Sickness (or Accident) Claim

Only for specialist physician

MØLHOLM FORSIKRING
I trygge hænder

REMEMBER TO ENCLOSE REFERRAL/DOCTOR'S NOTE FROM DOCTOR (GP)

To be completed by Mølholm Forsikring
Group insurance no._____ Claim no._____

Please use BLOCK CAPITALS

Contact information to the insured party (the person who is ill or injured)

Name			CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
Address	Postcode		City/town
Tel . (work) +45	Tel . (home) +45		E-mail
Parent's Danish CPR no. (if claim is made for a child)	Name		CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
	Name		CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
Company (through which you are insured)			Partner/cohabitant coverage ☐

Details of illness/disorder/accident

1A. What is the name of the illness/disorder? What is wrong with you?

1B. When did the disorder first occur?

1C. What are your symptoms?

1D. Where do you feel pain?

2. When did you first notice the symptoms / when did the disorder first begin (month and year)?

3. Have you previously had similar symptoms? Yes ☐ No ☐ When:

4. Are there any other disorders that affect our current condition?

5. Your height and weight	Height, cm	Weight, kg

Examination by your own doctor

6A. Has you own doctor examined you for this disorder? Yes ☐ No ☐

6B. If NO, when do you expect your own doctor to examine you (date)?

7A. Has your own doctor referred you to a specialist? Yes ☐ No ☐

7B. Name of specialist:

8A. The name of your own doctor (GP)

8B. Your own doctors address

9. Do you wish your own doctor to receive a copy of your journal? Yes ☐ No ☐

Have you received treatment already?

10A. Have you been treated already? Yes ☐ No ☐ If No - continue to section 11

Awaiting treatment ☐	As an out-patient ☐	By a specialist ☐	As an in-patient ☐

Related examinations performed by other physicians than your own doctor

Treatment 1		
Name of physician		
Address	Postcode	City/town
Treatment initiated (date)	Most recent treatment (date)	

Treatment 2		
Name of physician		
Address	Postcode	City/town
Treatment initiated (date)	Most recent treatment (date)	

Treatment 3		
Name of physician		
Address	Postcode	City/town
Treatment initiated (date)	Most recent treatment (date)	

Further informations

11. Are you unfit to work? Yes ☐ No ☐	
12. Are you a member of Sygeforsikringen Danmark? Yes ☐ No ☐	
Insurance group no.	Membership no./Policy no.
12. Do you have surgery coverage? Yes ☐ No ☐	
13. Any further comments	

Bank account details (for reimbursement of treatment fees)

Branch code	Account no.

Further personal information

14. Date of enrolment in healthcare insurance (to be completed by Mølholm Forsikring):
15. Date of employment (obligatory):
16. Have you previously received treatment under a healthcare insurance policy? Yes ☐ No ☐ When?

I have read the above responses and hereby declare that they are an accurate reflection of the truth. I understand that, in the event that of failure on my part to disclose information or if the responses I have given are incorrect, such that the misinformation may be of significance to the assessment of my condition of health or viability, the insurance coverage may be voided or reduced in accordance with the Danish Insurance Contracts Acts. I hereby grant Mølholm Forsikring A/S and the private hospital my permission to request details of my health prior to the date on which I was enrolled in Mølholm Forsikring A/S healthcare insurance. Medical records may be obtained from doctors, medical institutions and other insurance companies. The insurance company is also permitted to make other insurance companies and doctors aware of the information obtained.

Your signature (if you send the form as a hard copy/by post)

Date	Signature
Reserved for Mølholm Forsikring A/S	Serial no.