

Claim reports

Claim-No.

Medical and hospital costs ACCIDENT

HHD

Dear Customer,

In order to be able to provide you with insurance benefits quickly and straightforwardly, we require some important information from you. Please complete this notice of loss carefully and enclose the following documents, if applicable:

- Police report (if available)
- Original receipts with prescriptions
- Original invoices (physician, hospital)
- Copy of the insurance policy

Should you be unable to answer a question in whole or in part, please state the reasons therefor.

Questions regarding the policyholder (person who took out the insurance)

Name:

First given name:

Date of birth:

Road/House number:

Post code/Place:

Phone (reachable during the day):

E-mail adress:

Account number (IBAN):

Bank code (BIC/SWIFT):

Name, post code and place of the bank:

Questions regarding the insured person

Name:

First given name:

Date of birth:

Nationality:

Questions regarding accident insurance

1. Date the insurance contract was concluded:

2. Policy no.:

3. Are other insurance policies in place for this event?

Yes No

4. If so, which?

5. Was an indemnity paid or applied for elsewhere?

Yes No

6. If so, state name

Questions about the accident

7. Date of the accident:

Time of accident:

8. Site of the accident:

9. Accurate description of the injury:

10. Was the injured person under the influence of alcohol, medication or drugs? Yes No
11. Was a physician consulted? Yes No
12. If so, when was the first time? _____ Date: _____
13. Name and address of the attending physician:

14. Was the treatment completed? Yes No
15. If not, expected duration of treatment (end date): _____
16. Are additional invoices to be expected? Yes No
17. If so, from whom? Name and adress: _____

18. Who caused the accident? Name and address: _____

ERV shall be exempt from its obligation to pay if after occurrence of the insured loss, the insured person attempts to fraudulently misrepresent to ERV the circumstances that are significant for the cause and the amount of the benefits.

I authorise doctors, hospitals and insurances of all kinds of providing ERV with all required information and hereby release the above from their statutory confidentiality obligations.

Place and date

Signature of the damage originator or the statutory representative