A-VAKUUTUS

NOTICE OF ACCIDENT / OCCUPATIONAL DISEASE

Based on the Employment Accidents Insurance Act effected on August 20, 1948 and on related Acts and Decrees.
Please, use a ballpoint pen when filling in the form by hand.

Employer data

Name of employer (official name of company)			Business ID
Address		Postal code	City
E-mail address	Telephone		Fax
Field of operations	Policy code		Code of group of companies
Bank data (full bank account No.)	Unit or department or departmental code of the company		

Data on the injured person

Family name and all given names (first name underlined)		Language ☐ Fin ☐ Swe	Personal identity number
Address		Postal code	City
Occupation	Nationality		Telephone
Bank data (full bank account No.)	Withholding tax percentage (data in tax card)	Basic percentage	Additional percentage
Munsipality of taxation	Income limit up to which basic withholding tax percentage applies	In a year	
Scaled withholding tax percentage (e.g. school-children and students)	% up to EUR	% up to EUR	of which already paid in salary, EUR
Is the injured a shareholder in the company?	☐ Yes ☐ No	Percentage of shares owned by the injured either alone or together with family members	%
Does the injured live permanently in the employer's household?	☐ No ☐ Yes	How is the injured related to the employer or his/her spouse?	

Data on injury or illness

Date when injury occurred / occupational disease was detected	Date	Weekday	Time	On the accident day, work was supposed to	begin at	end at
Accident occurred in (city, municipality and address)						
Did the accident occur at work premises or in an area related to work premises?	☐ At work ☐ During coffee or lunch break ☐ Not in workin duties, specify where					
Did the accident occur outside work premises?	☐ In working duties ☐ During coffee or lunch break ☐ On the way home from work	☐ On the way from home to work ☐ On another trip, specify ☐ In leisure time				
Was a notification of accident made to employer or superior?	☐ Yes ☐ No	Notification date	Did the injured stop working after the accident occurred?	☐ No ☐ Immediately ☐ Later	Date and time	
Medical treatment began	☐ Immediately ☐ Later	Date	Name and address of hospital, health care centre or other nursing institution			
Duration of disability (estimated by the person filling in the form)	☐ 1 Date of occurrence ☐ 2 1 to 2 days	☐ 3 3 days to one month ☐ 4 Over one month	Has the injured returned to his/her previous work?	☐ Yes ☐ No	Date of return	
Additional information on accident is given by (e.g. superior, supervisor; name, address, telephone No. and e-mail)						

Type of injury

Type of injury (e.g. fracture, contusion, burn or scald, strain, rash; the view of the person filling in the form is sufficient)	
Injured part of the body (e.g. eye, back, fingers, legs)	☐ Right ☐ Left

How did the accident happen / occupation-al disease occur?

Explanation about the accident and the reasons behind it or about the occurrence of occupational disease and about the working environment.
1. WORKPLACE ACCIDENT: account shall be given of the following matters: the type of work (production, maintenance, seamen's work, etc.) and work duties (drove a forklift truck, lifted a load etc.) the person was performing at the time of accident. Which deviations from normal functioning caused the accident (power failure, losing control of a manual grinding machine, slipping, etc.)? How was the injury sustained (cut by a tool, piece of rubbish flew into the eye, etc.)? What caused the injury (pressing machine, lathe, ladders, racks, etc.)? **2. ACCIDENTS SUSTAINED ON THE WAY TO/FROM WORK:** account shall be given of what caused the accident, the way the person travelled, any deviation from the normal route to/from work, and the reason for the deviation. **3. OCCUPATIONAL DISEASE:** account shall be given of the suspected reasons for the occupational disease (name of chemical substance etc.)

A-Insurance Ltd, business-ID 1715947-2
Address: Lapinmäentie 1, FI-00350 Helsinki, domicile: Helsinki

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Additional information on accident	Registration number or other code of motor vehicle used by the injured	Motor third party liability insurer	Participation in traffic ☐ as passenger ☐ as driver
	Registration number or other code of vehicle used by the other party	Motor third party liability insurer	
	Was the accident caused by the injured person's intoxication, negligence or act against occupational safety regulations? ☐ No ☐ Yes: explain		
	Was accident caused by another person? How was it caused and by whom? Name and address ☐ No ☐ Yes		
	Was police investigation made? ☐ No ☐ Yes	Name of police department or police district	Accident eye-witnessed by, name and address
Notification in the event of death	Date of death of the injured	Next of kin (how related, name)	
	Manager of the decedent's estate, name, address and telephone No.		
Employment data	Date employment started	Type of employment ☐ Permanent employment ☐ Fixed-term employment	Date when fixed-term employment was supposed to end?
	Type of occupation ☐ Principal occupation ☐ Ancillary employment ☐ Pensioner ☐ Student, name of educational establishment		
	Weekly working hours	If part-time employment, daily working hours, number of working days per week and reason for part-time employment	
	Additional information on employment and salary given by (e.g. payroll calculation officer, name, telephone No. and e-mail)		

Data for payment of daily benefit

Illness pay **Total amount of illness pay for four weeks following the accident, but not for date of accident**	Illness pay for the period of	EUR	
	Illness pay for the period of	EUR	
	Date illness pay obligation ends	Illness pay is determined on the basis of	
	Was illness pay paid for the whole disability period or for only part of it e.g. because of lay-off or part-time pension? ☐ For the whole disability period ☐ Only partially (also fill in the item Salary data)		
	Was only part of the salary paid as illness pay? (e.g. 50% of salary in case the employment has lasted less than a month)? ☐ No ☐ Yes (also fill in the item Salary data)		
Salary data To be filled in if no illness pay was paid or if only part of the salary was paid as illness pay or if the illness pay was paid only for part of the time of disability.	Salary for four weeks before the accident (e.g. the last two two-week payroll periods) or for a shorter period which the employment lasted **(no salary data on the date of accident)**. State accrued salary for the period. Holiday pay of LEL (Temporary Employees' Pensions Act) employment relations, fringe benefits and end-of-holiday pay are not stated.		
	Period	EUR	
	Period	EUR	
	Basis of salary, EUR per hour	Number of workdays or working hours included in above period	
	Unpaid periods of absence in above period; time and reason		
	Monthly salary	Salary at the time of accident, EUR per month	Any bonuses, type of bonuses and average, EUR per month
Other employment and entrepreneurial activity	Are there other employers simultaneously? ☐ No ☐ Yes	Name and address of other employer	
	Has the injured simultaneously worked as an entrepreneur? ☐ No ☐ Yes ☐ As an agricultural entrepreneur ☐ As some other entrepreneur	Type of entrepreneurial activity	
Other payments or benefits from the employer	Other payments than illness pay, EUR, e.g. medical treatment expenses (enclose receipts)		
Payments by the injured	Medical treatment expenses (receipts), EUR	Travel expenses (receipts), EUR	Other expenses (receipts), EUR
Sickness insurance	Was daily benefit under sickness insurance applied for because of accident? ☐ No ☐ Yes	Name of local Social Insurance Institution office	
Signature	Place and date; signature, name in block letters, telephone No. and e-mail address of employer or representative of employer		

Address

P.O. Box 440, FI-00013 Pohjola

For more rapid claims settlement, call 010 253 1333 and www.a-vakuutus.fi

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