

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.

Client number

1 General information

1.1 First name Surname Date of birth Street address

Postcode/town Email Phone Available at (time)

1.2 Who was your employer at the time of the accident?

Name of employer Street, house number Postcode / town Number of hours per week

1.3 Do you know the name of your employer's accident insurance company?

Yes No

Name of insurance company Claim number

1.4 If you were not in a relationship of employment: why?

Self-employed* Homemaker* Pensioner* Not working* Child

*When were you last employed? From to Never been an employee

Name of employer Street, house number Postcode / town

1.5 Do you receive or have you received unemployment benefit?

Yes No From to

2 Circumstances of accident

2.1 When, where and how did the accident happen?

Date Time

Accident location Country

The accident occurred at work on the way to work outside work

Please describe how the accident happened (what you were doing, weather conditions, involved persons, vehicles, animals, machines etc.)

2.2 Was a police report filed?

Yes No By which police station?

2.3 Was a third party involved in the accident?

Yes No

First name/surname	Phone
<input type="text"/>	<input type="text"/>
Street, house number	Postcode / town
<input type="text"/>	<input type="text"/>
Name of third party's liability insurance	Policy number / claim number
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Third party's liability insurance not known	<input type="checkbox"/> The third party does not have liability insurance

2.4 Was the accident the fault of this third party?

Yes No

2.5 Are there any witnesses to the accident?

Yes No

First name/surname	Phone
<input type="text"/>	<input type="text"/>
Street, house number	Postcode / town
<input type="text"/>	<input type="text"/>

3 Injuries

3.1 What injury did you suffer?

Nature of injury	Part of body	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="text"/>	<input type="text"/>		

3.2 Did the symptoms occur immediately after the event?

Yes No

3.3 Was the pain or the injury triggered by an uncontrolled or sudden movement?

Yes	No	Remarks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

3.4 Who treated you first (doctor / hospital / dentist)?

Name	Postcode / town
<input type="text"/>	<input type="text"/>

3.5 Did anyone else provide further treatment?

Yes	No	Name	Postcode / town
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

3.6 Are or were you unable to work as a result of the injury?

Yes	No	Degree of incapacity to work	%	From		to	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>	

4 Other insurances

4.1 Do you have any other accident insurances cover?

Yes No As a supplement to mandatory accident insurance TCS ETI insurance card

Name of agency	Policy number
<input type="text"/>	<input type="text"/>
Name of insurance company	
<input type="text"/>	

If yes, please include a copy of your policy.

Please note: the following questions are to be answered *only in the case of road traffic accidents*.

5 Vehicles involved

5.1 Which vehicles were involved in the accident?

Your vehicle	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Moped	<input type="checkbox"/> Car	<input type="checkbox"/> Other	<input type="text"/>
Third party's vehicle	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Moped	<input type="checkbox"/> Car	<input type="checkbox"/> Other	<input type="text"/>

5.2 To whom does the vehicle belong (keeper / owner)?

Your vehicle	First name / surname <input type="text"/>	Postcode / town <input type="text"/>	Number plate / make <input type="text"/>
Third party's vehicle	First name / surname <input type="text"/>	Postcode / town <input type="text"/>	Number plate / make <input type="text"/>

5.3 Who was driving the vehicle at the time of the accident?

The keeper / owner was driving

First name / surname <input type="text"/>	Postcode / town <input type="text"/>
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5.4 With which insurance company do you/does the third party hold liability insurance?

Your vehicle	<input type="checkbox"/> Not known	Name of insurance company <input type="text"/>	Policy number <input type="text"/>
Third party's vehicle	<input type="checkbox"/> Not known	Name of insurance company <input type="text"/>	Policy number <input type="text"/>

5.5 With which insurance company do you/does the third party hold passenger insurance?

Your vehicle	<input type="checkbox"/> Not known	Name of insurance company <input type="text"/>	Policy number <input type="text"/>
Third party's vehicle	<input type="checkbox"/> Not known	Name of insurance company <input type="text"/>	Policy number <input type="text"/>

6 Remarks

Please confirm these details with your signature. Many thanks for your support.

The undersigned person hereby confirms that they have answered all questions in this form truthfully and in full.

The undersigned person hereby assigns to CSS any liability claims arising from the accident referred to above up to the amount in benefits it has paid and acknowledges that CSS may assert its claims against third parties. By signing the accident notification form, the applicant authorises CSS to share information and obtain such at any time from doctors, other service providers, social and private insurers, employers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover, process the claim and assert any recourse claims, while respecting statutory provisions on data protection. The undersigned hereby releases the aforementioned from their statutory duty of confidentiality and consents to the disclosure of the data by CSS to these bodies. These consents and exemptions apply without time limit. They can be revoked at any time [by declaration in text form (e.g. e-mail) to CSS]. A revocation is only effective for the future and may result in services not being provided. CSS may continue to process personal data even in the event of revocation, insofar as this processing is permitted by law or serves overriding interests.

Further information about the processing of your personal data by CSS can be found on our homepage css.ch/dataprotection

*Legal entity for basic insurance (KVG): CSS Kranken-Versicherung AG

*Legal entity for supplementary insurance (VVG): CSS Versicherung AG

Place <input type="text"/>	Date <input type="text"/>	Signature of the insured person or their representative <input type="text"/>
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Address of the insurer:
CSS, Tribtschenstrasse 21, P.O. Box 2550, 6002 Lucerne