### **Insured person:** Förnamn, Efternamn

### **Date of birth:** ÅÅÅÅ-MM-DD

### **Period of cover:** ÅÅÅÅ-MM-DD – ÅÅÅÅ MM-DD

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| --- | --- |
| **Insurance coverage:**  * Disability and death benefits * Visits by family members * Disruption cover * Assault cover * Medical and dental care, in respect of each event, such costs shall be paid for a period not exceeding ninety days commencing the first contact with a care advisor - no limitation in amount\* * Home transport cover - no limitation in amount | * Property cover * Baggage delay * Cover for crisis and catastrophe * Cash assistance * Liability cover, pay the damages that the insured is liable to pay according to applicable law, however not exceeding * SEK 5,000,000 USD 500,000 * Legal expenses cover * Motor deductible cover |
| The cover applies 24-hours a day.  There is no deductible in the insurance. \*100 % coverage of COVID19  Kammarkollegiet cooperate with Falck Global Assistance in case of emergency for our policyholders. Falck Global Assistance cooperate in turn with United healthcare Global when assistance is needed in the US or Canada. Falck Global Assistance and United healthcare Global set a payment guarantee to the hospital if needed and the hospital can send the invoice to Falck Global Assistance.  **Contact information to Falck Global Assistance:**  **Phone: +46 8 587 717 49**  **E-mail: fga@se.falck.com**  **Fax: + 46 8 587 717 62**  For detailed information please visit our website, [www.kammarkollegiet.se](http://www.kammarkollegiet.se). The insurance is backed by the full faith and credit of the Swedish government.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and status of representative  ÅÅÅÅ-MM-DD  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of the representative Stamp or seal of the institution | |