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E-mail: Phone: 010-184 77 90

Claim application Personal accident insurance for students etc.

Name of the injured person:

Surname	Name		Social security number		
Address		Post code	City		
Phone number	Mobile phone:	l	E-mail:		
The name of the school / preschool / activit	ty / business:	Phone:			
Description of accident:					
Date of the accident:		Time of the accid	lent:		
When did the accident occur:		1			
On the way to/from school/preschool/activity:	During school/prescho		During time outside school/preschool/activity:		
In the event of a traffic accident, enter					
Vehicle´s license plate:	Vehicle's license plate: Insurance company:				
Describe the injuries have you sustained be	ecause of the accide	nt:			
Clearly describe how the accident happene	d:				
When and where were doctors hired?					
Doctor's name and address					
Hospitalized From date:	To date:				
Are you still being treated?	Ye	es No			
Are you expecting permanent problems in the future?	Υє	es No	Do not know		
If Yes, which type?					

Has injured body part pre	viously been exposed				
to injury or illness?	, ,	Yes	No	If Yes, when (date)):
Was a doctor involved?		Yes	No)	
Compensation to be paid					
Name of payment recipie	nt if other than the in	sured:			
Bank name:	Bank	giro:		Plusgiro:	
Clearing number	Accor	unt number:			
Other involved insurance:	Yes If Yes	, which company?		Type of insurance? Accident insurance:	Other:
Has a claim been made to another insurance		, which company?		Claim number:	
company?	No				
Compensation claim No	tal Pacaints in origins	al need to be attached			Amount
					Total
School transport Need for a taxi to and fr certificate must state th Crawford & Co should be	e time during which	the taxi was prescrib	oed. Bef	ore ordering taxi journ	eys to and from school
Consent I give my consent to Craw healthcare costs in the EU			Social In:	surance Agency reclaim a	any reimbursement of
Mandatory signature I assure you that the infor	mation provided is co	mplete and truthful.			
City and date		Signature			
If minor, who has Guardia	inship	Name clarification			

Claim is sent to:

Crawford & Co/ Kommun Olycksfall Box 6044

171 06 SOLNA E-mail: sterik.olycksfall@crawco.se Telefon: 08-508 299 26 Fax: 08-124 459 49

Appendix to the claim report for dental damage

Collective accident insurance for Stockholms Stad				
Social security number	Claim date			
Surname and name				
MARK WHICH TEETH ARE DAMAGED. DO NOT FORGET TO MARK IF BABY TEETH OR PERMANENT TEETH Note! Certificate from Baby teeth dentist is NOT required. Permanent teeth Mark the damaged teeth in the picture.				
Right side of injured person injured person				
Right side Left side Cheek teeth Lower jaw	Right side Left side eth Cheek teeth Upper jaw			

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