Försäkringskassan
0771-524 524
www.forsakringskassan.se

Application

Activity compensation for impaired working ability, for persons living abroad.

Personal ID no.

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? ☐ No ☐ Yes	Have you in the last four months received an allowance from your unemployment insurance fund? ☐ No ☐ Yes
Name and address of the unemployment insurance fund	

3. Gainful employment in a country other than Sweden

Have you worked in another country?	☐ No	☐ Yes, in	country	
Do you receive a sickness benefit from another country?	☐ No	☐ Yes, from	country	
Are you receiving, or have you applied for a pension from another country?	☐ No	☐ Yes, from	country	annual amount
Do you receive perpetual annuity or a pension based on an occupational injury sustained in another country?	☐ No	☐ 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? ☐ Yes ☐ No
Income from employment (only choose one alternative	SEK per day	week	month	**Working hours** (only fill in average hours per week one alternative)	days per week on average	days per year
					hours per week average	hours per year
What are your working duties?						

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6. The reason why your ability to work is impaired

For what reason are you unable to work full time?

year, month

At what point was your working ability significantly impaired?

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?

name of physician

☐ I have attached a doctor's certificate ☐ I have requested a doctor's certificate

9. Secondary employment and assignments

Do you have any secondary employment or assignments? as of annual income

☐ No ☐ 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

annual amount

Do you receive income from any of your hobbies? ☐ No ☐ Yes

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? ☐ No ☐ Yes

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12. Post-compulsory education, or equivalent

Do you have any further education, after compulsory school or equivalent? ☐ No ☐ Yes	which type(s)?

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.

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16. Help at the home

Do you hire home help? ☐ No ☐ Yes	For what kind of work?
	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? ☐ No ☐ 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

	☐ I have provided information in an appendix.

22. Signature

I solemnly declare that the information provided in this form is correct and complete. Should this information change, I am obliged to inform Försäkringskassan. I am aware that it is a punishable offense to provide false information, omit information or to not notify Försäkringskassan if any of the information I have provided should change.		
Date	Signature	Telephone, including area

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

I am ☐ custodian ☐ trustee	Print name

Read more about how Försäkringskassan processes personal data at forsakringskassan.se.

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