

Reference number: (To be filled in by SRF)

CLAIM REPORT - Municipality

DETAILS OF THE CLAIMANT

Surname		Given name	
Social Security Number			
Residential Address <i>(For shared custody, fill in the second address under "Other information")</i>		Postcode and City	
Telephone/Mobile phone	Email	I agree to be contacted by e-mail	
Any compensation will be paid to:			
Name of the account holder			
Name of the bank		Account number incl. clearing	Bankgiro Plusgiro
Is there any insurance involved? Yes No	If yes, specify the company	What kind of insurance?	
Have you filed a claim with another insurance company? Yes No	If yes, specify the company	Claim Reference Number	

OTHER NOTIFIER – PERSONAL DATA OF THE NOTIFIER/CONTACT PERSON

Surname	Given name
Telephone / Mobile phone	Email

DETAILS ABOUT THE ACCIDENT

When did the accident occur? To/from the Organization In the Organization During spare time	Date	Time
In the event of a traffic accident, provide the vehicle's registration number and insurance company (if known)	Was a police report filed? (if yes, attach a copy of the report)	Yes No

WHERE DID THE ACCIDENT OCCUR? – Fill in every field even if the accident did not occur during operating hours

Municipality	
Name of the organization (e.g. name of the school, preschool etc)	Phone:
Address of the organization	
In case of other accident site, please describe the location	

What bodily injury have you sustained as a result of the accident? (In case of dental trauma, fill in the appendix below)			
How did the accident occur?			
Did you seek medical attention? Yes No		Date	
Name of the clinic			
Has the wound been treated by a medical professional?	Yes No	If yes, has the wound been taped, glued or sutured?	Has school transport been prescribed? (If yes, attach certificate) Yes No
Was hospitalization required?	Yes No	If yes, which hospital?	
Period of time for the hospitalization	From	To	Are you still being treated? Yes No
Were you under the influence of alcohol, medications or other intoxicants at the time of the accident?	Yes No		
Are there any concerns of future harm?	Yes No	If yes, specify	
Has the injured body part been previously injured or exposed to any illness in the past?	Yes No	If yes, when?	Did you seek medical attention? Yes No
Describe the previous injury/illness			

SCHOOL TRANSPORT

SCHOOL TRANSPORT

In cases where transportation to and from school is required as a result of the accident, a medical certificate must be provided. The certificate should clearly specify the period during which the transportation is necessary. Prior to arranging transportation services, it is mandatory to obtain approval from Stockholmsregionens Försäkring AB or the claims settlement company designated by them. Transportation arrangements may only proceed after confirmation has been granted

COMPENSATION CLAIMS (ATTACH ORIGINAL)

SUM

SUM	

MANAGEMENT OF PERSONAL DATA AND SIGNATURE - MANDATORY

Processing of Personal Data

To facilitate the assessment and settlement of your claim, we are required to collect and process your personal data. All personal data is managed in strict accordance with the General Data Protection Regulation (GDPR).

For detailed information about GDPR, your rights, and our data-handling practices, please visit our official website at www.srfab.net.

I hereby certify that the information provided in this form is accurate and complete to the best of my knowledge

Location and Date	Signature
Parent/Guardian	Printed name

OTHER INFORMATION

In case of shared custody - second address

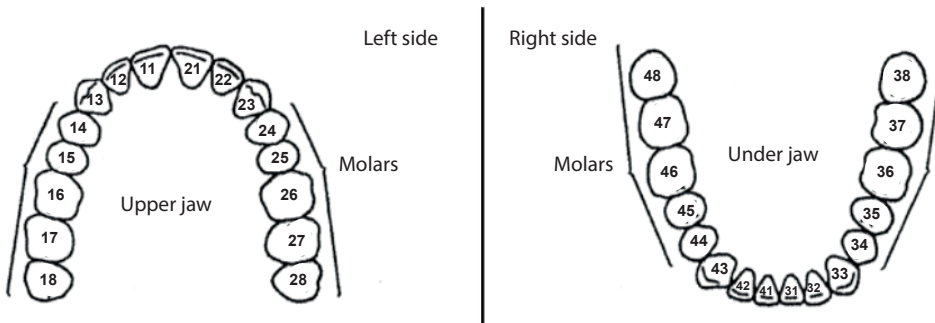
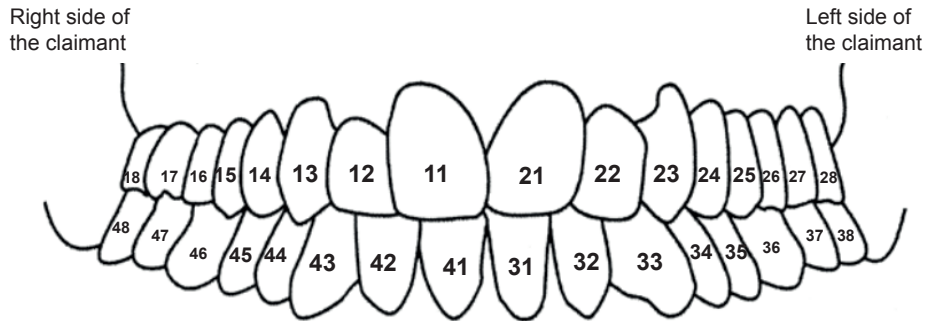
Address	Postcode and City
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INDICATE BELOW WHICH TEETH HAVE BEEN DAMAGED

A certificate from the dentist is NOT needed!
 Highlight the injured teeth below

Do NOT forget to tick for milk teeth/
 permanent teeth



Number of injured teeth:

Milk teeth

Permanent teeth

Location and Date	Signature
Signature of parent/guardian	Printed name