

Claim Private Healthcare Insurance

Products with a qualifying period

skandia:

Send this form to:
Skandia
Document handling, R 812
SE-106 37 Stockholm
Tel. 020-55 55 00
Fax: 08-568 866 52

Send this form to Skandia in original as soon as possible.

| | | | |
|--|-------------------|--------------------------------------|-------------------------------------|
| 1. Personal data – Please print | | Claim number: | <input type="checkbox"/> New report |
| Surname and first name (printed) | | National registration number | |
| Postal address | Postcode and city | Telephone work (including area code) | |
| E-mail | Telephone mobile | Telephone home (including area code) | |

2. Reason for visit to physician/treatment

| | | |
|--|---|-----------------------------------|
| Name of illness/type of complaint/bodily injury/accidental injury (indicate body part, right/left, etc) | When were the first symptoms noticeable? (year, month, day) | |
| Have you previously suffered from a similar illness/complaint? | When? (year, month, day) | How long? (from – to) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Have you, for this claim or similar symptoms, been treated or examined by a doctor, physiotherapist, naprapath, chiropractor, psychologist, other care personnel or at Skandia's health centres over the past 2 years? | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| State name and address of physician or other care provider you consulted | When? (year, month, day) | |
| State name and address of physician or other care provider you consulted | When? (year, month, day) | |
| State name and address of physician or other care provider you consulted | When? (year, month, day) | |
| State name and address of physician or other care provider you consulted | When? (year, month, day) | |
| Are you free of symptoms? | When? (year, month, day) | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Referral issued? | <input type="checkbox"/> No <input type="checkbox"/> Yes, copy enclosed | |
| Do you participate in any sports (not purely for exercise)? | Which one/ones? | At what level? (elite, div 1 etc) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

3. Complete in the event of an accident

| |
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| How did the accident occur? Describe the course of events. |
| |
| |

4. Complete in the event of an accident while travelling

| | | | |
|----------------------------------|----------------------|--|---|
| Date of departure from residence | Ordinary return date | Was SOS International in Copenhagen consulted? | Do you have health, accident, travel, household comprehensive or medical expense insurance? |
| | | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name of insurance company | | Policy number | |



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SID 1 (3)

Signature

5. Claims settlement questions

The following questions form the basis for setting your claim. It is therefore important that you respond to all of them.

| | | | |
|---|---|--------------------------|---|
| a. Have you been on sick leave (wholly or partially) for more than 14 consecutive days during the past 2 years for the claim you now report or for similar symptoms? All periods of illness lasting over 14 days must be indicated. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| When? | How long? | Reason | Name and address of physician who issued the insured's sick leave |
| When? | How long? | Reason | Name and address of physician who issued the insured's sick leave |
| b. Are you receiving sickness benefit, temporary disability pension, disability benefit or similar benefits, or do you have specially adapted duties due to reasons of health (e.g. lighter, semi-protected or protected work)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Which one? | Reason | If yes, since what date? | |
| c. Are you taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Which? | Name and address of prescribing physician | | Reason |
| How long have you been taking this medication? | | | |
| Which? | Name and address of prescribing physician | | Reason |
| How long have you been taking this medication? | | | |
| Which? | Name and address of prescribing physician | | Reason |
| How long have you been taking this medication? | | | |
| Which? | Name and address of prescribing physician | | Reason |
| How long have you been taking this medication? | | | |

6. Other information

| |
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| |

7. Signature

| | | | |
|--|-----------|-----------------------|--|
| I certify that the information I have provided above is complete and truthful. I give my consent for physicians, hospitals, other healthcare facilities and insurance institutions (including the Swedish Social Insurance Agency) to provide any information regarding my state of health that the company deems necessary to assess my claim for compensation. If the subject of the claim is a minor, a guardian's signature is required. | | | |
| Date (YYYY-MM-DD) | Signature | Name in block letters | |
| 2 0 - - | | | |

Claim for compensation

In order to facilitate the handling of your case, please attach all of the original receipts specified here on an A4 sheet of paper. Avoid the use of paper clips and staples.

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| | |
|--------------|-------------------------------------|
| Claim number | <input type="checkbox"/> New report |
|--------------|-------------------------------------|

1. Personal data

| | | |
|----------------------------------|--|------------------------------|
| Surname and first name (printed) | Telephone number (including area code) | National registration number |
| Postal address | City and postcode | |

2. Method of payment

| | | | | |
|-----------------------------------|-----------------------------------|---------------------------------------|-----------------|----------------|
| <input type="checkbox"/> Plusgiro | <input type="checkbox"/> Bankgiro | <input type="checkbox"/> Bank account | Clearing number | Account number |
|-----------------------------------|-----------------------------------|---------------------------------------|-----------------|----------------|

3. Prescription medicines

Applies for Lifeline Plus and Lifeline Basic. Attach original prescription pharmacy receipts.

| Name of medicine | Ver. no. | Amount SEK | Comments |
|------------------|----------|------------|----------|
| | | | |
| | | | |
| | | | |
| Total SEK: | | | |

4. Healthcare, travel expenses and medical devices

Attach original receipts

| Compensation concerns | Ver. no. | Amount SEK | Comments |
|-----------------------|----------|------------|----------|
| | | | |
| | | | |
| | | | |
| Total SEK: | | | |

5. Travel with own vehicle

| Date | Route (from - to) | Ver. no. | Number of km. | Comments |
|--------|-------------------|----------|---------------|----------|
| | | | | |
| | | | | |
| | | | | |
| Total: | | | | |

6. Signature

If the subject of the claim is a minor, a guardian's signature is required.

| | | |
|-------------------|-----------|-----------------------|
| Date (YYYY-MM-DD) | Signature | Name in block letters |
| 2 0 | | |

Försäkringsbolaget Skandia (publ) Registered office: Stockholm Co. reg. no. 502017-3083

Signature