

Mela sickness allowance application

This form is intended for use by persons covered by MYEL insurance applying for sickness allowance during the deductibility period in accordance with the Health Insurance Act (Act for compensation to farmers during the deductibility period in accordance with the Health Insurance Act 118/1991).

Note: Attach your medical certificate to this application.

Personal details

Family name and first names	Personal ID
Address	Telephone
Postcode and city	Please notify me In Finnish In Swedish

Payment details

Bank account (*BIC format for foreign accounts*)

Other compensation

Are you applying for or do you already receive a daily allowance or other compensation for lost income due to this work disability (e.g. on the basis of the Motor Liability Insurance Act, Employment Accident Insurance Act or Occupational Accident and Disease Act for Farmers)?

No Yes, I will apply Yes, I have applied Yes, I have received since (date)	
On the basis of which law?	Compensation paid by
Have you had a work disability for the same sickness for at least one month before the start of this work disability period?	
No Yes	

Further information

I have read the privacy statement, which describes the processing of my personal data by Mela. mela.fi/benefits-gdpr

Signature	<i>I hereby declare that the information provided in this form is true and correct.</i>
Date	Signature and name in block capitals

In addition to the information provided in this form, other pertinent information at Mela's disposal may be used for processing this sickness allowance application. Mela may also request information pertinent to this application from insurance companies, doctors, treatment facilities and other parties as provided by the law. Mela may disclose the information it receives for processing this application to other parties who are entitled to receive such information subject to confidentiality provisions. Mela may also use the information later for processing other claims.

To be filled in by the Mela representative (if the application has been submitted to the office of a Mela representative)

Date on which a doctor has confirmed the work disability	Date on which the work disability period began	Date on which the work disability period ends
New sickness Extension Registered Submitted to Mela		Mela representative number
		Date received

Mela

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