KAM22011

KAMMARKOLLEGIET

Notification of damage/loss

URA - Insurance for personnel stationed abroad

Terms and Conditions, 1 July 2011

This is how you fill in the form electronically.

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

Authority	Organisation no.
Department	

The insured's surname and first name		Personal ID no. (year, month, day, no.)
Address in Sweden		Postal code and place in Sweden
Telephone, residence (including dialling code) in Sweden	Telephone, mobile.	Telephone, work (including dialling code)
E-mail	Fax	
Bank account no. and bank or PlusGiro no.		

Date of injury/damage/loss	Time
Place of injury/damage/loss	

- ☐ Accident
- ☐ Emergency medical or dental care, and additional costs for home transport
- ☐ Visit by family member
- ☐ Baggage delay on outbound journey
- ☐ Home journey due to a family member's illness or death
- ☐ Other type of injury/damage/loss (describe on next page).

Has assistance been received from Falck Global Assistance?

- ☐ Yes, namely:
- ☐ No

I have also reported the injury/damage/loss to another insurance company. Company's name:

I have received compensation through another insurance policy and therefore only claim compensation for deductibles: SEK

Please note! You must describe the course of events on the next page.

www.kammarkollegiet.se

Postal address:
Kammarkollegiet
651 80 Karlstad

Visiting address:
Karolinen
Våxnäsgatan 10

Switchboard
+ 46 054-22 12 00

Fax
+ 46 054-15 56 10

Give a detailed description of what occurred.

Continued on another sheet of paper

Please note! You must sign the form on the next page.

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Compensation claim		Compensation in SEK
Continued on another sheet of paper	Sum SEK	

Authority's certification

☐ 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 this notification	
Signature	Authority
Name in block letters	Position
Telephone	E-mail

The insured's signature

I hereby certify that the information in this notification is true.	
Place and date	Signature

The notification is to be sent together with the Authority's certification to: KAMMARKOLLEGIET 651 80 KARLSTAD