

Claim report

Personal Injury



Staff posted abroad Business travel insurance Medical expenses insurance

Employer		Policy Number
Mailing Address	City and Zip Code	Telephone (include area code)
Family name and Christian name of claimant		Date of birth
Mailing Address	City and Zip Code	Telephone (include area code)
Location of Position Abroad	Departure Date from domicile	Ordinary Date of Return
Do you have health, accident, travel or medical expenses insurance with another company? <input type="checkbox"/> Yes <input type="checkbox"/> No	Company	Policy Number
Have you applied to If Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by an SAF/PTK agreement or similar agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ACCIDENT

When did the accident occur?	Where?
How did the accident happen?	
What type of bodily injuries did you sustain?	
What was the name of the doctor who treated the injury?	Has treatment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No

ILLNESS

Type of Illness	When did your first notice the symptoms?		
Have you previously been treated for a similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	What was the illness?	When?	For how long?
Which doctor did you then contact? Provide name and address of the doctor.			

INFORMATION ABOUT MEDICAL AND TRAVEL EXPENSES

Date of Treatment	Type of expense (doctor's fee, medicine)	Amount paid in foreign currency	Currency code	Compensated by another policy/social insurance	Remaining amount	Cost in Swedish Currency	Voucher No.

NOTE!

All expenses must always be substantiated with the original receipt. The insurance office may pay a portion of the expenses in certain cases. Therefore contact your insurance office.

Loss Deductible

Total

MANNER OF PAYMENT IN SWEDEN

To Bank Account, Clearing No.	Account No.	Owner of Bank/Checking Account
Checking Account	Postal Giro	

MANNER OF PAYMENT OUTSIDE SWEDEN

Account No	Name of bank and address
Swiftcode	

SIGNATURE OF EMPLOYER FOR BUSINESS TRIP

I hereby certify that the injured individual was on a business trip at the time of the injury.

Date	Employer's Signature
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SIGNATURE OF THE INJURED INDIVIDUAL

The undersigned hereby declares upon his honor that the information above is true. I give consent to the doctor, hospital or other care facility or insurance institution (including the general social insurance office) to provide If P&C Ltd all necessary information to make a decision on compensation claims.

Date	Signature of Injured Individual
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INFORMATION FOR TRAVEL INTERRUPTION COMPENSATION

Reason for interruption of travel

Illness or Death of Relative

Doctor's certification or death certification and proof of travel or ticket is enclosed.

Significant property damage to residence in place of domicile

When did you receive notice of damage?

Please describe what occurred.

DOCTOR'S CERTIFICATE (not applicable for travel interruption compensation)

Name of patient

Date of birth (year, month, day)

Address

When did the accident occur or the symptoms of illness first appear?

In case of accident how did it happen?

On what date did you start your treatment of the patient?

Diagnosis, with details of complications (intoxication, other illness etc) if any?

Symptoms?

Has the patient previously suffered from the same or similar illness or injury?

Has the recovery been normal?

Is the patient disabled?

From

To

No Yes Wholly Partly

HAVE YOU GIVEN THE PATIENT ANY INSTRUCTIONS RE

hospitalisation?

If yes, which instructions?

Yes No

change of accommodations?

If yes, which instructions?

Yes No

travelling home?

If yes, which instructions?

Yes No

DOCTOR'S SIGNATURE

Date

Signature



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