



Reference number of person insured:

Agency responsible:

Accident Report

Please complete this accident report form **in full**. Only a **fully completed declaration** will enable us to process the claim rapidly and avoid unnecessary queries on our part. Thank you for your cooperation!

Insured party

Name/ first name:

Private telephone number:

Street / town:

Work telephone number:

E-mail address:

Injured party

Name/ first name:

Date of birth:

Street / town as person(s) insured

other:

Relationship to person insured:

Accident details

Date/time of accident:

Place:

Complete and accurate description of the circumstances of the accident:

Is the cause of the accident attributable to a particular person?

yes no

Name/ first name:

Private telephone number:

Street / town:

Date of birth (age):

Name of third party liability insurance:

Policy number:

Additional questions for traffic accidents:

Type of vehicle (e.g. bicycle, scooter, car, motorbike etc.), make?

Number plate:

Person in possession of vehicle (owner): Name, address, telephone number:

Driver of the vehicle: Name, address, telephone number:

Name of third party insurance company, if known:

Vehicle used by you:

Other vehicle involved in collision:

Was a European accident declaration filled out?

yes no

If yes, please enclose a copy!

Accident details Additional questions for **accidents involving animals:**

Dog bites: (dog owner) - name, address, telephone number:

Riding accidents: (horse owner) - name, address, telephone number:

How many lessons did the insured person have?

Number of lessons:

Injuries

Type of injury:

Part of body injured:

right left

Is the injured party unable to work? yes no

If yes, since when?

Treatment

Name of the doctor or clinic who first treated the injured party:

Name / first name:

Business telephone number:

Street / town:

Was the injured party admitted to hospital? yes no

If so, when?

Name of the doctor or clinic that subsequently treated the injured party:

Name / first name:

Business telephone number:

Street / town:

Was the injured party admitted to hospital? yes no

If so, when?

Police / witnesses

Was the police called to the scene of the accident?

yes no

Was a report drawn up by the police?

yes no

If yes, please enclose a copy!

By whom was the police report recorded (police station responsible)?

Were there any witnesses of the accident? yes no

Name / first name:

Private telephone number:

Street / town:

Work telephone number:

Work-related information

Did you have a contract of employment **on the date of the accident?** yes no If yes, for how many hours per week?
Number of hours:

Name of accident insurance company on day of accident: Policy number:

Professional occupation: Name and address of employer on date of accident:

Are you in receipt of unemployment benefits: yes no If yes, since when?

Did the accident occur on the way to or from work, or at your place of work? yes no

Are the costs of treatment covered by any other source? yes no If yes, please specify?

Insurance company: Policy number:

Was the accident job-related? yes no Were you insured with the SUVA Accident Insurance Company on the day of the accident? yes no

Remarks

Authorisation

The injured party or his/her legal representative authorises ÖKK to consult any relevant medical, official and accident insurance documents, as well as documents of other social insurance providers such as AHV/AVS (old age pension scheme), IV (disability insurance), military insurance, etc. In addition the injured party or his/her legal representative confirms the accuracy of the information provided. The undersigned recognizes that incorrect or incomplete information could result in the loss or reduction of payments, as well as in a claim for return or in the subsequent rejection of the claim. Furthermore, the injured party recognises ÖKK's right to pass on to any third parties involved any information required to process the claim for compensation.

Place / date:

Signature of the injured party:

Place / date:

Signature of the insured party: