Accident report

Insurance no:

Please complete this accident report in full. This will allow us to process it more quickly and avoid any unnecessary questions.

Person suffering the accident

First name: Last name:

Address: Post code/place:

Private/mobile phone number: Business phone number:

E-mail address:

Date of birth:

Occurrence of accident

Date of accident: Time of accident:

Location:

Full description of how the accident occurred:

Was anyone at fault for the accident? ☐ yes ☐ no

First name: Last name:

Address: Post code/place:

Private/mobile phone number: Business phone number:

E-mail address:

Date of birth:

Liability insurer:

Policy no.:

ÖKK260e/11.23

ÖKK Kranken- und Unfallversicherungen AG
Out-patient Benefits
Bahnhofstrasse 13, P.O. Box, 7302 Landquart
info@oekk.ch, 0800 838 000

Injuries

Type of injury:

Body part injured: ☐ left ☐ right

Is the person unable to work? ☐ yes ☐ no

If so, since when and for how long?

Treatment

Doctor/Hospital providing initial treatment

First name: Last name:

Address: Post code/place:

Telephone:

Inpatient admission to hospital? ☐ yes ☐ no

If yes, since when? If so, where?

Are you a Rega donor? ☐ yes ☐ no

Additional information for traffic accidents	Vehicle used by you	Other vehicle involved in collision
Bicycle, moped, car, make:		
Number plate:		
Address:		
Telephone:		

Name of liability insurer:

Was a European accident statement completed? ☐ yes ☐ no If so, please enclose a copy.

Additional questions for accidents involving animals

For animal bites: Name, address, telephone number of owner

Did the police attend the scene of the accident? ☐ yes ☐ no

Was a police report filed? ☐ yes ☐ no

Who filed the police report (responsible department/agency)?

Are there witnesses to the accident? ☐ yes ☐ no

First name: Last name:

Address: Post code/place:

Private/mobile phone number: Business phone number:

E-mail:

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Professional information

On the day of the accident, was the person in employment? ☐ yes ☐ no

If so, how many hours a week did he/she work? hours

Employer (on day of accident) and address:

Occupation:

Accident insurer (on day of accident): Policy no.:

Was it a work-related accident? ☐ yes ☐ no

Suva/Accident insurance in place (on day of accident)? ☐ yes ☐ no

If not, specify accident insurer:

Is the person receiving unemployment benefit? ☐ yes ☐ no

If yes, since when?

Responsible unemployment insurance fund:

Did the accident occur on the way to/from work? ☐ yes ☐ no

Is there any other insurance covering treatment costs in place? ☐ yes ☐ no

Company: Policy no.:

Notes:

The person suffering the accident or his/her legal representative authorises ÖKK to inspect his/her medical, official and UVG files as well as those from other social insurers (AHV, DI, military insurance etc.). In addition, the person suffering the accident or his/her legal representative hereby confirms the accuracy of the information provided. The undersigned acknowledges that any incorrect or missing information could result in benefits being refused or reduced, a demand for repayment of benefits or the subsequent refusal of benefits. The person suffering the accident agrees that ÖKK may forward the information required to process the claim to third parties involved with the claim.

Place/Date: Signature of the person suffering the accident / of legal representative:

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