[Logo insurance company]

Annex 8

To be completed by your employer or Social Secretariat

LOSS-OF-INCOME CERTIFICATE

Reference/Claim-file no.: ……
Date of accident: ……..
Place of accident: ……

I, the undersigned (employer/Social Secretariat)

First name, last name: ……

Address: ……

hereby confirm that:

First name, last name: ……

Address: ……

1) is employed by us as a WORKER/EMPLOYEE/CIVIL SERVANT (delete as applicable) and was the victim of an accident which resulted in:
   - ☐ total incapacity from ……/……/…… to ……/……/…… inclusive
   - ☐ partial incapacity of ……% from ……/……/…… to ……/……/…… inclusive
   - ☐ recommencement of work as of ……/……/……

2) would have received <u>net income</u> of €…… if s/he had not been unable to work during the above period

3) is in receipt of a guaranteed net income (weekly/monthly) as a result of incapacity pursuant to the accident of:
   €…….. from ……/……/…… to ……/……/…… inclusive
   €…….. from ……/……/…… to ……/……/…… inclusive
   €…….. from ……/……/…… to ……/……/…… inclusive
   €…….. from ……/……/…… to……/……/…… inclusive

4) has lost €…….. as a result of incapacity pursuant to the accident in meal vouchers, bonuses and so forth.

Done at (place) ……
On ……/……/……

Signature and stamp of employer/Social Secretariat

[Logo insurance company]