

Send this form to

Försäkringskassans inläsningscentral

839 88 Östersund

1. Applicant

Name and surname		Personal ID no. (12 digits)
Postal address	Postal code and city	

2. Information about unemployment compensation

Are you a member of an unemployment insurance fund? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have you in the last four months received an allowance from your unemployment insurance fund? <input type="checkbox"/> No <input type="checkbox"/> Yes
Name and address of the unemployment insurance fund	

3. Gainful employment in a country other than Sweden

Have you worked in another country?	<input type="checkbox"/> No <input type="checkbox"/> Yes, in	country
Do you receive a sickness benefit from another country?	<input type="checkbox"/> No <input type="checkbox"/> Yes, from	country
Are you receiving, or have you applied for a pension from another country?	<input type="checkbox"/> No <input type="checkbox"/> Yes, from	country annual amount
Do you receive perpetual annuity or a pension based on an occupational injury sustained in another country?	<input type="checkbox"/> No <input type="checkbox"/> Yes	country annual amount
Enter the name and address of the paying authority		

4. Previous working conditions

Which type of work did you do in the years prior to your ability to work becoming impaired? Describe the extent of your work. If you were employed, you should also provide the name and address of your employer. If you were self-employed, state the name and address of the company.

5. Work and income (If you have more than one employer, you can also use "Other information")

Name and address of your employer, client or your own company.		Is your work or assignment permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Income from employment (only choose one alternative)	SEK per	Working hours days per week on average days per year
	day week month	(only fill in average hours per week hours per week average hours per year)
What are your working duties?		

6. The reason why your ability to work is impaired

For what reason are you unable to work full time?
At what point was your working ability significantly impaired? year, month

7. Remaining working ability

Which working duties are you still able to perform? Are there other duties that you could handle?

8. Treating physician or caregiver

Which treating physician(s) or caregiver(s) have you consulted for the illness or injury that affects your working ability?
<input type="checkbox"/> I have attached a doctor's certificate <input type="checkbox"/> I have requested a doctor's certificate name of physician

9. Secondary employment and assignments

Do you have any secondary employment or assignments? as of annual income
<input type="checkbox"/> No <input type="checkbox"/> Yes
Describe in as much detail as possible the type of tasks involved in your secondary employment or assignment.
How often, and for how long, do you carry out these tasks?

10. Hobbies

Describe your hobbies
Do you receive income from any of your hobbies? <input type="checkbox"/> No <input type="checkbox"/> Yes annual amount

11. Rehabilitation

Describe in as much detail as possible the rehabilitation that you have completed, both medical and occupational
Do you feel that occupational rehabilitation would be good for you? <input type="checkbox"/> No <input type="checkbox"/> Yes

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12. Post-compulsory education, or equivalent

Do you have any further education, after compulsory school or equivalent? | which type(s)?

No Yes

13. Family situation

Describe your family in terms of size, number of children, child minding etc. If you are married or living with someone, you should also state the occupation of your spouse.

14. Work in the home

Describe the work you previously did at home, such as housework, gardening, and caring for a relative.

Describe the work you are currently doing at home.

15. Living conditions

Describe your home; is it a house/apartment? Give the number of rooms, public transport facilities, etc.

16. Help at the home

Do you hire home help? | For what kind of work?

No Yes

| cost per month

17. Activities

State preferences regarding activities.

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18. Foreign bank account

Account number. If the deposit is for a bank in Europe, fill in the IBAN	
Name of foreign bank	
BIC of the foreign bank (swift address)	
Postal address of foreign bank	Postal code
City	Country

19. Occupational injury

Have you reported an occupational injury to Försäkringskassan?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	in which year
What injury or illness did the report relate to?			

20. Would you prefer it if someone else handled your contact with Försäkringskassan on your behalf?

Only fill out this section if you want to authorise someone else to represent you. Otherwise, skip to the next section of the form.

I hereby authorise the below person to represent me in my contact with Försäkringskassan, with regard to my application for activity compensation. This authorisation shall remain in force until I revoke it.			
Name of the person I authorise to represent me			Personal ID no. (optional)
Postal address		Postal code and city	
Telephone, daytime, including area code		Telephone, evening, including area code	

21. Other information

	<input type="checkbox"/> Additional information provided separately
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22. Signature

I declare upon my honour that the information in this form is correct and complete. If the information changes, I must notify Försäkringskassan. I am aware that it is an offence to provide incorrect information, to withhold any information or not notify Försäkringskassan if the information I have provided changes.		
Date	Signature	Telephone, including area

23. Fill in this section if you, the signatory, is the custodian or trustee of the applicant

I am <input type="checkbox"/> custodian <input type="checkbox"/> trustee	Print name
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Read more about how Försäkringskassan processes personal data at forsakringskassan.se.