Claim should be sent to:
SRFAB
Box 16250
103 24 Stockholm
Phone +46 (0) 8 412 97 40

skador@srfab.net

Claims number:
(Filled in by SRF)

CLAIM Collective Accident Insurance - Municipality

THE INJURED

Last name	First name	
Social security number		
Residential address (if more than one, fill in the other at Other information)	Postal code and address	
Phone/Mobile	Email Address	I agree to be contacted via email
Possible compensation is paid to:		
Name of the bank	○ Bank account + clearing ○ Bankgiro ○ Plusgiro	
Name if other payee than the injured		

Is other insurance affected? Yes | No	If yes, which company	What kind of insurance
Is the claim reported to other insurance company? ☐ Yes ☐ No	If yes, which company	Claims number

WHEN DID THE ACCIDENT OCCUR

When did the accident occur? ○ On the way to/from school/ activity ○ Inside school/ activity ○ Other time	Date	Time of occurance for the injury
In the event of a traffic accident, enter the vehicle reg. number and insurance company	Has a police report been made? If yes, please attach the report	☐ Yes ☐ No

WHERE DID THE ACCIDENT OCCUR? Fill in all the fields even if the accident occurred outside of the business

Municipality of residence	
Name of the school/activity (E.g. school, pre-school)	Phone
Address of the school/activity	
Other place, description and/or address	

WHAT HAPPENED? ALWAYS ANSWER ALL QUESTIONS

What kind of bodily injury has the injured suffered as a result of the accident (In case of dental injury, fill in the appendix below)					
What caused the injury?					
Has a doctor been consulted? __No__Yes	Date	Name of the hospital/treatment place		Phone	
At which healthcare institution did you consult a doctor? Enter name and department					
Has the injury been plastered?	Yes No	How many weeks should the plaster treatment last?		Has the doctor prescribed any school shuttle? If yes, attach the certificate	Yes No
Have you been hospitalized?	Yes No	If yes, which hospital?			
During which period did you stay in the hospital?	From	To		Is the injured still going on treatment?	Yes No
Has the injured person been on sick leave? If yes, please attach the certificate	Yes No	Were the injured affected by alcohol, drugs or other intoxicants at the time of the accident?			Yes No
Are there any fears of future defects?	Yes No	If yes, what kind?			
Has the injured body part previously been exposed to injury or illness?	Yes No	If yes, when?		Was a doctor consulted?	Yes No
Describe the previous injury or illness					

SCHOOL SHUTTLE

Need for taxi to and from school because of accidents must be substained by a certificate from the treating physician. The certificate shall indicate the period which the taxi was granted. Before ordering taxi journeys to and from the school, SRF AB or their appointed claims management company should be contacted for confirmation. After confirmation from Stockholmregionens Försäkring AB or by them appointed claims management, taxi travel orders can be made.

CLAIM FOR COMPENSATION (ATTACH THE ORIGINAL RECEIPTS) AMOUNT

TOTAL	0

MANAGING OF PERSONAL DATA AND SIGNATURE REGARDING CLAIMS HANDLING - OBLIGATORY

Managing of personal data

To be able to handle your claim we need to collect and handle personal data. We process your personal data in accordance with the new Data Protection Regulation (GDPR), which applies from May 25th, 2018.

On our website www.srfab.net you can read more about the Data Protection Regulation, your rights and how we handle personal data.

I gurarantee that the information provided is complete and true.

County and date	Signature
Guardian if underage	Printed name

OTHER INFORMATION

Injured with more than one residential address

Home address	Postal code and address

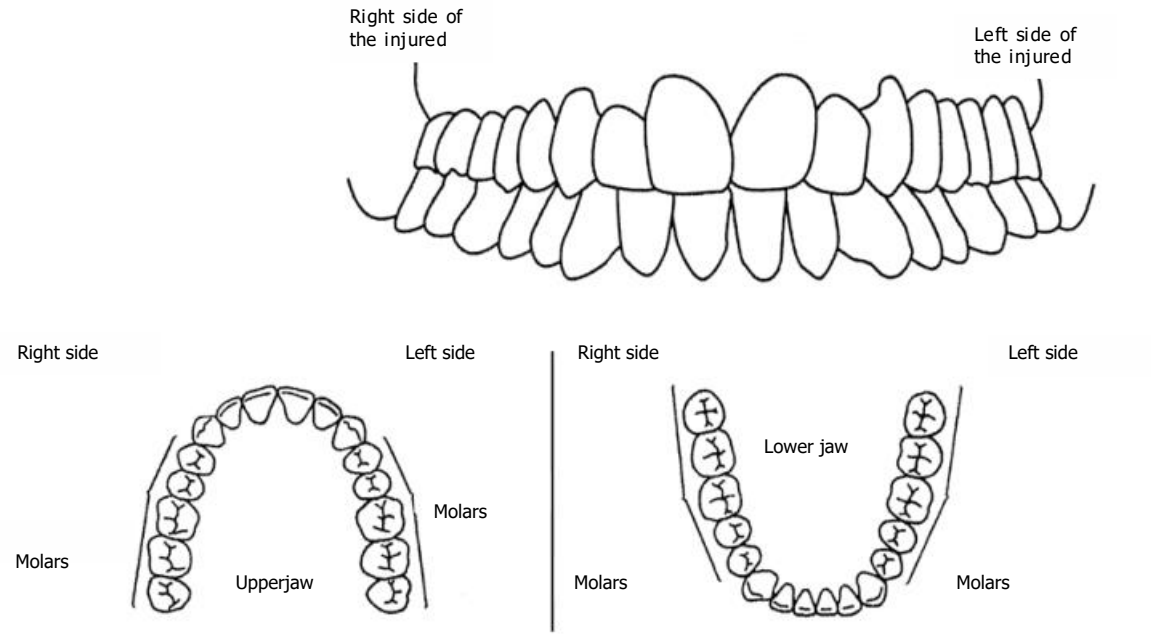
Claim Collective Accident Insurance for Municipality

Social security number	Date of injury
Last name and First name	

CHOOSE BELOW WHICH TEETH THAT HAS BEEN DAMAGED BY MARKING THEM, DON'T FORGET TO MARK IF CALF'S TEETH/PERMANENT TEETH.

NOTE! Certificate from dentist is NOT needed
Mark yourself in the picture which teeth that has been damaged

Calf's teeth
Permanent teeth



County and date	Signature
Guardian if underage	Printed name