Accident insurance claims form

Assekuranz Partner der Industrie
Versicherungsmakler GmbH
API

Policy holder:		
Surname:	First name:	Phone:
Street / post office box:		Fax:
Postal Code:	Place:	Email:

General details:		
Insured person:		
Insurance Company:		Insurance policy no.:
Date of claim:	Time of claim:	Place of claim:

Injured Person:		
Surname:	First name:	Date of birth:
Street / post office box:	Postal Code:	Place:
Phone (home):	Phone (daytime):	
married: ☐ yes ☐ no		
Occupation and short description of the activity:		

1. Description of the accident:		
Did the accident take place on the way to or from the place to work?	☐ yes	☐ no
During an official travel?	☐ yes	☐ no
Please provide precise description of accident:		

2. Health damage:
Type and extent of injuries:

3. Alcohol:				
Did the injured person drink any alcohol before the accident happened?	☐ yes	☐ no		
Blood test for alcohol?	☐ no	☐ yes, with the result:	‰	

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4. Traffic accident:						
How did the injured person take part on traffic? As / with...	☐ driver	☐ passenger	☐ pillion rider			
☐ car	☐ lorry	☐ scooter	☐ motorbike	☐ bicycle	☐ others	
Police notification?	☐ yes	☐ no				
Department:			Incident / Log no.:			

5. Attending doctor:	
First aid by doctor on:	Further treatment on:
Name / adress:	Name / adress:

6. Incapacitation for work:
When did inability to work start?
Expected discharge date?
Was / is the person treated in hospital? ☐ no ☐ yes, since: to: expected to:

7. Pre-existing conditions and accidents:	
Does the injured person suffer from any illness or have they had any accidents in the last 5 years? ☐ yes ☐ no	
On:	What kind:
On:	What kind:
On:	What kind:

8. Pension:		
Does the injured person get a war disability pension?	☐ no	☐ yes / war disability:
Does the i. p. get a pension from the prof. association ?	☐ no	☐ yes / type of injuries:
Does the injured person get a pension for invalidity?	☐ no	☐ yes / type of invalidity:
Was a pension for invalidity applied before this accident?	☐ no	☐ yes / reason:

9. Other insurance:		
Did the injured person have any other accident insurances? ☐ yes ☐ no		
1. Insurer:	Address:	Insurance no.:
2. Insurer:	Address:	Insurance no.:
By which professional association is the person insured?		
Name:	Address:	
Was the accident reported to the professional association? ☐ yes ☐ no		

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By which health insurance company is the person insured?		
Name:	Address:	Insurance no.:
With daily hospital benefit?	☐ yes	☐ no

Declaration:

I declare by signing below that I have answered the questions truthfully.
We wish to bring your attention to the fact that any information supplied that is knowingly false or incomplete may lead to loss the insurance cover, even when the insurer is not put to any disadvantage as a result of the information supplied.

Patient authorisation for release of health information

I am aware that the insurer will inspect any information provided by myself, documents submitted by myself (e.g. certificates and attestations), information supplied by myself as a direct request from a hospital or from members of health or medical profession which may form part of the justification for the claim, in order to make any decisions in respect of their obligation to provide idemnification.
Herewith, I release the members of a health or medical profession or the employess of a hospital or medical centre who are named in the information, or participated in the curative treatment from their duty of silence. Furthermore, I release the duty of silence in respect of any investigations relating to claims for benefits in the event of my death.
This release from the duty also applies to local officials, with the exception of social insurance agencies. This applies additionally to the members of other accident, medical and healthcare or life insurers who may be requested to provide information relating to my existing insurances.

This declaration is supplied for my legal representatives

who are not in a position to judge the import of the declaration.
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Bank details: (for transfer of insurance payments)		
Bank code:	Institute:	Account no.:
Account holder:		

Date: _____ Signature of the policy holder: _____

Date: _____ Signature of the injured person: _____

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