Accident report

Insured person:

Last name, first name | Customer no.

Date of birth | Telephone H | W

Occupation

Are you self-employed? ◯ yes ◯ no

Weekly working hours: ◯ 8 hours or more ◯ less than 8 hours

Are you unemployed? ◯ yes ◯ no

Address of employer: (if unemployed, address of last employer)

Last date of employment:

Do you draw unemployment benefit? ◯ yes ◯ no

If not, why not?

Date of accident: | Time of accident:

Exact place of accident:

The accident took place: ◯ on the way to or from work/school ◯ at work/school ◯ outside work/school

Description of accident: (detailed description including what you were doing

at the time of the accident, the people, vehicles, machinery involved, etc.)

Type of injury/injuries:

Part(s) of body affected (left/right):

Are you unfit for work? ◯ yes ◯ no

If so, from when? | Degree of incapacity %:

Doctor/hospital/clinic providing first treatment:

Last name, first name:

Address, Postcode/city:

Doctor/hospital/clinic providing subsequent treatment:

Last name, first name:

Address, Postcode/city:

If the accident was caused by a third party or due to an outside influence:

Name, address of the third party:

Liability insurance of the third party:

Type of outside influence:

Was a police report taken? ◯ yes ◯ no

Last and first name of police officer:

Were there witnesses? ◯ yes ◯ no

1. Last name, first name:

   Address, Postcode/city:

2. Last name, first name:

   Address, Postcode/city:

Does the person who had the accident have other insurance? ◯ yes ◯ no

◯ under the employer's mandatory accident insurance > fill out Table A

◯ with a private insurance company > fill out Table B

◯ with another health insurance company > fill out Table C

A

Medical expenses:

◯ general hospital ward

◯ semiprivate hospital ward

◯ private hospital ward

◯ as a supplement to basic health insurance

Loss of earnings:

◯ UVG/LAA

◯ other

_____ CHF/day

_____ % of salary

Last name, first name:

Address, Postcode/city:

B

Medical expenses:

◯ general hospital ward

◯ semiprivate hospital ward

◯ private hospital ward

◯ as a supplement to basic health insurance

Loss of earnings:

◯ UVG/LAA

◯ other

_____ CHF/day

_____ % of salary

Last name, first name:

Address, Postcode/city:

C

Medical expenses:

◯ general hospital ward

◯ semiprivate hospital ward

◯ private hospital ward

◯ as a supplement to basic health insurance

Loss of earnings:

◯ UVG/LAA

◯ other

_____ CHF/day

_____ % of salary

Last name, first name:

Address, Postcode/city:

Did the accident involve a motor vehicle? ◯ yes ◯ no

◯ Driver of your own vehicle Registration no:

◯ Driver of another vehicle Registration no:

◯ Accompanying passenger Registration no:

Are passengers insured? ◯ yes ◯ no

Has a claim been made? ◯ yes ◯ no

Last name, first name:

Address, Postcode/city:

The insured person authorises the insurance carrier to inspect official and medical records and the records of social security institutions and private insurers. The insured person further authorises the insurance carrier to pass information necessary for the settlement of the claim on to third parties, namely the insurance companies involved, and to obtain the necessary information from these parties.

Place and date

Signature of insured person or their legal representative,
guardian or guardianship authority