APPLICATION TO PENSION FUNDS FOR DISABILITY PENSION - 1/4

Information on the applicant

Name: ______________________ ID No.: ______________________

Address: ______________________ Tel.: ______________________

Post code: __________ Place: ______________________ E-mail: ______________________

Information on bank accounts

Bank: __________ Account type number: __________ Account number: __________

Account number must be registered to the name of the applicant.

Information on child support – children under the age of 18

ID No.:	Name:

Confirmation to Tryggingastofnun

☐ The undersigned requests that confirmation of the submission of the application for disability pension be sent to Tryggingastofnun.

Withholding taxes

Please note: Contact the fund as soon a ruling has been made if you wish to take advantage of the personal tax allowance. In addition, send notification if you want the payments to be taxed according to tax bracket 2.

APPLICATION TO PENSION FUNDS FOR DISABILITY PENSION - 2/4

BIRTA LÍFEYRISSJÓÐUR

VIRK Vocational Rehabilitation

Have you been to Virk Vocational Rehabilitation? ☐ Yes ☐ No

From what time? ______________________

Information on other pension funds

Have you been paid disability pension from other pension funds? ☐ Yes ☐ No

If yes, which fund(s) and for what period? ______________________

Do you receive the following payments?

Payments from employer: ☐ Yes ☐ No

When will payments from the employer cease? ______________________

Payments from the Directorate of Labour: ☐ Yes ☐ No

From date: ______________ To date: ______________ Amount per month: ______________

Payments from Tryggingastofnun: ☐ Yes ☐ No

Disability pension from date: ______________ ☐ Being processed

Have you used rights from the union's sickness fund? ☐ Yes ☐ No What union?: ______________

Payment period: ______________ Amount per month: ______________

Other payments: ☐ Yes ☐ No Which: ______________

To date: ______________ Amount per month: ______________

APPLICATION TO PENSION FUNDS FOR DISABILITY PENSION - 3/4

BIRTA
LÍFEYRISSJÓÐUR

Information on work capacity

When did you become unable to undertake the work to which the inability is linked (day, month, year)? ______________

What is your work capacity outside the home? ☐ None ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Are you employed at present? ☐ Yes ☐ No If yes, what work? ______________

How many hours a day? ______________ From what time (month, year)? ______________

Your career

Job title:	Employer:	Duration:

Anything else you wish to include

APPLICATION TO PENSION FUNDS FOR DISABILITY PENSION - 4/4

Power of attorney

I, the undersigned, confirm that this application applies to all the pension funds in which pension rights have been created, and I agree that the application and documentation relating to the application may be sent to such pension funds. I, the undersigned, consent to the following. Such consent applies to all the pension funds in which pension rights have been created:

- ☐ to provide all information on my health, as necessary, to assess my entitlement to disability pension.
- ☐ that a company physician may assess my disability and submit a copy of the disability assessment. The disability assessment and its timing is based on information on my medical history and work capacity back in time and my prognosis. In addition, I am under obligation to undergo a medical examination by the company physician if deemed necessary to assess my entitlement to disability pension.
- ☐ to obtain information from VIRK – Vocational Rehabilitation Fund or the relevant rehabilitation entity on the progress of my rehabilitation, providing that this can verifiably relate to the assessment of my loss of capacity.
- ☐ that VIRK – Vocational Rehabilitation Fund may obtain a copy of my application, the assessment of the company physician, data from the physician issuing certificates and to collect further data relating to my health, as this may have an impact on the assessment of my loss of work capacity and my possible rehabilitation.
- ☐ to regularly obtain information from the tax authorities on my income. I also consent to and permit that information on my wage income contained in the withholding tax records be obtained for up to 4 years prior to the date that such information is requested according to this letter of proxy, together with my tax returns for the past 4 years as well as authorisation to obtain information on public dues levied over the past 4 years. This information will be kept confidential. All the aforementioned information may be collected electronically. The information will be used to process this application for disability pension and for regular income monitoring.
- ☐ to gather information on my premium payments to other pension funds.
- ☐ to call for information from employers as regards termination of employment and/or changes to the proportion of employment.
- ☐ to gather information from unions in relation to entitlement of payment of sickness per diem payments.
- ☐ electronic registration of my information, including information from the tax authorities.
- ☐ I understand that my participation in rehabilitation may be a precondition for the payment of disability pension according to the Articles of Association.
- ☐ with this application, I confirm that the above information is provided to the best of my knowledge and that I am under obligation to send notification of any changes to my circumstances to the extent that such changes may have an effect on my entitlement to disability pension or its amount, such as information relating to health or income.

To be kept in mind!

On having received information on your medical history and previous work capacity together with the opinion of the fund's company physician, the fund's Board will issue a ruling on the loss of capacity and its timing. All information that the pension fund receives as regards this application will be kept in the strictest of confidence.

Attachments with applications for pension

- ☐ Medical certificate, no older that three months.
- ☐ Birth certificates of children (under the age of 18) not living with the fund member.

Attachments must be submitted to the fund within three months from the receipt of the application. Otherwise, the application shall be cancelled without further notice.

Signature

I understand that through my signature, I provide my consent that the information that I supply in this application is stored and recorded in my transaction history at Birta lífeyrissjóður. All processing of personal information, including the collection, registration, storing and treatment of such information is in accordance with the Act on Data Protection and the Processing of Personal Data and the Data Protection Policy of Birta lífeyrissjóður.

Place and date: ____________________

Applicant's signature: ____________________