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Avenir Assurance Maladie SA – Easy Sana Assurance Maladie SA
Philos Assurance Maladie SA – SUPRA-1846 SA
Groupe Mutuel Assurances GMA SA - Mutuel Assurances SA

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

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 employed, name and claim number of your employer's LAA/UVG accident insurance :
(If you did not report the accident to your employer, please do so and send us the information.)

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: _____

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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: _____