Accident claim form (LAMal/KVG – LCA/VVG) – Accident No.

So that we may determine rapidly whether you are entitled to benefits following the accident described below, please complete this form and return it to us duly signed.

General information

Name of injured person: Client No.:

Date of birth: Home phone: Work phone:

Date of the accident: Time: Place:

Witnesses? ☐ no ☐ yes If yes, name and address:

Please give a detailed description of the accident: (if you need to draw a diagram or if more details are necessary, please use the second page of this document)

What was the exact cause of the accident?

Was another person involved in the accident? ☐ no ☐ yes

If yes, › Name and address of the person:

› Name and address of the third party insurer (RC):

› Number plate of the car or cycle (if the accident is traffic-related):

Was a police report filed? ☐ no ☐ yes - If yes, by which police station?

Was a joint insurance statement made? ☐ no ☐ yes - If yes, please attach it to this claim.

Was a criminal complaint lodged? ☐ no ☐ yes - If yes, with whom?

Detected injuries

Injuries: (part of body injured – left/right – and nature of injuries):

First aid treatment by doctor, hospital, clinic, dentist: Subsequent treatment by:

Treatment finished? ☐ no ☐ yes If no, date of next visit:

Were there any dental lesions? ☐ no ☐ yes

Name and address of dentist:

Do you hold other insurance coverage (LAA/UVG or optional LAA/UVG insurance, SUVA, disability insurance (AI/IV), military insurance, private insurance such as school insurance, sports club, passenger insurance or with another health insurer)? ☐ no ☐ yes
If yes, which ones? (policy number, claim number, address of the insurer)

Occupation at the time of the accident

Status at the time of the accident: ☐ schoolchild ☐ student ☐ without a gainful activity ☐ unemployed ☐ military service ☐ pensioner ☐ apprentice ☐ self-employed worker ☐ employee ☐ housewife/-husband

› If you were an employee, name and address of your employer at the time of the accident:

Average number of working hours per week: ☐ less than 8 hours ☐ more than 8 hours

› If you were without a gainful activity or unemployed:

Where did you work for the last time and until when?

Have you received any benefits from the unemployment insurance? ☐ no ☐ yes from: to:

Incapacity for work from: to:

Date and place: Signature of the insured person or legal representative:

Groupe Mutuel
Rue des Cèdres 5
P.O. Box - CH-1919 Martigny
Tel. 0848 803 111 - www.groupemutuel.ch

Accident claim form (LAMal/KVG – LCA/VVG) – Accident No.

General information

Name of injured person: Client No.:

Date of the accident:

Additional description and/or diagram of the accident

Date and place: Signature of the insured person or legal representative: