

## Accident form

Mr. / Mrs.

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Insurance No.

### 1. General questions

1. Name of the victim		Date of birth (day, month, year)
		Telephone, private
		Telephone, business
2. Date of accident	Time	Location of accident (with postcode)
3. Precise location of accident (street, carriageway, pavement, part of building)		
4. Which police station recorded the accident?		
5. Which public prosecutor's office is investigating the accident?		
6. Which lawyers have been retained?		
7. Was a blood sample taken from the victim?		
<input type="checkbox"/> Yes: blood alcohol level: _____ ‰ <input type="checkbox"/> No		
8. Type of injuries		
9. Emergency treatment was provided by		Period of time (from – to)
a) a doctor (name and address)		
b) a hospital (outpatient)		Period of time (from – to)
c) a hospital (inpatient)		Period of time (from – to)
10. People at work The accident occurred		Children / students The accident occurred
a) in the company or while working for the company		a) while attending kindergarten / the educational facility
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
b) on the way to or from work		b) on the way to or from the kindergarten / educational facility
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Statutory accident insurance institution – employers' liability insurance association, if applicable (full name and address)		
Was the accident reported to the statutory accident insurance institution? <input type="checkbox"/> Yes <input type="checkbox"/> No      Reference _____		
12. Does the victim have health and/or personal accident insurance elsewhere?		
Insurer(s)		
		<input type="checkbox"/> with cash benefits from income protection      Amount: _____ €
Insured since _____		<input type="checkbox"/> with hospital cash plan      Amount: _____ €

**2. Please also answer the following questions if the accident was a traffic accident**

1. The victim was	
<input type="checkbox"/> on foot <input type="checkbox"/> cycling <input type="checkbox"/> driver of the vehicle with licence number _____ <input type="checkbox"/> passenger in the vehicle with licence number _____	
Name and address of the driver	
Name and address of the owner	
Motor liability insurance	Insurance No.
2. If the victim was in the vehicle, was he/she wearing a seat belt at the time of the accident?	If the victim was riding a motor cycle/moped, was he/she wearing a crash helmet at the time of the accident?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Other vehicle involved in the accident; licence number _____	
Name and address of the driver	
Name and address of the owner	
Motor liability insurance	Insurance No.
4. Have damages already been claimed from the other party's liability insurer?	The case is being processed by the insurer under the claim No. _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	

**3. Please also answer the following questions in the case of other accidents**

1. Name and address of the person causing the accident (e.g. person responsible for gritting the road, owner of the animal, houseowner)	
2. Third-party liability insurance of the person causing the accident	
Insurance No.	
3. Have damages already been claimed from the other party's liability insurer?	The case is being processed by the insurer under the claim No. _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Name and address of people who witnessed the accident	
_____	

**4. Detailed description of the accident, including a drawing where applicable**

Do not simply refer to the police record! Continue on additional sheets if necessary.

Place and date \_\_\_\_\_

Signature \_\_\_\_\_