POWER OF ATTORNEY

The power of attorney can be submitted via www.dkvhalsa.se or postage free to:
DKV Health, Frisvar 121 420 300, 110 00 Stockholm

Issuer of power of attorney (the person with an insurance via DKV Hälsa)

SURNAME

FIRST NAME

POLICY NUMBER*

E-MAIL

PHONE NUMBER PRIVATE

*You can find your personal policy number in your policy document

Authorized representative (e.g. partner, parent, assistant)

SURNAME

FIRST NAME

E-MAIL

PHONE NUMBER PRIVATE

Issuer of power of attorney´s signature

I (the issuer of the power of attorney) have an insurance with DKV Hälsa and I hereby give the person above (the authorized representative of the power of attorney) the right to represent me in contact with DKV Hälsa. This includes the right to get access to all the information re- garding my insurance, terms and conditions, clauses and other health-related information, as well as the mandate to book appointments for me.

I certify that the power of attorney is valid until I revoke it. The power of attorney ceases to apply if my insurance is terminated.

Place

Date

Issuer of power of attorney´s signature