Verkalýðsfélag Akraness
Þjóðbraut 1 - 300 Akranesi
430-9900 - vlfa@vlfa.is
www.vlfa.is

Application for sickness benefits

☐ Sickness ☐ Accident ☐ Work related accident ☐ Sickness of spouse/child

Name: _____ Social security nr.: _____

Address: _____ Phone nr.: _____

Place - postal code: _____ E-mail: _____

Place of work: _____ Job percentage: _____ %

First day of absence from work due to sickness (date): _____

Able to work from (date): _____

Salary payments ends (date): _____ Children (under 18) living with applicant:

Other payments: ☐ No ☐ Yes - where from: _____ ☐ No ☐ Yes Number of children ____

Bank information: _____ Use my personal tax credit : ☐ No ☐ Yes

Along with the application it is necessary to submit the following:

☐ Medical certificate due to incapacity for work
☐ Employer confirmation that sick days have ended

☐ **I give my consent to Verkalýðsfélags Akraness employees to collect, record and process information regarding this application. The processing of personal information is based on the Act no. 90/2018 on personal data protection and processing of personal data. This consent may be withdrawn in writing, in whole or in part at any time and such withdrawal will not affect the processing of the application until then.**

☐ **I agree to the registration of my email address, phone number and other information which VLFA will use to provide information to members, e.g., information related to collective agreements, vacation options and other information the union considers relevant.**

With my signature, I declare that the above information is correct and given to the best of my knowledge. In addition, I will inform of any changes of circumstances that may affect the application, which will then be reviewed.

_____ _____
Date Signature

Afgreiðsla umsóknar, fyllist út af Verkalýðsfélagi Akraness

Greiðsla hefst: _____
80% meðaltal: _____
Réttur SÍ frá: _____
_____

Tímabil/fjöldi daga
_____
_____
_____
_____

Akranesi, ____ /____ 202

_____
Staðf. starfsm. VLFA