

Medical basis

- For assessment of entitlement to premium waiver /compensation from incapacity insurance.
- Please fill in this form in English. If extra space is required the back of the form may be used.

Please send this form to:
SPP's Sickness Claims Department
at address below.

1. Diagnosis/es or symptoms causing the incapacity

2. Anamnesis/history of the current illness and other illnesses of significance

3. Status, objective findings from examination

4. How does the illness restrict the patient's capacity to work?

5. Prescription - treatment or measure(s) necessary to restore capacity to work

6. In my assessment, the patient's capacity to work will be

- reduced by $\frac{1}{4}$ _____ from (day, month, year) _____ until (day, month, year) at the latest
- reduced by $\frac{1}{2}$ _____ from (day, month, year) _____ until (day, month, year) at the latest
- reduced by $\frac{3}{4}$ _____ from (day, month, year) _____ until (day, month, year) at the latest
- reduced to zero _____ from (day, month, year) _____ until (day, month, year) at the latest

7. Prognosis - in your assessment, will the patient be able to regain his/her capacity to work?

8. Other information

9. Date (day, month, year)

Name, address of clinic, country, telephone no. (including country and area codes), stamp

Signature of doctor