



Accident report

1/1

Insured

Please complete
all fields

Surname	<input type="text"/>	Name	<input type="text"/>
Date of birth	<input type="text"/>		
Street/number	<input type="text"/>	Post code/place	<input type="text"/>
Customer number	<input type="text"/>	Social insurance number	<input type="text"/>

Further information regarding the injured person

- How can we reach you (or your legal representative) during the day if we have any further questions?
Telephone number E-mail
- Were you in employment at the time of the accident? no yes
If yes, how many hours per week?
Name of the accident insurance Policy number
 self-employed employed apprentice intern child/student pensioner
- Were you in receipt of unemployment benefits at the time of the accident? no yes

Circumstances of the accident

- Date of accident
- Cause of accident in detail. Accident location/injuries?
- Has the accident been caused by a third party? no yes
If yes, please provide the perpetrator's name, address and liability insurance details; eye witnesses and their addresses

In the event of third-party liability, we will seek recourse against the liable party. You can make a direct claim against the liable party or their liability insurer for your own cost which are not covered (including the co-payment and deductible).
- Has a police report been drawn up? no yes
- Do you have an additional personal accident insurance? no yes
If yes, please note the name of the company Policy number
- Do you support the Rega Service? no yes

Confirmation

By signing this form,
you confirm that
these details have been
declared truthfully.

Place and date

Signature (policyholder, legal representative)