthcare provider

Other parties or institutions granting benefits, even from abroad

Report any other benefits you have received.

☐ Pension provider

Name of the provider

Benefit received

☐ Social Insurance Institution of Finland Kela

Benefit received

☐ Unemployment fund

Name of fund

Benefit received

☐ Other party

Name of provider

Benefit received

Vocational rehabilitation

Have you undergone vocational rehabilitation due to the patient injury or is such rehabilitation being planned?

Insurance institution providing the rehabilitation

Name of the institution

What kind of vocational rehabilitation have you undergone or are going to undergo?

Additional information

Signature

The party claiming compensation must undersign this form. Otherwise, the claim will not be processed.

I affirm that all the information I have provided with this form and its appendices are correct and that I have not applied or received any other compensation for the costs and losses now claimed for from anyone else than is stated on this form and its appendices.

The Patient Insurance Centre has the right, without being prevented by provisions on personal data security, to obtain information that is necessary for handling a claim from insurance and pension institutions, authorities and other parties subject to the Act on the Openness of Government Activities (621/1999), employers, healthcare providers, parties performing rehabilitation, and parties providing social welfare services (Patient Insurance Act section 54). The Centre also has the right to obtain information on wages, salaries and benefits from the Incomes Register for the determination of the grounds for compensation and the scope of the liability to compensate (Act on the Incomes Information System, chapter 5, section 13).

By signing this document, I agree that doctors and other healthcare professionals, healthcare units, pharmacies and parties providing rehabilitation and other healthcare units, as well as providers of social welfare services and treatment institutions may provide the Patient Insurance Centre with claimant's documents and other material related to examination or treatment as well as information regarding the patient's state of health, working capacity and rehabilitation without being prevented by non-disclosure provisions, where such documents, material or information are related to the claimant's state of health and are necessary for the assessment of an injury case or the claims handling thereof.

I also agree that the tax authorities, the employers of the injured person, the pension and insurance institutions, the Finnish Centre for Pensions, Kela and other authorities may, without being prevented by non-disclosure provisions, give the Patient Insurance Centre the information, documents and decisions regarding the compensation and salary received by the claimant, which are necessary to resolve the compensation case.

Date Name and signature of the applicant

Empty the form

Patient Insurance Centre
P.O. Box 1, 00084 VAKUUTUSKESKUS
Phone +358 40 450 4505
www.pvk.fi/en