Forenede Gruppeliv

Guidance on application for payment of insurance sum on certain critical illnesses

Before the application can be processed, we draw attention to some practical issues.

1. **Application for payment in connection with certain critical illnesses**
   You must fill out items 1-8 on the application form. It is important that you fill out all the items.

2. **Your declaration**
   In "Your declaration", you must disclose the group life agreement number and the date as from which you were employed/covered by the group life agreement.

   If you do not know the group life agreement number, you may find it under Pensionsinfo, "Mit Gruppeliv" at FG's website www.fg.dk or on your insurance overview if this has been provided to you.

   If you cannot find information about the group life agreement number, you may contact:
   - you employer/HR department if you are insured pursuant to your employment contract,
   - the secretariat if you are insured through a pension fund, a union or an association.
   - If you are insured through a bank or an insurance company, please contact the bank/insurance company where you bought the insurance.

     If you are in doubt, please contact FG at tel. no. +45 39 16 78 00 or by e-mail via FG's contact form at www.fg.dk.

If you are covered by the group life insurance via your employment contract, please enclose a copy of your most recent payslip on which the group life premium is disclosed. If your diagnosis was not made within the period covered by your most recent payslip, please also enclose a copy of the payslip for the month in which the diagnosis was made.

3. **Bank information**
   If you are entitled to payment of the insurance sum, the amount will be deposited on your NemKonto (Easy Account). If you do not want the insurance sum deposited on your NemKonto, you may provide another account number.

4. **Consent form**
   Please sign the consent form on page 3 regarding obtaining and passing on information.

Why do you have to give your consent?
In order to process your application for payment of the insurance sum, FG needs information about your illness. Typically, FG will need information about your illness and any treatments.

In many cases, the information provided on the application for payment of the insurance sum is insufficient. Information dating back several years may be hard to remember. Consequently, it is necessary for FG to be able to obtain such information from hospitals, medical specialists and other health care professionals with knowledge of the illness and documentation of information from medical records, case files, etc.

Information regarding the case will be treated in accordance with the rules of the Danish Act on Processing of Personal Data.

If you are covered by the group life insurance via **a pension fund, an association or a union**, please also sign the consent form on page 2. The consent form is necessary for FG to be able to obtain additional information. This may include information as to when you entered or left the group life agreement. At the same time, you give your consent that FG may pass on information regarding the outcome of the application. This may be necessary in order for the pension fund, the association or the union to be able to advise you or adjust the premium after payment of the insurance sum.

5. Please send the form to FG when you have filled out all the items. Immediately after receipt of your application, we will contact the relevant hospitals to obtain your medical records.

   If you have a copy of your medical records, please enclose it. This may speed up the case handling.

Forenede Gruppeliv

Application for payment of insurance sum on certain critical illnesses

Please fill out the form in block letters:

Full name:	
Address:	
Postal code:	**City:**
Telephone no.:	**Civil reg. no.:**
Occupation:	**E-mail address:**

1. **What is the name of the illness?**

2. **When did you fall ill? (Date and year or date of diagnosis)**

3. **When were you examined/treated initially? (Hospital/medical specialist – date and year)**

4. **State the name of the hospital and the departments where you have been treated**

5. **When and for how long have you been hospitalised?**

6. **Have you previously had a critical illness ☐NO ☐YES**

   If yes:

   Which one? _____

   When? _____

   Where were you hospitalised/treated? _____

7. **Name, address and telephone number of your general practitioner:**

Please send the application form to:
Forenede Gruppeliv, P. O. Box 442, Krumtappen 4, DK-2500 Valby
Telephone +45 39 16 78 00

YOUR DECLARATION

8. Before we can process your application, it is important that you fill out the below items:
Group life agreement no.: _____

The date when you were employed/entered the group life agreement: _____

If you are covered by the group life insurance via your employment contract, please provide the following information:

Name of your employer: _____

Date of resignation, if relevant: _____ Have you resigned due to illness? YES☐ NO☐

Please enclose a copy of your most recent payslip on which the group life premium is disclosed and the payslip for the month in which the diagnosis was made.

If you are covered by the group life insurance via a pension fund, an association or a union, please provide the following information:

Name of fund/association/union: _____

Resignation, if relevant: _____ Have you resigned due to illness? YES☐NO☐

CONSENT
I hereby consent to FG obtaining and passing on relevant information to the pension fund, association or union. This may include information:

- as to when I entered or left the group life agreement, including information about the cause of my exit in preparation for offer on waiver of premium or continuing insurance,

- about the outcome of the application.

Date: _____ Signature: _____

BANK INFORMATION

9. If you are entitled to payment of the insurance sum, the amount will be deposited on your **NemKonto**.

If you do not want the insurance sum deposited on your NemKonto, please provide the account number for the account on which the insurance sum should be deposited.

Name of bank: _____

Address: _____

Reg. no._____ Account no. _____

If the amount is to be transferred to a foreign bank, please provide the following:

SWIFT/BIC code:	Bank code*:	Account no./IBAN no.:

*Sorting, Fedwire, Bankleitzahl, Routing no.

FP 006 Consent: When I become ill
Certain critical illnesses

With my signature, I consent to Forenede Gruppeliv (FG) collecting, using and disclosing, in connection with my claim for payment, the information required for the company's consideration of my claim and to FG disclosing, in that connection, information that identifies me and my insurance case to the parties from which the company collects the relevant information. The company will specify to the party from which information is collected what information is relevant.

From whom can information be collected?
With this consent, FG may collect relevant information from the following parties that I have been or will be in contact with during the period specified below:

- My current and former general practitioner.
- Public and private hospitals as well as laboratories, out-patient clinics and other clinics.
- Medical specialists.
- Other parties of which I have informed FG in connection with my claim for payment.

With this consent, the specified parties may disclose the relevant information to FG.

To whom may the collected information be disclosed?
With this consent, FG may disclose the collected information to the following parties which help FG consider my claim for payment:

- The Danish Centre of Health & Insurance

What information may be processed?
The consent covers collection, use and disclosure of the following categories of information:

- Medical information, including information about illnesses and contacts to the health services.

For what period of time may information be collected?
The consent covers information for a period of 10 years prior to the date of injury or the time of onset of the disease and until the time when FG has considered my claim for payment.

If the information for that period so warrants, FG may, providing a specific reason, also collect information relating to the time before that period.

Time limit, notification, etc.
The consent is valid for one year. I may at any time revoke my consent and/or have any incorrect or misleading information corrected or deleted. The parties involved in my case will be informed of my consent.

I will be notified every time FG collects information. I will be informed of why the information is obtained, what type of information is collected and disclosed, what period the information covers and of the parties from which the information is collected and to which it is disclosed.

Date: …… Signature: …… Civil reg. no.: _ _ _ _ _ _ - _ _ _ _

Please send the application form to:
Forenede Gruppeliv, P. O. Box 442, Krumtappen 4, DK- 2500 Valby