Accident questionnaire				
Policy holder			Policy number	
Insured person				
Who suffered the accident?				
Name			Date of birth	
When and where did the accident take place?				
Date of accident	Time		Place of accident	
How did the accident take place? (please state details of the event)				
Was the accident registered by the police?				
Yes No	Police station		Reference number	
Type of accident				
Was it a traffic accident?	Yes	No		
Was it a work accident or an accident while traveling?	Yes	No		
Is there a social accident insurance in place?	Yes	No		
Are you a member of an employers' liability insurance association?				
Yes No	If yes, which one?			
When did you inform your employers' liability insurance association about the accident?			Reference number	
What are the names of the witnesses of the accident and where do they live?				

Who caused the accident?				
Name				
Address				
Does the party responsible for the accident have liability insurance?				
Yes No If yes, with which insurance	company?			
Address				
Insurance certificate number	Reference number			
Are you related or related by marriage to the party responsible for the accident?				
Yes No				
Have you already made claims for compensation against the party responsible for the accident?				
Yes No				
Has the party responsible for the accident accepted the claims?	☐ Yes ☐ No			
Have the consequences of the accident been fully treated?				
Yes No				
Are there any outstanding invoices?				
Important information/Signature				
The policyholder and the insured person are obliged to make a true and comprehensive statement. The company is exempt from the requirement to pay, if the policyholder				
or the insured person acted intentionally or grossly negligent in making incomplete or false statements or fraudulent misrepresentation. In case of false statements that were given intentionally, this legal consequence is also followed if it neither affects the stipulation or the amount of the benefits that are incumbent on the insurer. In case of a viola-				
tion caused by gross negligence, the insurer is entitled to reduce the benefits in relation to the seriousness of the fault.				
Place, date				
Signature of the policyholder	Signature of the injured party			
Professional secrecy obligation				
for (insured person)	Policy number			
I hereby authorize the insurer to collect information at any time about any former illness	, disease, consequence of an accident and infirmity and such that occurred until the			
end of the contract. The same applies for information about any applied for, current or ended personal insurance. For this purpose, the insurer is allowed to ask physicians, dentists, alternative practitioners, any type of hospital, insurance institution and pension office. I hereby exempt them from their professional secrecy and authorize them to provide the insurer with all necessary information.				
Place, date	Signature of the insured person			