

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.: _____

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:

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: _____
