KAM22011

KAMMARKOLLEGIET

Claim form

URA - Insurance for personnel stationed abroad

Please complete the form in block capitals

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 please make sure you fill in the form correctly and sign it. Please note that the form has to be printed on white paper.

Employer

Authority	Organisation no.
Department	

Policy holder information

Policy holder's surname and firstname	The claim regards ☐ Policy holder ☐ Accompanying adult ☐ Accompanying child
Policy holder's personal ID number (personnummer)	Name and personal ID number of the accompanying person
Address	Telephone, mobile
Postalcode, city and country	E-mail

Claim information

Date and time of incident	Location

Manner of payment

Bank	Clearing number	Account number
Foreign bank	Swift code (BIC)	IBAN code or ABA code

The authority's confirmation

☐ It is hereby certified that the claim/costs arose at a time when the insured was covered by the insurance policy. A copy of the insurance confirmation must be attached to the claim if it relates to an individual insurance	
Signature	Authority
Name in block capitals	Position
Telephone	E-mail

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Type of claim

The claim regards:

- ☐ Emergency medical or dental care as well as additional costs for repatriation
- ☐ Baggage delay on outbound journey
- ☐ Accident ☐ Working hours ☐ Leisure time
- ☐ Liability cover/Legal cover
- ☐ Travel due to a close relative's life-threatening illness or death.
- ☐ Visits by close family members

Has help been obtained from Falck Global Assistance?

☐ Yes, (What kind?) ☐ No

I have also reported the injury/damage/loss to another insurance company	I only request compensation for the excess
☐ Yes (name of insurance company?)	☐ Amount in SEK

Give a detailed description of what occured.

☐ Continued on another sheet of paper or on the back of the document

List of costs for which the insured claims compensation

Compensation claim, cost type	Attachment no.	Cost in local currency	Compensation in SEK
☐ Continued on another sheet of paper or on the back of the document		Total amount in local currency	Total amount in SEK

Insured person's signature

I hereby confirm that the information in this claim is accurate

Place and date	Signature

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

www.kammarkollegiet.se/insurance

Kammarkollegiet
SE- 651 80 Karlstad

Switchboard number:
+46 54 22 12 00