

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

> 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: _____

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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: