Försäkringskassan
Swedish Social Insurance Agency
0771-524 524
www.forsakringskassan.se

Application

Sickness compensation (time-limited sickness compensation) for those who are resident outside Sweden

Personal ID no.

Please send the form to
Försäkringskassans inläsningscentral
839 88 Östersund

1. Applicant

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

2. Details of unemployment benefit

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

3. Gainful employment outside Sweden

Have you been gainfully employed outside Sweden	☐ No	☐ Yes , in	Country	
Do you receive sickness benefit outside Sweden	☐ No	☐ Yes, from	Country	
Have you applied for or been granted a pension outside Sweden	☐ No	☐ Yes, from	Country	annual amount
Are you entitled on grounds of occupational injury to an annuity or pension from abroad	☐ No	☐ 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 used.)

Name and address of employer, contractor or own business				Is your work or contract assignment permanent? ☐ Yes ☐ No
Income from work (fill in only one of the alternatives)	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?				

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6. Reason for reduced work capacity

Why are you unable to work full-time?

When did your work capacity become significantly reduced? | year, month

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.

☐ I enclose a medical opinion ☐ I have requested a medical opinion | Name of doctor

9. Secondary employment and assignments

Do you have any secondary employment or assignments? | From | Annual income

☐ No ☐ 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? ☐ No ☐ Yes | annual amount

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? ☐ No ☐ Yes

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12. Education beyond compulsory school or equivalent

Do you have any education beyond compulsory school	Which
☐ No ☐ 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.

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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

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18. Occupational injury

Have you notified any occupational injury to Försäkringskassan?	☐ No	☐ Yes	Which year
What injury or illness did you notify?			

19. 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

20. Additional information

	☐ Additional information provided separately

21. 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.		Telephone, daytime, including area code
Date	Signature	Telephone, evening, including area code

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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