This is how you fill in the form electronically
You can fill in this form electronically. However, we need your signature so you have to print the form and send it to us by mail. To obtain a faster decision from us make sure you fill in the form correctly and sign it. Please note that the form has to be printed on white paper.

Swedish University

Department/Equivalent

FAS

FAS+

Surname and first name

Personal ID no. (year, month, day, no.)

Address

Post code and place

Postal address in home country/abroad

Telephone home/mobile (including Swedish area code)

Post code, town and country

Telephone abroad/mobile

E-mail address

Period of stay

20 - 20

Payment method – Swedish account

Bank account

Bank's name

Clearing number

Account number

PlusGiro:

Bankgiro:

Payment method – Foreign account

IBAN number/Bank account:

SWIFT:

Bank code (e.g. BLZ, SORTCODE)

Bank's name and address:

Unless otherwise stated above, the compensation will be paid through a postal check.

The authority’s confirmation

It is hereby confirmed that the claim relates to a person covered by FAS/Group.

It is hereby confirmed that the claim relates to a person covered by FAS+/Group.

Signature

Authority and department

Name in print

Position

Telephone

Fax

E-mail

The costs have been paid in advance by the authority

Compensation shall therefore be paid to the authority’s PlusGiro/Bankgiro account:

Reference

www.kammarkollegiet.se/forsakringar
# Incident details

<table>
<thead>
<tr>
<th>Date of the incident</th>
<th>Time</th>
<th>Place of the incident</th>
<th>Country</th>
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</table>

## Type of claim
- [ ] Accident (incl. doctor`s note)
- [ ] Healthcare and dental cover
- [ ] Repatriation
- [ ] Property cover (FAS+ only)
- [ ] Liability cover
- [ ] Legal expenses cover

## Healthcare facilities visited:

## Admitted to hospital for the following days:

I have insurance with another company:  [ ] Yes  [ ] No

Yes, company's name:

Has the claim been reported to the company?  [ ] Yes  [ ] No

Provide a detailed description of what occurred/the need for care:

[ ] Continued on another sheet
Compensation claim (medical care, medicines, dental care, etc.)
List of costs that the insured person is claiming compensation for. Receipts must be included.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Cause</th>
<th>Compensation claim in SEK</th>
</tr>
</thead>
<tbody>
<tr>
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☐ Continued on another sheet
Sum SEK

List of property that the insured person is claiming compensation for (FAS+ only)
Include receipts

<table>
<thead>
<tr>
<th>Property</th>
<th>Make, model</th>
<th>Purchase date</th>
<th>Purchased new or used</th>
<th>Place of purchase</th>
<th>Purchase price</th>
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☐ Continued on another sheet
Sum SEK

Insured person’s signature
I hereby confirm that the information in this insurance claim is true. I also consent to Kammarkollegiet reviewing the relevant medical journals.

Place and date
Signature and name in print

Send your insurance claim to Kammarkollegiet within three years of the date of the incident.

The claim is sent together with the authority’s confirmation to: Kammarkollegiet, 651 80 Karlstad

www.kammarkollegiet.se/forsakringar