

Send to

Labour Market Insurance (AES)
Arbejdsmarkedet Erhvervssikring
Kongens Vænge 8
DK-3400 Hillerød

Labour Market Insurance (AES)

Important information before filling out your application

- Your disease must be recognised by Labour Market Insurance (AES) as an industrial injury (occupational disease).
- There must be a direct correlation between your occupational disease and the treatment.
- Your doctor must document that your treatment is necessary in order for you to recover optimally from your disease, as otherwise it will worsen.
- AES only pays expenses (your own payment/patient share) that you have not been paid for by public subsidies or the health insurance "Danmark".
- Any potential compensation is paid out as a lump sum.

Print the application and fill it out together with your doctor. Remember to sign it. Make a copy of your documentation and send it alongside your application to:

Labour Market Insurance (AES)
Arbejdsmarkedets Erhvervssikring
Kongens Vænge 8
DK-3400 Hillerød

Telephone +45 72 20 60 00 - aes@atp.dk

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Kongens Vænge 8
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Labour Market Insurance (AES)

Application for payment of
future treatment expenses

Your information

Name	AES case no., for example 123456-7890/01/80/V2
If relevant, email address	Phone no.
Are you a member of the health insurance "Danmark"?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes - which group?	<input type="checkbox"/> Basis <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5

Which expenses do you wish to be paid for? (for example, medicine, disposable gloves, etc.)

Declaration

<input type="checkbox"/> I have read "Important information before filling out your application" and am attaching documentation for all of my expenses (for example, receipts from the pharmacy, invoice from physiotherapist, medical acupuncture or chiropractor)

Date and signature

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Labour Market Insurance (AES)
Information from the
doctor:

Your information

Name	AES case no., for example 123456-7890/01/80/V2
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Information from your doctor:

The doctor's name	SE no. or civil registration number
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The doctor's description of needed treatments now and in the future

What type of treatment have you prescribed?
What medication must the patient take and how much in one year (fill out medication card)
How long do you expect that the patient will take the mentioned medication?

AES pays your fee for filling out the form. See 'Your payment' on the next page.

Date and signature and, if relevant, stamp
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