KAM22006

KAMMARKOLLEGIET

Insurance Claim

FAS and FAS+

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 Lund University, LTH
Name in print Cecilia Nilsson		Position International coordinator
Telephone 046-222 97 22	Fax	E-mail cecilia.nilsson@lth.lu.se
☐ The costs have been paid in advance by the authority		
Compensation shall therefore be paid to the authority's PlusGiro/Bankgiro account:		Reference

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Incident details

Date of the incident	Time	Place of the incident	Country

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**

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Compensation claim (medical care, medicines, dental care, etc.)

List of costs that the insured person is claiming compensation for. Receipts must be included.

Cost	Cause	Compensation claim in SEK
☐ **Continued on another sheet**		**Sum SEK**

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

Include receipts

Property	Make, model	Purchase date	Purchased new or used	Place of purchase	Purchase price
☐ **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