Maßstäbe / neu definiert

Accident report for accident insurance
taken out with AXA Versicherung AG

Mr/Mrs/Company

Please send this accident report to:

AXA Versicherung
Aktiengesellschaft
Abt. Unfallschaden
Colonia-Allee 10-20

D-51067 Köln

Please quote at all times

Certificate of insurance number:

In case of group accident insurance

Group

Consecutive no.:

Are any other claims being asserted against AXA in association with this claim?

☐ yes ☐ no

☐ Motor liability ☐ Own damage claim ☐ Other policy

Certificate of insurance or claim number:

Injured party

Surname, Christian name

Date of birth

Street and house number

Telephone No.

Post code/Town/City

Occupation

Course of accident events

When and where did the accident occur?

Date

Time of accident

Location of accident (street, square, no.)

On what occasion?

☐ at the work, in school, at nursery
☐ on the way to or from there
☐ in the home
☐ while out shopping
☐ a different occasion

How did the accident happen?
Please explain in detail

What is the nature of the injuries?

Was the accident recorded by the police?

☐ yes ☐ no

Address of the attending police station

Was a blood alcohol test performed?

☐ yes ☐ no

Result ‰

File number

In case of motor vehicle accidents

What type of vehicle was used?
Type (e.g. private motor vehicle, motorcycle) | Vehicle registration number

Who was driving the vehicle?
Surname, Christian name | Driving licence class | Date of issue

Please also answer the following in case of claims submitted under a accident insurance for occupants:
Is the vehicle driver employed by the insurance policyholder as a driver or codriver? ☐ yes ☐ no
How many persons were on the journey? Number | How many of them were under the age of 14? Number
Was the injured party wearing his/her safety belt? ☐ yes ☐ no

Medical treatment

When was medical treatment first administered?
Date | Time | Doctor´s name and address
Was in-patient medical treatment necessary? ☐ yes ☐ no from | to
Name and address of the hospital
Which additional doctors were consulted?
Name and addresses
Is the injured party still receiving medical treatment? ☐ yes ☐ no
Anticipated duration of treatment
Which doctor is treating the injured party now?
Name and address
Is the injured party still incapacitated in his/her ability to work? ☐ yes ☐ no

Previous illnesses and accidents

Was the injured party completely healthy prior to this accident? ☐ yes ☐ no
Nature of illnesses or afflictions
Has the injured party received compensation for accidents on a previous occasion? ☐ yes ☐ no
When? | Amount of compensation | From which company?
Does the injured party draw a pension? ☐ yes ☐ no
Pension award amount % | From which insurance carrier?

Other insurances

Does the injured party have any other personel accident insurance policies? ☐ yes ☐ no
Name of companies, insurance certificate no., sums insured
To which Employer´s Liability Insurance Association does the injured party belong?
Name and address

Preferred method of payment

☐ Cheque ☐ Transfer
Payment recipient
Address of the bank, savings bank or postal giro office
Account no. | Bank sort code

Furthermore, I am aware that, in order to assess his obligation to perform, the insurer may check information, which I submit to substantiate my claims or which can be deduced from the documents I submit (e.g. invoices, prescriptions) as well as information I arrange to be provided by hospitals or members of medical professions. For this purpose, I also release members of medical professions and clinics, named in the aforementioned documents, or persons involved in the administration of treatment, from their obligation to preserve professional secrecy. I also hereby release persons from any obligation to preserve professional secrecy also to examine benefits payable in case of my death. This release from obligation to professional secrecy shall also apply to public authorities - with the exception of social insurance carriers - and also to the members of other accident or health insurance companies, who may be questioned regarding insurance policies in place with their companies. I hereby submit this declaration also on behalf of any co-insured persons I legally represent, who are not in a position to appraise the significance of this declaration.
Important note: Please note that any information submitted which is deliberately incorrect or incomplete could jeopardise insurance cover even in cases where the insurer is not put at a disadvantage as a result thereof.

Location, Date | Policyholder´s signature | Signature of the injured party