



## 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? <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 fund	

### 3. Gainful employment outside Sweden

Have you been gainfully employed outside Sweden	<input type="checkbox"/> No <input type="checkbox"/> Yes	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)	SEK per	Hours of work (fill in only one of the alternatives)
	day   week   month	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.
<input type="checkbox"/> I enclose a medical opinion <input type="checkbox"/> 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 _____
<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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes

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**18. Occupational injury**

Have you notified any occupational injury to Försäkringskassan?	<input type="checkbox"/> No	<input type="checkbox"/> 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**

	<input type="checkbox"/> Additional information provided separately
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**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.		Telephone, daytime, including area code
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, evening, including area code
Date	Signature	

**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](http://forsakringskassan.se).