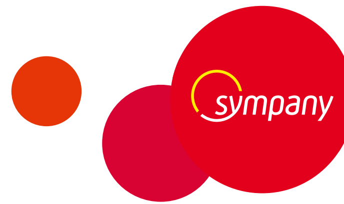
Sympany
Peter Merian-Weg 4, 4002 Basle
+41 58 262 42 22



Notice of dental accident

Insured

Please complete all fields

Surname		Name	
Date of birth			
Street/number		Post code/place	
Customer number		Social insurance number	

Further information regarding the injured person

1. How can we reach you (or your legal representative) during the day if we have any further questions?

   Telephone number ______ E-mail ______

2. 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

3. Were you in receipt of unemployment benefits at the time of the accident? ☐ no ☐ yes

Circumstances of the accident

1. Date of accident ______
2. Cause of accident in detail. Accident location/injuries?

   ______

3. Has the accident been caused by a third party? ☐ no ☐ yes

   If yes, please provide their 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).

4. When did you first consult the dentist in connection with the accident?

   Date ______

5. What is the dentist's exact address?

   First name and surname ______

   Address ______

6. Did you suffer additional injuries? ☐ no ☐ yes

   If yes, please specify. ______

1212/e/09.16

Sympany
Peter Merian-Weg 4, 4002 Basle
+41 58 262 42 22

Continued from page 1

Insured

Customer number

7. Have you seen a physician for care? no yes

First name, surname

Address

Accident while eating

1. Did a foodstuff cause the accident? no yes

If yes, please specify (precise description of the foodstuff or object that you bit into).

2. Do you have any proof? no

If yes, where is this proof?

Please enclose any proof in reference to a dental accident to this notice of dental accident.

3. Did you or a third party notify the point of sale or restaurant of the incident? no yes

If yes, when and where?

4. Do you have an additional accident insurance with any other insurance company? no yes

If yes, name of the company

Policy number

Confirmation

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

Place and date

Signature (policyholder, legal representative)

1212/e/09.16