

Informed consent

To be filled out by the claimant

Vátryggingafélag Íslands hf
Ármúla 3, 108 Reykjavík, 560 5000
kt. 690689-2009, www.vis.is



Date of the accident _____

Informed consent

I hereby authorize VIS, ID no. 690689-2009 to obtain information from medical doctors, hospitals and other treatment facilities regarding my present state of health and with regard to previous/later illnesses or accidents that may be of importance to VIS when this claim for insurance benefits is processed.

Furthermore I authorize VIS to obtain necessary information from the State Social Security Institute, pension funds, trade unions, tax authorities, as well as reports from the Administration of Occupational Safety and Health and information from other insurance companies as needed for deciding liability and the amount of insurance benefits that result from the accident.

VIS treats all information it acquires as confidential.

This statement entails that I accept the processing of personal data in accordance with Act No. 77/2000, with the proviso that I may revoke this acceptance by written notification to VIS.

Town/city and date

ID no. of injured person

Witness 1 - Signature and ID no.

Witness 2 - Signature and ID no.