Assuria VERZEKERINGEN

Claim form for Assuria Accident Insurance (SOR)

For giving notice of an accident or occupational illness as referred to in Articles 11, paragraph 2, and 27 of the "1947 Accident Scheme".

This form should be completed in full, signed and sent to the office as soon as possible, within 2x24 hours of the accident
Complete in full, or else this case cannot be dealt with.

To be completed by Assuria:

Policy no.: Claim no.:

1. Name, first names and address of the employer. Name and address of the company	
2. *(If different from point 1)* Name, first names and address of the person reporting	
3. a. Name, first name and address of the injured party. b. Date of birth c. Sex	a. b. c. ❑ Male ❑ Female
4. a. Company which employed the person affected. b. Type of work the person affected was usually charged with or position he usually held	a. b.
5. Names and addresses of eyewitnesses to the accident	
6. If the report is related to an accident, a. date and time of the accident b. place of the accident c. what other persons have sustained injuries as a result of the same accident?	 a. b. c.
7. If the report is related to a person affected by an occupational illness, a. date on which the occupational illness manifested itself b. where were the activities that gave rise to the onset of the occupational illness usually performed? c. date on which the person affected started the activities referred to in b for the employer d. date on which the person affected entered the employer's service.	 a. b. c. d.

8. Were the activities that the person affected was engaged in when the accident happened and that gave rise to the occupational illness part of his usual work? If not, did he carry out the activities acting on the instructions of his employer or of the latter's representative?	
9. Cause of the accident and the way in which it occurred, cause of the occupational illness (State, among other things, the activities the person affected was carrying out at the time of the accident; machines or tools he was using insofar as they caused injuries; the events or actions on the part of the person affected or third parties giving rise to the accident; possible inebriation, deliberate intent, playing, fooling around, fighting etc.)	
10. a. What was the pay in money of the person affected in the calendar week preceding the accident? b. Does he have a five-day or a six-day working week? c. In addition to pay in money, were any other benefits provided, like board and lodging, clothing and the like? d. If so, which benefits and what was their estimated monetary value?	a. b. c. d.
11. a. When did the person affected stop his activities? b. Has the person affected now resumed work? If so, when? c. Has the person affected resumed his usual activities, or is he only partially fit for work? If so, in how far?	a. b. c.
12. Further remarks the person making the report may wish to make.	

Completed to the best of my ability in accordance with the truth,

in

on

Signature of the person making the report

DOCTOR'S STATEMENT

13. Name and address of the physician who administered first aid.	
14. a. On what date and at what time did medical treatment start. b. Is the treatment continued? If so, by whom?	a. b.
15. Is the person affected treated as an ambulant patient, in a hospital or at home?	
16. a. Has the accident/occupational illness resulted in death? b. is the accident/occupational illness likely to result in death? If not, what is the likely duration of the period of recovery going to be? c. What part of the body has been injured (specify anatomically, e.g. femur or tibia, right or left etc.) d. What is the nature of the injury/occupational illness? e. Is the injury of a serious nature? f. In case of an accident Did the injury, from a medical point of view, cause the person affected to stop work at once or some time later? g. In case of an occupational illness When did the illness manifest itself and when did the partial incapacity for work occur. h. Was the person affected referred to a specialist? If so, to what specialist?	a. b. c. d. e. f. g. h.
17. Further remarks that the physician may wish to make.	

Completed to the best of my ability in accordance with the truth,

in

on

Signature of the physician who administered first aid