### **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:**  * Personal injury 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\*   Dental care maximum SEK 3,000/year   * Emergency mental health care, in/outpatient 100% coverage - no limitation in amount\* * Pre-existing conditions are covered in case of emergency and non-elective care - no limitation in amount * Home transport cover - no limitation in amount | * Repatriation of remains - no limitation in amount\* * Visit by relatives * Disruption cover * Connection cover * Property cover * Baggage delay * Cash assistance * Crisis and disaster cover * Liability cover, pay the damages that the insured is liable to pay according to applicable law, however not exceeding SEK 10,000,000 USD 1,000,000 * Legal expenses cover |
| The cover applies 24-hours a day. \*100% coverage of medical care due to COVID19 There is no deductible in the insurance except for Property cover and Legal expenses cover.  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  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of the representative Stamp or seal of the institution | |