Sympany
Peter Merian-Weg 4, 4002 Basle
Tel. 0800 955 955

Notice of dental accident

Insured

Please complete all fields

Surname | Name

Date of birth (DD.MM.YYYY)

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 (DD.MM.YYYY)
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 (DD.MM.YYYY)
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.

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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

DD.MM.YYYY

Signature (policyholder, legal representative)