

**Estonian Unemployment Insurance  
Fund**

**Social Insurance Board**

**Application form for the assessment of work  
ability, for the determination of the degree of  
severity of a disability and for obtaining  
benefits**

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Before submitting an application, you must have had an appointment during last six months with your general practitioner, occupational physician or the medical doctor who has primarily been treating you. If the extent of your work ability cannot be determined by the available health information, the Estonian Unemployment Insurance Fund has the right to refer you for an appointment with a medical expert for visit-based assessment.

If your work ability has been determined as partial, you must meet at least one of the activity requirements (e.g. be working, studying or registered as unemployed) to receive the work ability allowance.

Please mark the appropriate response with an X for all multiple-choice questions.

# I GENERAL

## 1.1. APPLICANT'S DETAILS

First name: .....	Surname: .....
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Personal identification code: \_\_\_\_\_

If you do not have an Estonian personal identification code, please provide your date of birth: \_\_\_\_\_ and gender:  M  F

Foreign personal identification code (if applicable):  
.....  
Country of issue of personal identification code:  
.....

Postal address (to receive a work ability card and disabled person's card): .....

E-mail address: .....	Telephone: .....
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If you have a speech or hearing difficulties or any other problems making communication over the phone impossible, please specify who is the person you wish us to contact (first name and surname and contact details):  
.....  
.....

**If you are a resident of both Estonia and another country, provide the name of the foreign country and the address of your residence in the foreign country:**  
.....

**Data of living / working abroad**

If you live/work or have lived/worked in a foreign country, provide the name of the country and the periods during which you lived/worked there (full dates).

<b>Country</b>	<b>Period</b>	<b>If you worked in said country in the last five years, please indicate your profession (take all forms of work into account when answering this question)</b>

## DETAILS OF APPLICANT'S REPRESENTATIVE

Please name the representative (authorised representative, parent or guardian) if the applicant is under 18 years of age or is under guardianship or has determined other person by proxy as authorized representative.

Parent/guardian

Authorised representative

First name: .....	Surname: .....
Personal identification code: _____	
E-mail address: .....	Telephone: .....
Postal address: .....	

If the authorized representative of the applicant is a legal entity, please provide the name of the legal entity:

.....

**If the application is submitted by a person holding the proxy, please provide the proxy identifying the right of representation as an annex to the application.**

**APPLYING FOR:**

<input type="checkbox"/>	Work ability assessment
<input type="checkbox"/>	Work ability allowance
<input type="checkbox"/>	Determination of degree of severity of disability
<input type="checkbox"/>	Disability allowance for person of working age
<input type="checkbox"/>	Disabled parent's allowance (paid to one disabled parent or to a disabled parent, guardian or foster parent who is raising a child on their own)

**Which office of the Estonian Unemployment Insurance Fund do you wish to contact in case you have any questions?**

.....



## Agreement for the processing of health data held in the health information system

I agree that Estonian Unemployment Insurance Fund and Social Insurance Board processing the following data for the purpose of assessing my work ability and the degree of severity of my disability:

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | my/person`s on my guardianship health data in the health information system (regarding the doctors who made the entries and the health data, incl. visits, hospital stays and medication, that they entered). The data mentioned above will only be processed by employees who have gone through medical training and the healthcare provider involved in assessing work ability. The name of the doctor who made the entry and the time the entry was made are processed by authorised employees. |
|--------------------------|--|

I am aware that this agreement also extends to the personal health data in the information system that I have forbidden health care providers to access.

I am aware that I have the right to withdraw my agreement at any time (and that agreement cannot be withdrawn retrospectively) by submitting the appropriate request to the Estonian Unemployment Insurance Fund or Social Insurance Board.

The criterias of processing personal data are available on the Unemployment Insurance Fund website at [www.tootukassa.ee](http://www.tootukassa.ee) or the Social Insurance Board website at [www.sotsiaalkindlustusamet.ee](http://www.sotsiaalkindlustusamet.ee).

## 1.2. THE METHOD OF OBTAINING DECISIONS OF WORK ABILITY ASSESSMENT AND ALLOWANCE, NOTICE OF DETERMINATION OF DEGREE OF SEVERITY OF DISABILITY AND BENEFITS

Please issue the DECISIONS/NOTICE to the:	
Applicant <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Representative with proxy <input type="checkbox"/>	
Please mark only <b>one</b> way to receive decisions and notices with an X.	
I wish to receive the DECISIONS OF MY WORK ABILITY ASSESSMENT AND WORK ABILITY ALLOWANCE*:	
<input type="checkbox"/> By e-mail	<input type="checkbox"/> As a standard letter
<input type="checkbox"/> From an office of the Estonian Unemployment Insurance Fund I wish to be notified when the decision becomes available: By e-mail <input type="checkbox"/> Over the phone <input type="checkbox"/>	
I wish to receive the NOTICE ABOUT THE DETERMINATION OF THE DEGREE OF SEVERITY OF MY DISABILITY:	
<input type="checkbox"/> As a standard letter	<input type="checkbox"/> By registered mail
<input type="checkbox"/> By e-mail (the decision will be sent by e-mail if the degree of severity of disability was not determined)	

\* The decision of your work ability assessment and work ability allowance and the opinion of an expert are available via the Estonian Unemployment Insurance Fund's self-service portal at [www.tootukassa.ee](http://www.tootukassa.ee). The expert's opinion is also available via the patient portal at [www.digilugu.ee](http://www.digilugu.ee).

**Please transfer the ALLOWANCES to:**

**The applicant's Estonian bank account:**

Bank account number: \_\_\_\_\_

**A foreign bank account at the applicant's expense:**

Bank account number: \_\_\_\_\_

SWIFT/BIC:

Bank:

The bank account of **another person in Estonia incl. a local government or other establishment:** (applicable only if this application is signed in an office of the Unemployment insurance Fund or Social Insurance Board, submitted with a digital signature or authenticated by a notary public)

First and family name of other person/ name of local government or other institution:

Personal identification code of other person: \_\_\_\_\_

Bank account number: \_\_\_\_\_

Reference number:

**The applicant's home address by mail at the applicant's expense:**

provide the applicant's home address: .....

.....

<p><b>The applicant's home address by mail at the expense of the Unemployment Insurance Fund/Social Insurance Board, because I am severely disabled and:</b></p> <ul style="list-style-type: none"> <li>- my movement is restricted;</li> <li>- I live in a low-density area and have limited access to bank services.</li> </ul> <p>Provide grounds for your request: .....</p> <p>.....</p> <p><b>If you are applying for mail delivery to your home address at the expense of the Unemployment Insurance Fund/Social Insurance Board, please mark an alternative method of payment in case mail delivery is not approved.</b></p>	<input type="checkbox"/> <input type="checkbox"/>
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If you wish to receive the work ability allowance paid by the Estonian Unemployment Insurance Fund in a different way or a different account from the one in which you receive your disability allowance, please indicate how you would like the work ability allowance to be paid and fill in the data for the appropriate payment method above.

**Transfer the work ability allowance to:**

The applicant's Estonian bank account	<input type="checkbox"/>
A foreign bank account at the applicant's expense	<input type="checkbox"/>
Another person's Estonian bank account incl. a local government	<input type="checkbox"/>
The applicant's home address by mail at the applicant's	<input type="checkbox"/>
The applicant's home address by mail at the expense of the Estonian Unemployment	<input type="checkbox"/>

**If you receive an allowance, a pension or other cash benefits that serve the same purpose as the work ability allowance from a foreign country, indicate:**

the country that pays you the allowance, pension or other benefits	
the type, amount and payment period of the allowance, pension or other benefits you receive from the foreign country (attach a document to the application for proof, e.g. the decision to grant the allowance, pension or benefit)	

### **1.3. PHYSICIANS AND OTHER SPECIALISTS**

**Have you been on a physician's appointment during the last six months?**

YES       NO

If you live or work abroad and have been to a physician there during the last six months, please indicate the country in which you attended the physician's appointment:

.....

**1.3.1. Name the physicians who have the health data regarding your disorders in order to assess your work ability. Provide only the names of those physicians who have diagnosed or treated your permanent illnesses.**

<b>PHYSICIAN</b>	
First and last name	
Specialty	
Institution	

Last appointment with them (month and year)	
<b>PHYSICIAN</b>	
First and last name	
Specialty	
Institution	
Last appointment with them (month and year)	
<b>PHYSICIAN</b>	
First and last name	
Specialty	
Institution	
Last appointment with them (month and year)	
<b>PHYSICIAN</b>	
First and last name	
Specialty	
Institution	
Last appointment with them (month and year)	

**You may also provide the names of any specialists / therapists who could provide additional data about your limitations.**

<b>SOCIAL WORKER</b>	
First and last name	
Institution	
<b>PSYCHOLOGIST</b>	
First and last name	
Institution	
<b>SOCIAL SERVICE PROVIDER</b> (incl. support persons and care workers)	
First and last name	
Institution	
<b>OTHER</b> (e.g. physiotherapist, occupational therapist, special education specialist or speech therapist)	
First and last name	
Institution	

## II HEALTH CONDITIONS PRECLUDING WORK ABILITY

In case you have one or more of conditions listed below, your application will be processed under a simplified procedure.

If the health condition precluding work ability is not confirmed by expert of the assessment, you will be asked to fill in the application for the assessment of work ability in full.

### 2.1. Do you have any of the conditions mentioned below?

YES

NO

- alleviating ailments associated with a malignant tumour or hospice care when oncospecific treatment is not available and only the best supportive care is provided with a malignant tumour
- dialysis treatment;
- artificial ventilation or constant oxygen therapy for respiratory insufficiency;
- dementia;
- a moderate or severe intellectual disability;
- permanently bedridden (requiring 24-hour personal assistance)

**I undertake** to immediately notify the Estonian Unemployment Insurance Fund of any circumstances affecting my right to receive the work ability allowance and its amount, including moving to and commencing employment in a foreign country and any remuneration, unemployment insurance benefits, parental benefits, benefits for temporary incapacity for work and pensions and allowances, pensions or other cash benefits that serve the same purpose as the work ability allowance received in a foreign country.

**I undertake** to immediately notify the Social Insurance Board of any circumstances affecting my right to receive social benefits for disabled persons, including stopping a child's studies (disabled parent's allowance), moving to a foreign country and any allowances or other

cash benefits that serve the same purpose as social benefits for disabled persons received in a foreign country.

**I am aware** that the Estonian Unemployment Insurance Fund/Social Insurance Board can demand the repayment of benefits/allowances granted and paid without a legal basis.

**2.2. If you answered YES to a state of health precluding work ability for question 2.1 and do not wish to continue filling in the application form, please sign the form.**

\_\_\_\_\_  
(date)                      \_\_\_\_\_  
(name of applicant)                      \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)                      \_\_\_\_\_  
(name of applicant's representative)                      \_\_\_\_\_  
(signature)



### III WORKING

If you have difficulty performing work tasks in your current job because of your health, please describe them:

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If any of your previous employment relationships ended because of the state of your health, please specify the reasons:

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# **IV PERSONAL ASSISTANCE, REHABILITATION AND SOCIAL SERVICES**

## **Personal Assistance**

Do you use the assistance of other people in your daily activities?

YES       NO

## **Rehabilitation**

Have you used the social rehabilitation service provided by the Social Insurance Board in the last three years?

YES       NO

(Data regarding vocational rehabilitation is accessible to the Estonian Unemployment Insurance Fund.)

## **Social Services**

If you use social services, please specify which services you use:

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## V PHYSICAL AND MENTAL ABILITIES

Please assess how you can perform different activities, taking into account your physical and mental abilities.

Your own opinion regarding the limitations of activity is very important in the ASSESSMENT of your work ability. Please describe the occurrences, frequency and extent of your limitations as accurately as possible.

Performing an activity without difficulties means that you are able to engage in the activity safely and repeatedly without excessive effort.

Select the option 'My ability varies' if you are sometimes able to perform the specified activity and sometimes unable to do so (e.g. if your illness is periodically more severe). Please describe 'good' and 'bad' days as accurately as possible, specifying the frequency of occurrence of your limitations.

Before starting to fill out the questionnaire, please read the entire application form. This will make it easier for you to understand the areas in which you should describe your limitations.

**Do you have the will to engage in daily activities?**

YES  NO

If you selected NO, please describe how often and with regard to which daily activities you struggle with your will.

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# 1. Moving

In this section you will be asked about how easily you are able to move around, climbing the stairs, exceed the obstacles, maintaining standing and sitting positions and changing the body positions.

If you use assistive technology aids or the assistance of another person to move around, stand up or sit down, indicate this under the corresponding activity.

Mobility aids include: lower limb prosthetic(s); manual and electric wheelchairs; crutches, walking sticks and walkers; adapted cars; two- and three-wheeled scooters and adapted bicycles (incl. motorised ones); aids for transferring and relocating the body (transfer boards, lifts and ramps); and white sticks, guide dogs and arm, leg, back or neck orthoses.

## 1.1. Moving on different surfaces

Moving around means that a certain distance is covered on one surface at an ordinary speed. Please compare yourself to a friend, family member or colleague who has no limitations. Can you keep up with them? Has it ever happened that your companion has had to stop and wait for you? Moving on different surfaces means walking on an uneven surface, exceed the obstacles and climbing the stairs. Your moving ability is without difficulties if you do not experience any pain, weakness, fatigue, gasping, imbalance, etc.

**I am able to move around and climb the stairs without difficulty.**

YES  NO

If you selected YES, please proceed to question 1.2 (page 21). If you selected NO, please continue answering the questions below.

**1.1.1. What distance are you able to cover without pain, weakness, fatigue, vertigo, gasping or imbalance?**

- More than 200 metres
- 200 metres
- 100 metres (roughly the length of a football pitch)
- 50 metres (roughly the length of five buses)
- I am not able to move independently at all
- My ability to move varies

Please specify the answer you selected. Describe how you move and what limits or interferes you in moving around freely. Add the frequency of occurrence of your limitations (in a day, a week, etc.) and the severity of your pain if you experience it. If you use any assistive technology aids, please name them and describe how the device or aid helps you. If you cannot use a recommended or prescribed aid, please explain why.

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**1.1.2. Are you able to climb the stairs and exceed the obstacles (the thresholds of doors, pavement curb stones, etc.) if needed?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to move up and down stairs varies

Please specify the answer you selected. Clarify if you need to use any assistive technology aids in order to be able to do this. Do you experience any pain, imbalance, gasping, palpitation or falls while exceeding the obstacles or climbing stairs, and how often any of these occur?

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## **1.2. Moving around safely**

Moving around safely means reaching the desired place in a reasonable amount of time, without difficulty and safely (e.g. without loss of balance or falling over and on different surfaces). Here, safe movement applies in terms of musculoskeletal diseases and sight or hearing difficulties. Difficulties caused by fear or anxiety are not covered here.

**I am able to move around safely both indoors and outdoors.**

YES  NO

If you selected YES, please proceed to question 1.3 (page 23). If you selected NO, please continue answering the questions below.

### **1.2.1. Are you able to move around on the street safely, incl. in places you have not been before?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to move safely varies

Please specify the answer you selected, incl. whether you use any aids. Describe the difficulties that inhibit you from moving around safely. If you use any assistive technology aids (incl. seeing, hearing and mobility aids), please name them and describe how they help you.

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**1.2.2. Are you able to move around safely indoors, incl. in rooms that you have not been in before?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to move safely indoors varies

Please specify the answer you selected, incl. whether you use any aids. Describe the difficulties what inhibit you going to new places and moving around safely.

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### 1.3. Standing and sitting

Standing is defined as staying in one place using an aid or leaning on something (e.g. a table or a chair) if necessary. Another person's help cannot be taken into account here.

Sitting is defined as staying in a seated position on a chair without armrests. You can change sitting and standing positions, which means you can sit for two to three minutes between periods of standing and vice versa.

**I am able to maintain and change positions without difficulty or feeling any pain.**

YES  NO

If you selected YES, please proceed to question 1.4 (page 24). If you selected NO, please continue answering the questions below.

**1.3.1. Are you able to remain in one place standing or sitting without experiencing pain or fatigue?**

- Yes
- With mild difficulty
- I am able to for up to three hours
- I am able to for less than an hour
- No
- My ability to remain in one place while sitting, standing or changing positions varies

Please specify the answer you selected. Describe your ability to stay in one place and the difficulties that occur while you are doing so. If you use any assistive technology aids, please name them and describe how they help you.

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**1.3.2. Are you able to change positions, e.g. stand up, sit on a chair, bend over, etc.?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to change positions varies

Please specify the answer you selected. Indicate whether you have difficulty changing positions and how this difficulty expresses itself. If you use any assistive technology aids, please name them and describe how they help you.

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**1.4. Other limitations related to moving**

If you have difficulty moving and maintaining or changing positions but the questions above did not enable you to describe them, please describe them here.

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## 2. Manual activity

In this part you will be asked if you are able to stretch your arms, hold and move large objects and make precise movements with your fingers without excessive effort in your daily life. You can perform hand activities without difficulty if you do not experience pain, weakness or trembling, movement restrictions, etc.

If you use assistive technology aids or the help of another person, describe this under the corresponding activity.

Aids for hand activity include upper limb or hand prosthetics, robot arms, grabbers, upper limb, hand or finger orthoses and special keyboards and/or mice for computers.

**I am:**

- Left-handed
- Right-handed

### 2.1. Stretching your arms

Stretching your arms is defined as extending your arms to different heights, bending the arms at the shoulder or elbow joints, including reaching for and throwing items.

**I am able to raise my arms without difficulty.**

YES       NO

If you selected YES, please proceed to question 2.2 (page 26). If you selected NO, please continue answering the questions below.

**2.1.1. Are you able to raise your arms enough to, for example, reach an object on a shelf?**

- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to lift and bend my arms to perform activities varies

Please specify the answer you selected. If you cannot raise your arms, give the reason for this and whether it affects both of your arms. If you use any assistive technology aids, please name them and describe how they help you.

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**2.2. Moving objects**

Moving objects is defined as grabbing them with two hands and lifting them from one place to another at waist level (from one side of the body to the other).

**I am able to move objects with my hands without difficulty.**

YES       NO

If you selected YES, please proceed to question 2.3 (page 28). If you selected NO, please continue answering the questions below.

**2.2.1. Are you able to lift and move a container filled with one litre of liquid?**

- Yes
- With mild difficulty
- With moderate difficulty
- I can lift a container filled with up to half a litre of liquid
- I cannot lift any object regardless to its weight
- My ability to lift and move such containers varies

Please specify the answer you selected. If you cannot move a container filled with one litre of liquid, describe how the difficulty expresses (e.g. if instability in your hands causes the liquid to spill or if you need to use two hands because your hands are too weak). If you use any assistive technology aids, please name them and describe how they help you.

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**2.2.2. Are you able to lift and move a large but lightweight object such as a pillow or empty cardboard box without difficulty?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to lift and move such an object varies

Please specify the answer you selected. If you are not able to lift objects, please indicate why.

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### **2.3. Manual dexterity**

Manual dexterity is defined as the mobility and strength of your fingers and wrists, the ability to turn your wrists inwards and outwards and the precise movement of your hands and fingers (grabbing, holding and handling small objects).

**I am able to use my hands and fingers without difficulty.**

YES  NO

If you selected YES, please proceed to question 2.4 (page 29). If you selected NO, please continue answering the questions below.

#### **2.3.1. How well are you able to use your hands and fingers?**

- With mild difficulty when performing certain activities
- With moderate difficulty
- With severe difficulty (almost impossible)
- I cannot
- My ability to use my hands and fingers varies

Please specify the answer you selected. List the activities you experience difficulty with and why. If you use any assistive technology aids, please name them and describe how they help you.

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## **2.4. Other limitations related to manual activities**

If you have difficulties with any manual activities that the questions above did not enable you to describe, please describe them here.

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## **3. Transmitting and receiving the information**

In this part you will be asked if you are able to communicate taking into account your ability to see, hear, speak for transmission and receiving information.

If you use assistive technology aids or the help of another person to communicate, describe this under the corresponding activity.

Communication aids include glasses, a magnifying glass, reading TVs, video magnifying or other systems, materials written with a tactile writing system, hearing aids, hearing aids used with implants, hearing glasses, audio amplifiers, electronic devices for close communication (dialogue devices) and alternative communication aids (communicators).

### **3.1. Transmitting the information**

Transmission of information is described as communicating through speech and writing. Information can be transmitted among other ways by signing, typing, etc.

**I am able to communicate with other people without difficulty by speaking and writing.**

YES  NO

If you selected YES, please proceed to question 3.2 (page 30). If you selected NO, please continue answering the questions below.

**3.1.1. Are you able to transmit a simple message to another person?**  
(A simple message could be defined as, for example, a warning or information about the time or a location)

- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to transmit a simple message varies

Please specify the answer you selected. Describe how you communicate with other people. How your difficulty in transmitting messages to other people is expressed? If you use any assistive technology aids, please name and describe how they help you.

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### **3.2. Receiving information**

In this part you will be asked whether you are able to receive information using hearing or seeing.

**I am able to hear what has been said and read what has been written down without difficulty.**

YES       NO

If you selected YES, please proceed to question 3.3 (page 32). If you selected NO, please continue answering the questions below.

**3.2.1. Are you able to hear and/or lip-read another person's simple message?**

(A simple message could be defined as, for example, a warning or information about the time or a location)

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to receive verbally forwarded message varies

Please specify the answer you selected. List the activities you experience difficulty with and why. If you use any assistive technology aids, please name and describe how they help you.

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**3.2.2. Are you able to see and read a message printed in a large font?**

(A large font can be defined as a text that is in a font larger than used for regular newspaper and book texts, i.e. at least 14 p).

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to read written messages varies

Please specify the answer you selected. Describe how you are able to see and receive messages. If you use any assistive technology aids,



please name and describe how they help you.

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### **3.3. Other limitations related to exchanging information**

If you have any difficulties communicating because of your vision, hearing or speech that the questions above did not enable you to describe, please describe them here.

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## **4. Remaining conscious and self-care**

In this part you will be asked:

- 1) whether and how often you experience fainting and/or other problems related to consciousness (e.g. loss of consciousness);
- 2) whether you have any difficulty controlling your bowels and/or bladder and what kind of difficulties you have;
- 3) whether you are able to eat and drink without difficulty.

If you use any assistive technology aids or the help of another person to control your bowels and/or bladder or to eat and drink, please describe this under the corresponding activities.

Aids that help control your bowels and bladder include urine and faecal collection devices, urine-directing devices, skin protection and cleaning products, urine-absorbing single-use inserts, diapers etc.

Aids for eating and drinking include special-purpose cutlery, drinking straws and special-purpose mugs, plates, bowls etc.

Aids related to self-care include armrests for toilet seats, commode seats and chairs, shower and bath seats and chairs, toilet paper grabbers, tracheostomy care products etc.

## 4.1. Remaining conscious

Remaining conscious is defined as usual wakefulness and the ability to make contact while awake. This does not include vertigo or drowsiness.

**I am able to remain conscious without difficulty.**

YES  NO

If you selected YES, please proceed to question 4.2 (page 34). If you selected NO, please continue answering the questions below.

### 4.1.1. How often do you experience consciousness-related disorders?

(This includes fainting, epileptic seizures and altered consciousness related to diabetes).

- Once every couple of years
- A couple of times a year
- Monthly
- At least once a week

Please specify the answer you selected. Describe why and how these disorders occur.

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## 4.2. Toileting

Toileting can be defined as the ability to control your bladder and bowels, incl. difficulties related to aids like frequent soiling of clothes and the need to change them.

When answering, take into account any use of special undergarments or collection devices (ostomy bags and bladder catheters), small leaks (i.e. controllable with single-use inserts or diapers) that do not require a change of clothes and limitations related to bowel or bladder content retention (constipation).

**I am able to control my bowels and bladder without difficulty.**

YES  NO

If you selected YES, please proceed to question 4.3 (page 35). If you selected NO, please continue answering the questions below.

**4.2.1. Do you have difficulties with controlling your bladder or bowels or other such difficulties?**

- Yes, at random times throughout the year
- Yes, monthly
- Yes, daily
- My bladder or bowel control varies

Please specify the answer you selected. Describe your bowel and bladder control, how you manage it using assistive technology aids and how often you have to wash or change your clothes because of soiling, wetting or leaks.

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### 4.3. Eating and drinking

Eating and drinking is defined as independently eating and drinking the given food and beverages, using the special cutlery if needed.

**I can eat and drink without difficulty.**

YES  NO

If you selected YES, please proceed to question 4.4 (page 36). If you selected NO, please continue answering the questions below.

#### **4.3.1. Are you able to put food and drink to your mouth without being helped by another person?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to eat and drink varies

Please specify the answer you selected. List the activities you experience difficulty with and why. Describe what kind of special aids you use and for which activities.

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**4.3.2. Are you able to chew and swallow freely?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to chew and swallow varies

Please specify the answer you selected. Describe how you eat and drink and what kind of difficulties can occur when you chew and swallow. Describe what kind of special aids you use and for which activities.

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**4.4. Other limitations related to remaining conscious and self-care**

If you have any other difficulties with self-care that the questions above did not enable you to describe, please describe them here.

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## 5. Learning and performing activities

In this part you will be asked how freely you are able to acquire and use new skills and plan and perform activities. When answering, take into account your motivation and energy, your ability to control your emotions, mood drop, your ability to understand the time, place and personality, your ability to focus and maintain your attention, etc. If you use the help of another person, describe this under the corresponding activity.

This includes activity-related difficulties caused by mental and psychological limitations.

### 5.1. Learning activities

Learning activities are defined as the ability to learn and complete both simple and complex activities in daily life.

A simple activity can be defined as an activity involving one or two parts. For instance, it could be switching TV channels with a remote control, sweeping the floor or placing cutlery to the table.

A complex activity involves several consecutive parts, such as buying and preparing food, buying laundry detergent and using a washing machine and using an ATM or mobile phone.

**I am able to learn and perform both simple and complex daily activities without difficulty.**

YES  NO

If you selected YES, please proceed to question 5.2 (page 39). If you selected NO, please continue answering the questions below.

**5.1.1. Are you able to learn how to perform simple activities?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to learn how to perform simple activities varies

Please specify the answer you selected. Describe which activities you have difficulty to learn and which skills you have difficulty using and why.

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**5.1.2. Are you able to learn doing complex activities?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to learn how to do complex activities varies

Please specify the answer you selected. List which activities you have difficulty to learn and which skills you have difficulty using and why.

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## 5.2. Starting and completing activities

Starting and completing activities is defined as the ability to plan and perform daily activities. When answering, take into account whether you experience any difficulty with memory and the ability to concentrate and how much will, energy and motivation you have to start and complete activities.

Only activity-related difficulties caused by mental and psychological limitations are described here.

**I am able to handle daily activities without difficulty.**

YES       NO

If you selected YES, please proceed to question 5.3 (page 40). If you selected NO, please continue answering the questions below.

**5.2.1. Do you recognise the need for daily activities and are you capable of planning, starting and completing these on your own?**

- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to start and complete activities varies

Please specify the answer you selected. Describe how you manage in terms of remembering, planning and organising activities. Indicate what can make this difficult for you and how often and with what things you need other people's help.

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### **5.3. Other limitations related to learning and performing activities**

If you have any difficulties learning new skills or performing or repeating activities that the questions above did not enable you to describe, please describe them here.

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## **6. Adapting to changes and perception of threat**

In this part you will be asked whether you are able to move around outside of your home without becoming agitated or feeling excessive anxiety and whether you can assess dangerous situations and adapt to changes in your daily life. If you use the help of another person, please describe this under the corresponding activity.

Only activity-related difficulties caused by mental and psychological limitations are described here.

### **6.1. Going outside**

Emotional and mental tension related to going outside is defined as feeling anxious, uncomfortable or afraid when moving around outside of your home. These difficulties can be connected to understanding the time and place and to memory or delusions.

**I am able to go outside without emotional or mental tension.**

YES       NO

If you selected YES, please proceed to question 6.2 (page 42). If you selected NO, please continue answering the questions below.

**6.1.1. Are you able to go to the familiar places without experiencing emotional or mental tension and anxiety?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to go to the familiar places varies

Please specify the answer you selected. Describe whether you need someone to go with you and why.

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**6.1.2. Are you able to go to the unknown places without experiencing emotional or mental tension and anxiety?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- I am not able
- My ability to go to the unknown places varies

Please specify the answer you selected. Describe whether you need someone to go with you and why.

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## 6.2. Recognising risks or threat

Recognising threat is defined as understanding which daily activities could be dangerous to your or others health and safety and acting in a way that avoids causing dangerous situations.

**I am able to perform daily activities safely and understand threats related to traffic.**

YES  NO

If you selected YES, please proceed to question 6.3 (page 43). If you selected NO, please continue answering the questions below.

### 6.2.1. Do you need someone with you to avoid danger?

- No
- For some activities, but not every day
- Yes, always, during the day
- Yes, around the clock
- My need to have someone with me varies

Please specify the answer you selected. Describe what kind of dangerous situations can occur and how you deal with them.

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### 6.3. Coping with change

Coping with change is defined as adapting to unexpected situations that interfere your daily routine.

**I am able to cope with changes in my daily life without difficulty.**

YES  NO

If you selected YES, please proceed to question 6.4 (page 44). If you selected NO, please continue answering the questions below.

#### 6.3.1. Are you able to cope with changes in your daily life?

(For example, if your mealtime shifts to an earlier or later time, if a bus or train arrives at a different time than expected or if a friend or carer arrives earlier or later than planned.)

- With mild difficulty
- Yes, if I know in advance about change
- No, if the change is unexpected
- I am not able to cope with change at all
- My ability to cope with change varies

Please specify the answer you selected. Describe how you cope with change and what your difficulties are related to.

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## 6.4. Other limitations related to coping with change and recognising threat

If you have any difficulties coping with change or recognising threat due to a lack of will or energy that the questions above did not enable you to describe, please describe them here.

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## 7. Communication

In this part you will be asked whether you have any difficulty communicating with people you know or do not know and how you manage in situations that require communication. If you use the help of another person, describe this under the corresponding activity.

### 7.1. Coping with communication

Interpersonal communication is defined as being prepared to meet people and to communicate with people you know and do not know.

**I am able to handle communicating with people without feeling too anxious or afraid.**

YES  NO

If you selected YES, please proceed to question 7.2 (page 45). If you selected NO, please continue answering the questions below.

**7.1.1. Are you able to meet with people you know without feeling too anxious or afraid?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to meet people I know without feeling anxious or afraid varies

**7.1.2. Are you able to meet with people you do not know without feeling too anxious or afraid?**

- Yes
- With mild difficulty
- With moderate difficulty
- With severe difficulty (almost impossible)
- No
- My ability to meet people I do not know without feeling anxious or afraid varies

Please specify the answer you selected. Describe what your difficulty in meeting and communicating with people is related to.

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**7.2. Appropriate behaviour**

Appropriate behaviour is defined as controlling your emotions and acting in a way that is appropriate and corresponds to the situation – how you express your feelings and whether your behaviour (be it intentional or unintentional) bothers other people.

**I am able to control my emotions and behaviour.**

YES  NO

If you selected YES, please proceed to question 7.3 (page 46). If you selected NO, please continue answering the questions below.

**7.2.1. How often do you lose control of your emotions and behaviour?**

- Rarely
- Sometimes
- Often
- Every day

Please specify the answer you selected. Describe how often, in which situations and how your behaviour bothers other people.

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**7.3. Other limitations related to communication**

If you have any difficulties with interpersonal communication that the questions above did not enable you to describe, please describe them here.

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## 8. Influence of addictive substances and adverse drug reactions

8.1. Do you have difficulties with activities due to consumption of alcohol or other addictive substances?

YES  NO

If you selected YES, please specify your answer. Describe the problems you have related to substance consumption, the frequency of their occurrence and how they affect your ability to perform activities.

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**8.2. Do you experience adverse reactions related to taking medications (e.g. vomiting, nausea or light-headedness)?**

YES  NO

If you selected YES, please specify your answer. Describe the problems you have related to taking medications, the frequency of their occurrence and how they affect your ability to perform activities.

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## 9. Other health problems

In this part you will be asked to describe **only those** activity-related problems caused by the state of your health that you have not mentioned to this point.

**9.1. Do you have any activity-related difficulties that the questions above did not cover?**

YES  NO

If you selected YES, describe the difficulties and specify how often they occur.

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## DOCUMENTS ENCLOSED

Please list the documents you are submitting with your application.

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\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
(date)                                      (name of applicant)                                      (signature)

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
(date)                      (name of applicant's representative)                      (signature)

If you filled out the application form for the assessment of work ability above, only **fill out part two** of the work ability allowance application (activity requirements) by marking which activity requirement you fulfil.

If you filled out the application for the assessment of work ability above and indicated that you have a condition precluding work ability in question 2.1, you do not have to fill out the work ability allowance application below.

If your work ability has already been assessed and you wish to apply for the work ability allowance, fill out every part of the work ability allowance application below.

## **APPLICATION FOR WORK ABILITY ALLOWANCE**

### **1. DETAILS OF WORK ABILITY ALLOWANCE APPLICANT**

First name: .....	Surname: .....
Personal identification code: _____	
If you do not have an Estonian personal identification code, please provide your date of birth: _____._____._____ and gender: <input type="checkbox"/> M <input type="checkbox"/> F	

Foreign personal identification code (if applicable):

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Country of issue of personal identification code:

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Postal address:

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E-mail address:

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Telephone:

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If you are a resident of more than one country, please provide the name of the foreign country and the address of your residence there:

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If you live/work or have lived/worked in a foreign country, write down the name of the country and the period for which you were living/working there with accurate dates

Country	Period

**If you receive an allowance, a pension or other cash benefits that serve the same purpose as the work ability allowance from a foreign country, indicate:**

the country that pays you the allowance, pension or other cash benefits	
the type, amount and payment period of the allowance, pension or other benefits you receive from the foreign country (attach a document to the application for proof, e.g. the decision to grant the allowance, pension or benefit)	

## DETAILS OF WORK ABILITY ALLOWANCE APPLICANT'S REPRESENTATIVE

Please fill in the details of the representative (authorised representative, parent or guardian) if the applicant is under 18 years of age or has a designated guardian or representative.

Parent/guardian

Authorised representative

First name: .....	Surname: .....
Personal identification code: _____	
E-mail address: .....	
Telephone: .....	
Postal address: .....	

If the representative of the applicant is a legal entity, please provide the name of the legal entity:

.....

**If the application is being submitted by a person with power of attorney, please provide the power of attorney on which the right of representation is based as an annex to the application.**

**I wish to receive decisions related to my work ability allowance (mark one option):**

**at the applicant's address  at the representative's address**

at my e-mail address:

as a standard letter:

from an office of the Estonian Unemployment Insurance Fund:

Indicate the office of the Unemployment Insurance Fund from which you wish to collect the decisions

.....

I wish to be notified when decisions become available:

- via e-mail
- over the phone

Regardless of the option you selected, all decisions related to the granting of the work ability allowance can be viewed on the Estonian Unemployment Insurance Fund's self-service portal at [www.tootukassa.ee](http://www.tootukassa.ee).

**I would like to receive the work ability allowance.**

## **2. ACTIVITY REQUIREMENT**

**A person with partial work ability will only be paid an allowance if they meet at least one of the following requirements: Mark which requirement you fulfil below.**



<input type="checkbox"/>	I work under an employment contract, contracting agreement, authorisation agreement or other agreement under the law of obligations entered into in order to provide a service or sell goods under the Simplified Business Income Taxation Act or I work for the civil service
<input type="checkbox"/>	I am a member of the Riigikogu, a member of the European Parliament, the President of the Republic, a member of the Government of the Republic, a judge, the Chancellor of Justice, the Auditor General, a Public Conciliator, a rural municipality or city district elder, the chairman or deputy chairman of a council of a local government working in a remunerative position, a member of a rural municipality or city government working in a remunerative position, including a rural municipality or city mayor
<input type="checkbox"/>	I am engaged in a profession in public law as an independent person
<input type="checkbox"/>	I am a member of the management or controlling body of a legal entity
<input type="checkbox"/>	I am registered as a sole proprietor
<input type="checkbox"/>	I am listed in the register of taxable persons as a spouse participating in the activity of a sole proprietor's enterprise
<input type="checkbox"/>	I am registered as unemployed
<input type="checkbox"/>	I am acquiring level-based (primary, secondary or higher) or vocational education
<input type="checkbox"/>	I am on academic leave for health reasons
<input type="checkbox"/>	I am raising or caring for at least one child under three years of age

**I am caring for a family member (child, parent or spouse) with a severe or profound disability who needs assistance**

name and personal identification code or, in the absence thereof, date of birth of the family member being cared for

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**I am caring for a disabled person under paragraph 26 of the Social Welfare Act**

**I receive support from an artistic association**

**I have been placed, without my consent, in a social welfare institution in order to receive 24-hour specialist care**

**I am receiving treatment as an outpatient or inpatient or am subject to another alternative sentence or sanction provided by law that prevents me from fulfilling any of the other listed requirements**

medical facility

.....

**I am participating in compulsory military service,**

**I am fulfilling one of the requirements mentioned above in a foreign country**

requirement .....

country .....

start date of requirement .....

**Please attach to your application a document proving that you are fulfilling the requirement.**

### 3. PAYMENT METHOD OF WORK ABILITY ALLOWANCE

Please transfer the work ability allowance to:

<b>The applicant's Estonian bank account:</b>	<input type="checkbox"/>
Bank account number:	
<b>A foreign bank account at the applicant's expense:</b>	<input type="checkbox"/>
Bank account number:	
SWIFT/BIC:	
Bank:	
<b>To the bank account of another person in Estonia incl. a local government or other establishment:</b> (applicable only if this application is signed in an office of the Estonian Unemployment insurance Fund, submitted with a digital signature or authenticated by a notary public)	<input type="checkbox"/>
First and last name of other person/ name of local government or other institution:	
Bank account number:	
Reference number:	
<b>The applicant's home address by mail at the applicant's expense:</b> provide the applicant's home address: ..... .....	<input type="checkbox"/>

**The applicant's home address by mail at the expense of the Estonian Unemployment Insurance Fund, because I am severely disabled and:**

- my movement is restricted;
- I live in a low-density area and have limited access to bank services.

Provide grounds for your request: .....

.....

**If you are applying for mail delivery to your home address at the expense of the Estonian Unemployment Insurance Fund, please mark an alternative method of payment in case mail delivery is not approved.**

**I undertake** to immediately notify the Estonian Unemployment Insurance Fund of any circumstances affecting my right to receive the work ability allowance and its amount, including moving to and commencing employment in a foreign country and any remuneration, unemployment insurance benefits, parental benefits, benefits for temporary incapacity for work and pensions and allowances, pensions or other cash benefits that serve the same purpose as the work ability allowance received in a foreign country.

**I am aware** that if my work ability has been determined as partial, I must meet at least one of the activity requirements (e.g. be working, studying or registered as unemployed) to receive the work ability allowance.

**I am aware** that the Estonian Unemployment Insurance Fund can demand the repayment of a work ability allowance granted and paid without a legal basis.

\_\_\_\_\_  
(date)                                  \_\_\_\_\_  
(name of applicant)                                  \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)                                  \_\_\_\_\_  
(name of applicant's representative)                                  \_\_\_\_\_  
(signature)

## To the Estonian Unemployment insurance Fund

Lasnamäe 2, 11412 Tallinn

info@tootukassa.ee

# PROXY

*[Place and date of drafting document]*

Hereby, I, *[PRINCIPAL'S first and last name]* .....,  
personal identification code *[personal identification code]* .....,  
residing at *[address of residence]* .....,  
authorise *[first and last name of AUTHORISED person]* .....,  
personal identification code *[personal identification code]* .....,  
with the contact details *[e-mail and/or phone number]* .....,  
and residing at *[address of residence]* .....,  
to represent me in the Estonian Unemployment Insurance Fund in the following  
activities (mark YES or NO):

- 1  submitting an application for the assessment of my work ability/determination of the degree of severity of my disability and activities related to the processing of said application;
- 2  submitting an application for the work ability allowance and activities related to the processing of said application;
- 3  submitting an application for social benefits for disabled persons;
- 4  clarification applications related to fulfilling the decisions made in the assessment of my work ability and work ability allowance;
- 5  appealing decisions made in the assessment of my work ability and work ability allowance;
- 6  appealing decisions made in the determination of the degree of severity of my disability and benefits for disabled persons.

This power of attorney is valid from the date of granting authority until *[the representative completes the activities for which the authority was granted (points 1-3 or 5)] / [the end of the term of validity of the decisions on work ability assessment and the work ability allowance (point 4)]*<sup>1</sup>.

This power of attorney has been issued without the right of delegation.

*[PRINCIPAL'S signature]*

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<sup>1</sup> Choose one option and erase or cross out the other inapplicable option