DA1

Entitlement to Health care cover under insurance against Accidents at work and Occupational Diseases

EU Regulations 883/04 and 987/09 (*)

INFORMATION FOR THE HOLDER

This document is for insured persons who move to, reside or stay in a EU State other than the State of insurance against Accidents at Work and Occupational Diseases (AWOD). You must present this document to the healthcare/AWOD institution in the State of residence or stay to gain entitlement to health care benefits. You may be entitled to a supplementary reimbursement according to national reimbursement rates of the place of stay.
Your health care institution will advise you on this. For a list of health care institutions, see http://ec.europa.eu/social-security-directory/

1. PERSONAL DETAILS OF THE HOLDER

1.1 Personal Identification Number in the competent Member State

1.2 Surname

1.3 Forenames

1.4 Surname at birth (**)

1.5 Date of birth

1.6 Status

☐ 1.6.1 Employee ☐ 1.6.2 Self-employed person ☐ 1.6.3 Unemployed

1.7 Address in the State of residence/stay

1.7.1 Street, N° 1.7.3 Post code

1.7.2 Town 1.7.4 Country code

2. THE HOLDER MAY RECEIVE BENEFITS IN KIND

☐ 2.1.1 for accident at work ☐ 2.1.2 for occupational disease

2.2 Expected period of treatment

☐ 2.2.1 for a period laid down in the provisions of the legislation of his State of residence

☐ 2.2.2 start date end date

☐ 2.2.3 for a maximum of three months ☐ 2.2.4 for an unlimited period

(*) Regulations (EC) No 883/2004, article 36, and 987/2009, article 33.
(**) Information given to the institution by the holder when this is not known by the institution.

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3. THE HOLDER HAS A RIGHT TO HEALTH CARE ON GROUNDS OF

☐ 3.1 The accident at work sustained 3.1.1 on (date)

3.1.2 which had the following consequences

☐ 3.2 The occupational disease diagnosed 3.2.1 on (date)

3.2.2 which had the following consequences

☐ 3.3 The authorisation which we have granted to the person concerned to retain the rights to benefits in kind in (State) where he is going

- ☐ 3.3.1 to take up residence
- ☐ 3.3.2 to receive medical treatment

4. THE REPORT OF OUR EXAMINING DOCTOR

☐ 4.1 is attached in a sealed envelope

☐ 4.2 may be obtained on request

☐ 4.3 was sent 4.3.1 on 4.3.2 to

☐ 4.4 has not been drawn up

5. INSTITUTION COMPLETING THE FORM

5.1 Name

5.2 Street, N°

5.3 Town

5.4 Post code 5.5 Country code

5.6 Institution ID

5.7 Office fax N°

5.8 Office phone N°

5.9 E-mail

5.10 Date

5.11 Signature

STAMP