Accident Notification Form



Mandatory healthcare insurance (KVG) and supplementary insurance plans (VVG)

This form must be completed by the insured person or their legal representative. You can also complete this document online on our website css.ch (search for «claim notification form»). Please send us the form as quickly as possible to the address shown on the last page. Unfortunately, we are unable to review your entitlement to benefits without this information. Please return the form even if no accident has happened, and include a note to this effect in the «Remarks» field at the end of the form. Questions 1.2, 1.3, 1.5 and 3.6 do not need to be answered for children younger than 15. If you have any questions, our Customer Service Center will be happy to help on 0844 277 277. Thank you.

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	General information							
	First name	Surname		Date of birth	Street address			
	Postcode/town	Email		Phone	Available at (time)			
••••	Who was your employ							
	Name of employer	Street, house numbe	er —	Postcode / town	Number of hours per week			
	Do you know the name	e of your employ		surance company?	Claim number			
	Yes No							
	If you were not in a rel	lationship of emp	oloyment: why?	·	·			
	Self-employed*	Homemaker*	Pensioner*	Not working*	Child			
	*When were you last employed Name of employer	1?	From	Street, house number	Never been an employee Postcode / town			
	Do you receive or have	e you received u	nemployment b	enefit?				
	Circumstances of acci	ident						
	When, where and how	did the accident	happen?	4				
	Accident location			Country				
	The accident occurred	at work	ere doing weather con	on the way to work outside work nditions, involved persons, vehicles, animals, machines etc.)				
	Was a police report file	ed?	<u></u>					
	Yes No	By which police stati						

2.3	was a tr	nird party inv	olved in the accident?		81					
	[[<u>-</u>	First name / surname		Phone					
	Yes	No	Charact have a superhan		D					
			Street, house number		Postcode / town					
			Name of third party's liability incursors		Policy number / claim number					
			Name of third party's liability insurance		Policy number / claim number The third party does not have liability insurance					
			Third party's liability insurance not kno	wn						
2.4	Was the	accident the	e fault of this third party?							
	Yes	No								
2.5	Are ther	e any witnes	sses to the accident?							
			First name/surname		Phone					
	Yes	No								
			Street, house number		Postcode / town					
3	Injuries									
3.1	What inj	ury did you	suffer?							
	Nature of in			Part of body		···•				
						Right Left				
	Did 4ba									
3.2	Did tile	symptoms o	ccur immediately after the event?							
	Yes	No								
3.3	Was the	pain or the	injury triggered by an uncontrolled	d or sudden mo	vement?					
			Remarks							
	Yes	No								
3.4	Who tre	ated you firs	st (doctor/hospital/dentist)?							
	Name			Postcode / town						
3.5	Did any	one else pro	vide further treatment? Name		Postcode / town					
	<u>.</u>	[rvaire		1 Ostcode/town					
	Yes	No								
3.6	Are or w	ere you una	ble to work as a result of the injur	y?						
	Yes	No	Degree of incapacity to work	%	From to					
4	Other in	surances								
4.1	Do you	have any oth	ner accident insurances cover?							
	Yes	No	As a supplement to mandatory accider	nt insurance	TCS ETI insurance card					
			Name of agency		Policy number					
			\	Name of insurance c	ompany					
	lf von ri-	seo includo a co	mu of vous policy							

1											
5.1	Which vehicles were involved in the accident?										
	Your vehicle	Bicycle	Moped	Car	0	her					
	Tour venicle	i Dicycle	i Moped	Cai							
	Third party's vehicle	Bicycle	Moped	Car	O	her					
	To whom does the vehic	cle belong (k	eeper/owner)?	•							
		First name/surna	ame	Postcode / town			Number plate / make				
	Your vehicle										
		First name/surna	ame	Postcode / town			Number plate / make				
	Third party's vehicle										
	Who was driving the ve	hicle at the ti		dent?	Postco	de/town					
		Thornamo ounic			1 00100	20710411					
	The keeper / owner was driving	g									
	With which insurance co	ompany do v	ou/does the th	ird party hold lia	ability in	surance	?				
		. , ,		Name of insuran	-		Policy number				
	Your vehicle	Not	known								
	Tour venicle	INOL	Not known		ce company		Policy number				
	Third party's vehicle	Not	Not known								
	With which insurance c	ompany do y	ou/does the th	ird party hold p	assenge	insura	nce?				
				Name of insuran	Name of insurance company		Policy number				
	Your vehicle	Not	Not known								
			MIOWII	L			Policy number				
	Tour verticle			Name of insuran	ce company						
		Not	known	Name of insuran	ce company						
	Third party's vehicle	Not	known	Name of insuran	ce company						
	Third party's vehicle	Not	known	Name of insuran	ce company						
		Not	known	Name of insuran	ce company						
	Third party's vehicle	Not	known	Name of insuran	ce company						
	Third party's vehicle	Not	known	Name of insuran	ce company						
	Third party's vehicle	Not	known	Name of insuran	ce company						
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Address of the insurer: