Assuria VERZEKERINGEN

CLAIM FORM PERSONAL ACCIDENT (PO)

To be completed by Assuria:

Policy no.: Claim no.:

To be completed by the policyholder / representative company:

QUESTION	ANSWER
1. a. Name and first name insured b. Date of birth c. Occupation d. Address	a. b. c. d.
2. a. When (date and time) did the accident take place? b. Where (address) did the accident take place?	a. Date: Time: b.
3. a. What did the victim do when the accident happened to him? b. How did the accident happen? c. Were there any witnesses? If so, please mention their names and contact details	a. b. c.
4. Which injury did the insured sustain as a result of the accident? Please specify as accurately as possible	
5. a. When (date and time) did the insured first receive medical assistance? b. Which doctor provided that first aid? c. What is the address of that doctor?	a. Date: Time: b. c.
6. In case of hospitalization: a. in which hospital is the insured being nursed? b. which doctor is currently treating the insured?	a. b.

QUESTION	ANSWER
7. a. Did the attending doctor prescribe the insured bed rest as a result of the accident? If so, for how long? b. Has the insured not been able to exercise his profession ever since the accident? If so, please mention the dates.	a. b. ❑ No ❑ Yes, dates:
8. a. Is the insured also covered elsewhere against accidents? b. If so, with which company? c. For which amounts? d. Is the insured also entitled to payment by virtue of the Accident Act?	a. b. c. d.

Completed truthfully and to the best of my knowledge

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on

Signature of the person completing the form