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Arbejdsmarkedets Erhvervssikring

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Kongens Vænge 8
DK-3400 Hillerød

COMPLAINT

I wish to complain of the decision made in connection with the following claim:

File number ☐ Name ☐

I wish to complain of the part decision on (mark with an X):

- ☐ Recognition/dismissal of the claim
- ☐ Permanent injury
- ☐ Loss of earning capacity
- ☐ Medical expenses

Grounds for the complaint:

☐

Party to the case (mark with an X):

☐ Injured person ☐ Holder of power of attorney ☐ Insurance company ☐ Employer

☐ No documents enclosed ☐ The following documents are enclosed ☐

Date: ______________ Signature: ______________________________