Claim form

Wollmar Yxkullsgatan 14
SE-118 50 Stockholm
Telefon: 08- 615 28 00
Fax: 08- 641 84 80

1 Policy number: ______ | Claim number: (To be completed by Första AB)

2
Name : ______________________ Civil register nr :
Address: ______________________ Tel. home : ____________
Postal code: ________ Town: ______________ Tel. work: ____________
Country : ______________________ E-Mail : ____________

3 Nature of loss/injury
(Please give specific description)

____
____
____
____
____
____
____

4 Date of injury: ______

5 Under which type of coverage are you filing the claim?

☐ Medical/dental care ☐ Transport home ☐ Assault ☐ Cancellation cover
☐ Travels for care ☐ Liability ☐ Property cover ☐ Next of kin journey
☐ Disablement/death ☐ Legal expences ☐ Education costs ☐ Examination
☐ Other: ____________

6 Journey

Regarning: ☐ Holiday ☐ Education ☐ Holiday/ Education ☐ Practical training ☐ Other
Departure : ________ Arrival : ____________
Travel organizer : ________________ Destination : ____________________

7 Iillness/injury/accident

Date and time for illness/accident: ______________ 1:st consultation : ______________
Reported fit for work: ___________ Hospitalisation (from-to) : ___________ -____________
Confinement to bed ordered by doctor (from-to) : ___________ - ___________ (Medical certificate enclosed)
Have you previously suffered from the same symptom : ☐ Yes ☐ No When : ______________
Name/address/tel. to doctor : ______________________________
Hospital : ______________________________
Were you repatriated by ISIS Assistance? ☐ Yes ☐ No Date : ________________

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	Diagnosis	Expences for	Amount (currency)	Payment made

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When was the loss/damage ascertained : __________ When did it occur (if other date): __________
To whom was the claim reported :

☐ Police ☐ Transport company ☐ Hotel ☐ Guide ☐ ISIS ☐ Goudse
Other :____________________ **Original documentation must be enclosed**

Where were the objects when the loss/damage occured :

☐ Car ☐ Boat/Tent ☐ Train ☐ Aeroplane ☐ Hotel ☐ Bus ☐ Apartment
Other place :____

Had the luggage been checked in/deposited : ☐ Yes ☐ No By whom : ___________________________
Was the storage area locked : ☐ Yes ☐ No
Were there signs of forced entry : ☐ Yes ☐ No Which : ______________________________

Objects (enclose original voucher/reciepts)	Date of purchase :	Purchase price :	Claim :

If the compensation is to be credited to your bank account, please state the following:
Bank ____________________ Sort code __________ Account number ____________________

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Have you taken out a householders´/contents policy or other charge card insurance: ☐ Yes ☐ No
If Yes, with which company: ___________________________________
Policy no : ____________ Has the claim been reported to that company ☐ Yes ☐ No Date: ______

Signature

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I, the undersigned,solemnly declare that the above information is correct, and authorise the insurance company to obtain medical information about any previous illness or treatment, if such information is relevant to the handling of the claim.

Date : _____________ Signature : ____
Please, remember to enclose original documentation.