

OVERSEAS CONTACT

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ADDRESS

Victor Hortaplein 11
1060 Brussels

CLAIM FOR PAYMENT OF SICKNESS AND DISABILITY INSURANCE BENEFITS

REQUEST FOR INFORMATION ADDRESSED TO THE EMPLOYER

Surname:	Firstname:	Civil status:	Place and date of birth: ____/____/____
Nationality:	Resident in:	Street:	N°:

FOR THE ATTENTION OF THE EMPLOYER

The person named above, covered by the General Directorate VII Overseas Social Security - Section periodic benefits, has submitted a claim for sickness and disability insurance benefits.
To enable the Office to process this claim, please **fully** complete this document and return it as soon as possible to the address mentioned above.
The data will be treated in accordance with the Act on the protection of privacy (Act of 8 December 1992). You may consult and rectify your data at any time. They are used only to process the claim.

Employer's name and address:

Person to contact:

Telephone: Fax:

E-mail:

- Reason for interruption of occupational activity:
- illness (*)
 - maternity leave (*)
 - accident at work (*)
 - accident other than accident at work (*)

Date of start of incapacity for work: ____/____/____

Date when remuneration (guaranteed salary) ended: ____/____/____ (included)

Period covered by a severance allowance or paid leave: from ____/____/____ to ____/____/____

Date on which the person concerned stops contributing to insurance: ____/____/____

Do you want to continue paying contributions for the health care insurance contract? Yes No

Remark: contributions must be paid at least up to and including the month in which the incapacity for work occurs.

Done at on ____/____/____

Signature*

*The offices are open to the public from 9 am to 12 noon and in the afternoon only by appointment.
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