GLOBALITY HEALTH
premium health insurance worldwide

Accident Form

Policyholder (full name)

Insurance No.

Please note that fields marked with an * are mandatory. The form may be returned to you if the mandatory fields have not been filled out.

1. General questions*

1. Name of individual injured			Date of birth (day, month, year)
Phone number (+ country code/area code)			
2. Date of accident		Time of accident	
3. Precise location of accident (full address)			
4. Were police called? If yes, please provide us with the police report.	☐ Yes	☐ No	
5. Are you being represented by a lawyer or any other party in relation to this claim?	☐ Yes	☐ No	
If so, please provide all contact details including the case number:			
6. Were alcohol/drugs in any way a contributing factor to the accident?	☐ Yes	☐ No	
If yes, please provide details:			
7. Was a blood sample taken in order to analyse alcohol and/or drug levels?	☐ Yes	☐ No	
If yes, please provide us with a copy of the results.			
8. Description of injury sustained (e.g. nature of the injury, body part injured)			
9. Emergency treatment was provided:			
a) On an outpatient basis in a doctor's practice (name and address)			Date(s) (from – to)
b) On an outpatient basis in a hospital (name and address)			Date(s) (from – to)
c) On an inpatient basis in a hospital (name and address)			Date(s) (from – to)

2. Work accidents

1. Profession

2. Did the accident occur

- ☐ while working at your usual workplace?
- ☐ while working away from your usual workplace (business trip, short term delegation etc.)?
- ☐ while travelling to or from work?
- ☐ while playing a sport professionally?

3. Are you

- ☐ an employee?
- ☐ self-employed?

Should both of the above apply, please specify:

4. If you are an employee:

Does your employer have worker's liability insurance? ☐ Yes ☐ No

Was the work accident reported to your employer? ☐ Yes ☐ No

5. If you are self-employed:

Do you have statutory accident insurance? ☐ Yes ☐ No

If so, please provide full contact details:

3. Preschool and school accidents

1. Did the accident occur

- ☐ while attending the preschool/educational facility?
- ☐ while travelling to or from the preschool/educational facility?
- ☐ on the preschool/educational facility premises outside of pre-school/school hours?

Should none of the above apply, please specify:

4. Leisure accidents

1. Did the accident occur

- ☐ during a company sponsored/organized sporting event (marathon, volleyball etc.)?
- ☐ while participating in a sports club activity?

If you are a member of a sports club, does the club have liability insurance? ☐ Yes ☐ No

Please provide full contact details for the sports club:

- ☐ during a leisure activity not related to the above (jogging, skating, skiing etc.)?

Please specify:

5. Traffic accidents

1. Were you

- ☐ on foot?
- ☐ cycling?
- ☐ the driver of the vehicle with registration number
- ☐ a passenger in the vehicle with registration number

If you were in a vehicle, were you wearing a seatbelt? ☐ Yes ☐ No

If you were riding a motorcycle/moped at the time of the accident, were you wearing a helmet? ☐ Yes ☐ No

2. Name and address of the driver of the vehicle

Was a blood sample taken from the driver in order to analyse alcohol and/or drug levels? ☐ Yes ☐ No

If yes, please provide us with the results.

3. Name and address of the owner of the vehicle

Motor insurance company (name and address)

Policy number

4. Was another vehicle involved in the accident? ☐ Yes ☐ No

If so, please provide the licence number of the other vehicle:

Name and address of the driver of the other vehicle

Name and address of the owner of the other vehicle

Motor insurance company (name and address)

Policy number

5. Have you made (or are you making) claim(s) against any other party? ☐ Yes ☐ No

Have any claims been made against you? ☐ Yes ☐ No

6. Accidents caused by a third party

1. Was the accident caused by a third party? ☐ Yes ☐ No

If so, was the accident caused by an animal? ☐ Yes ☐ No

Name and address of the person who caused the accident (or of the owner of the animal)

Name and address of the third party liability insurance of the person who caused the accident (or of the owner of the animal)

Policy number

Have you made (or are you making) claim(s) against the other party's liability insurance? ☐ Yes ☐ No

Name and address of possible witnesses to the accident

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

I have read the information provided in this form. I declare that the information that I have supplied in this form (as well as any attachments to this form), is true and correct to the best of my knowledge. I understand that the making of a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted.

I understand that Foyer Global Health S.A. might require additional information before processing my claim. I understand that my claim is not payable if I refuse to pursue the claim without adequate cause.

Place and date

Signature