LÖF En patientförsäkring för alla

CLAIMS REPORT

If you have a Swedish BankId you can submit a more detailed report via Mina sidor, at www.lof.se

* = Mandatory field

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

1. Personal details

Namn *	Swedish personal identity number, or date of birth (yyyy-mm-dd) *
Street address *	Postcode * / City *
Phone number 1 (including area code) *	Phone number 2 (including area code)
E-mail address	

2. Health care facility

Why did you first seek care? (Base injury/disease) What kind of problem made you seek care (eg left knee, foretooth, mental health)? *	When was the treatment that caused the injury performed? (yyyy-mm-dd) *
Name of the hospital/primary care/dental clinic where the treatment that caused the injury was performed *	Name of the department/clinic *
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 Continue on separate attachment if required	

3. Insurance questions

When the injury occurred, care was being administered due to:

☐ Road traffic inj. ☐ Occupational inj. ☐ Other reason, indicate:

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

4. The personal injury is caused by:

The damage I report applies to medical area:

☐ Tooth ☐ Surgery ☐ Orthopedics ☐ Gynecology ☐ Other, specify which one:

The injury is caused by: *

☐ Care in connection with examination or treatment	☐ Incorrect prescribing of medicines
☐ Incorrect / delayed diagnosis or treatment	☐ Accidents associated with care and treatment
☐ Infection	☐ Incorrect medical device

5. What personal injury do you think you have suffered? *

(Also indicate location / location of injury if possible, eg left knee, foretooth, mental health)

Have you been on sick leave due to the personal injury reported?	If you have been on sick leave, state occupation / employment
☐ No ☐ Yes, from - to:	

6. Describe the injury reported *

(Also describe what happened and how the injury occurred)

Continue on separate attachment if required

Are you medically clearance? Is your treament finished? *	If yes, when did the treatment finish?	Are you restored / healthy today? *
☐ Yes ☐ No		☐ Yes ☐ No

7. Processing of your personal data

In order to handle and regulate your claim for damages and to comply with our legal obligations under the Patient Injury Act (1996: 799) and the Insurance Contracts Act (2005:104), Löf needs to register, process and save your information. If required, Löf's hired independent medical adviser may also receive your notification and medical examination in the case. In some cases, Löf is obliged to disclose the information to different authorities, e.g. tax authorities and Kronofogden, and current care providers. All processing of personal data is in accordance with the General Data Protection Regulation (EU) 2016/679. Personal data controller is the Löf regionernas ömsesidiga Försäkringsbolag (Löf), organization number 516401-8557. Please visit www.lof.se for more information.

8. Consent that your personal data is used for other purposes *

Löf works actively for increased patient safety in Swedish healthcare. In order to reduce the number of patient injuries, Löf runs an extensive educational activity, offers active cooperation in patient safety projects and supports research in the field of patient safety. In order for this to be possible, Löf needs to use the information in the resulting claims cases, which together form the basis for extensive injury statistics. All personal data is treated confidentially and in accordance with research ethical principles.

- Do you consent that your personal data including the actions of your claimant may be used in harm prevention patient safety projects, research projects and scientific studies? Please tick yes or no.

  ☐ Yes ☐ No

- Do you consent that your personal information including the actions of your claim will be communicated to the healthcare practitioner and the affected care institution in order to improve their patient safety work? Please tick yes or no.

  ☐ Yes ☐ No

In order to develop and improve Löf's business, regular customer surveys are carried out. Personal data may therefore be disclosed to partners who carry out customer surveys on Löf's mission.

- Do you consent that your personal data may be used in Löf's customer surveys? Please tick yes or no.

  ☐ Yes ☐ No

You may at any time withdraw a given consent by contacting Löf via the contact details at the bottom of this form.

9. By signing, the information stated in this report is correct *

Place and date	The injured / guardian's signature
Signature of representative / Attorney / Good Man / Trustee, if applicable (power of attorney or the District Court's decision shall be attached)	Printed name of the injured / guardian
	Printed name of representative, if applicable

Claims report will be sent to:
Löfs inläsningscentral,
Box 334, 151 24 Södertälje

Note that you do not need to submit any journals yourself. When we begin the investigation, we request medical records from your healthcare provider. At www.lof.se you can find more information on how to report an injury, how the investigation goes on and how we process personal data.