LÖF

En patientförsäkring
för alla

CLAIMS REPORT

The form will be scanned. Please use block capitals and please do not use paper clips or staples.

* Mandatory field

Read more about Löf at *www.lof.se*. For complete terms of insurance or additional information, please feel free to contact us or the Patients' Advisory Committee or Complaints Committee of the county concilor or region.

1. Patient's details

Name *	Date of birth (YYYY-MM-DD). Alternatively, Swedish personal identity number for those registered in Sweden (10 digits) *
Address (street adress, postcode, location)*	
Daytime telephone number 1 (including area code) *	Daytime telephone number 2 (including area code)
E-mail address	Profession/occupation and employer

2. Healthcare facility

Name of the hospital/primary care/dental clinic where the treatment that caused the injury was performed *	Name of the clinic
Address of the above healthcare facility	
All other care providers who have been contacted as a result of the injury. Please always state the clinic's name and healtcare facility's address.	

When was the treatment that caused the injury performed? YYYY-MM-DD *	Admitted to hospital when the injury occurred? ☐ No ☐ Yes	Was the patient sick-listed? ☐ No ☐ Yes, from - to:

3. Insurance questions

When the injury occurred, care was being administered due to:
☐ road accident ☐ occupational injury ☐ other reason, please indicate:

Has the occupational insurance organisation (AFA Insurance) been informed? ☐ No ☐ Yes, company?	Has the vehicle liability insurance company been informed? ☐ No ☐ Yes, company?
Has the provider of accident insurance for leisure injuries been informed? ☐ No ☐ Yes, company?	Has any other insurance company, for example, pharmaceutical insurance, been informed? ☐ No ☐ Yes, company?

4. Which injury is being reported? *

Please turn over

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Complete information faciliates our processing

5. Description of injury

Please continue on a separate sheet if necessary.

6. Signature,* including consent to processing of personal data under the Swedish Personal Data Act, see below

By signing this form, you consent to:
- personal data and information about the reported injury being processed by Landstingens Ömsesidiga Försäkringsbolag (Löf), corporate ID number 516401-8557
- documents containing personal data and health data being disclosed to medical advisors for investigation of the reported injury.

All information is processed confidentially, but must be registered, processed and saved so that Löf can handle your claim. Your date of birth/personal identity number will be used as a reference number in correspondence. All processing of personal data takes place in accordance with the Swedish Personal Data Act.

One of Löf's assignments is to promote greater patient safety in Swedish healthcare. Activities aimed at preventing injuries are based on injury reports received, which form the basis for comprehensive injury statistics.

By signing this form, you also consent to:
- personal data related to your case being registered, processed and saved for injury prevention activities. This also means that personal data (i.e. the documents relating to your case) may be disclosed to the relevant Head of Health Care Services (county concil/region), relevant healthcare facility, universities, colleges and national quality registers
- the claims report and Löf's decision on the patient injury may be disclosed to Head of Health Care Services and the relevant healthcare facility so that they can improve their patient safety efforts.

For the purpose of being able to develop Löf's operation regular customer surveys are conducted. Personal date may consequently be disclosed to our cooperating partners who perform customer surveys on behalf of Löf. Löf does not disclose health status information to such cooperating partners.

By your signature consent is also given to:
- personal data relating to the matter being registered, processed and saved in conjunction with customer surveys,
- personal data, that is required to be able to conduct customer surveys, being forwarded to our cooperating partners.

Location and date	Signature of claimant/legal guardian
Signature of representative/trustee/administrator, if applicable (power of attorney or the City/District Court's decision sholud be attached)	

Send the claims report to:
Löf, Box 17830, 118 94 Stockholm, Sweden
Telephone: +46 (0)8-551 010 00, website: www.lof.se