

Please send the form to  
 Försäkringskassans inläsningscentral  
 839 88 Östersund

**1. Personal particulars**

Forename(s) and Surname		Personal ID no.
Address		Postcode, Town/City
Home telephone no. including area code	Work telephone no. including area code	Cell phone

**2. Details of unemployment benefit**

Do you belong to an unemployment fund? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have you in the past four months received a daily allowance from any unemployment fund
Name and address of the unemployment fund	

**3. Gainful employment outside Sweden**

Have you been gainfully employed outside Sweden	<input type="checkbox"/> No <input type="checkbox"/> Yes, in	Country
Do you receive sickness benefit outside Sweden	<input type="checkbox"/> No <input type="checkbox"/> Yes, from	Country
Have you applied for or been granted a pension outside Sweden	<input type="checkbox"/> No <input type="checkbox"/> Yes, from	Country   annual amount
Are you entitled on grounds of occupational injury to an annuity or pension from abroad	<input type="checkbox"/> No <input type="checkbox"/> Yes	Country   annual amount
Fill in the name and address of the authority making the payment.		

**4. Previous employment**

What type of work did you do before your work capacity was reduced? State the extent to which you worked. Give the name and address of your employer if you have been an employee. State your business' name and address if you have been self-employed.

**5. Employment and income** (If you have more than one employer, "Other information" may also be used.)

Name and address of employer, contractor or own business		Is your work or contract assignment permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Income from work (fill in only one of the alternatives)	kronor (SEK) per day   week   month	Hours of work (fill in only one of the alternatives) days per week on average   days per year hours per week on average   hours per year
What work duties do you have?		

**6. Reason for reduced work capacity**

Why are you unable to work full-time?
When did your work capacity become significantly reduced? <span style="float: right;">  year, month</span>

**7. Remaining work capacity**

What work duties can you still carry out? Are there any other work tasks that you could carry out?

**8. Treating doctor/care provider**

What doctor(s) or care provider(s) have you received treatment from for the illness or injury that affects your work capacity.
Name of doctor
<input type="checkbox"/> I enclose a medical opinion <input type="checkbox"/> I have requested a medical opinion

**9. Secondary employment and assignments**

Do you have any secondary employment or assignments? <span style="float: right;">  From</span> <span style="float: right;">  Annual income</span>
<input type="checkbox"/> No <input type="checkbox"/> Yes
Describe in as much detail as possible what duties are involved in any secondary employment or assignments.
How often and for what period of time do you carry out this work?

**10. Leisure interests**

Describe your leisure interests
Do you earn any income from any spare-time occupation? <span style="float: right;">  annual amount</span>
<input type="checkbox"/> No <input type="checkbox"/> Yes

**11. Rehabilitation**

Describe in as much detail as possible any rehabilitation, whether medical or work-related, which you have undergone
Do you think that work-related rehabilitation would be good for you? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>

**12. Education beyond compulsory school or equivalent**

Do you have any education beyond compulsory school <span style="float: right;">  Which</span>
<input type="checkbox"/> No <input type="checkbox"/> Yes

**13. Family circumstances**

Give details of your family, number of children, childcare arrangements, etc. State the employment of your husband, wife or partner if you are married or have a partner.

**14. Work at home**

Describe your previous work at home, for example, work in your own household, gardening, and care of relatives.

Describe your present work at home.

**15. Accommodation**

Give details of your housing, for instance, detached house, apartment, the number of rooms and public transport facilities.

**16. Domestic services**

Do you employ the services of anyone to help at home? | If so, for what tasks?

No  Yes

| Cost per month

**17. Foreign bank account**

Account number. The IBAN number must be stated if payment is to be made to a bank in Europe.

Name of the foreign bank

The foreign bank's BIC code (SWIFT address)

The address of the foreign bank

The postcode of the foreign bank

City

Country

**18. Occupational injury**

Have you notified any occupational injury to Försäkringskassan? | Which year  
 No  Yes

What injury or illness did you notify?

**19. Additional information**

	<input type="checkbox"/> I have provided information in an appendix.

**20 Signature**

To the best of my knowledge and belief, the details I have given in this form are correct and complete. I will notify Försäkringskassan of any change in this information.

I am aware that it is a punishable offence to provide incorrect information, to withhold any information or not to notify Försäkringskassan when information which I have provided changes.

Date

Signature

Your details will be processed in Försäkringskassan's computer system. More information is available in Försäkringskassan's brochure "Försäkringskassans personregister" [Försäkringskassan's personal files].