Accident report

aquilana
Gesundheit für Generationen

Bruggerstrasse 46, Postfach, 5401 Baden
Tel. +41 56 203 44 44, Fax +41 56 203 44 99
www.aquilana.ch

Please answer all questions accurately and complete, then sign the form and return it to us without delay.

Personal particulars

Surname _____ **Forename** _____

Date of birth _____ **Insuree no.** _____

Street, no. _____ **Post code, place** _____

Horne tel. _____ **Business tel.** _____

E-mail _____

Occupational situation

In employment? ☐ yes ☐ no ☐ employee ☐ self-employed
☐ student ☐ pensioner ☐ child ☐ housewife/husband

Name and address of the employer at the time of the accident _____

Your weekly working hours ☐ more than 8 hours ☐ 8 hours or less

Are you unemployed? ☐ yes ☐ no

If yes, do you receive ALV daily allowances? ☐ yes, since _____ ☐ no

Information about the accident

Accident date _____ day _____ month _____ year _____ time

The accident occurred ☐ on the journey to work ☐ in your leisure time ☐ other reason
☐ at the workplace ☐ during military service

Place of the accident (presice designation) _____

How the accident happened (precise description of the accident in concise terms)

Involvement of third parties

Was the accident caused by a third party?
(If a road traffic accident, see question «Accidents with motor vehicles») ☐ yes ☐ no

If yes,
name and address of the third party _____

Name of the civil liability insurance of the third party involved, agent responsible and policy or claim no.

Police report

Was a police report written? ☐ yes ☐ no

If yes, by which police station?

Witnesses

Were there witnesses? ☐ yes ☐ no

If yes,
name and address of the witness/witnesses _____

Please see next page

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Injury

What is the nature of the injury? _____

_____

Which part(s) of the body is/are involved? _____ ☐ right ☐ left

Incapacity from work

Did the accident cause incapacity for work? ☐ yes ☐ no

If yes ☐ full ☐ partial

since when? _____

(If a daily allowance insurance has been taken out with Aquilana, please enclose medical certificate of incapacity for work)

Treatments

Date of first treatment _____

Name and address of the treating doctor or hospital _____

_____

Other insurance policies

Do you have other accident insurance? ☐ yes ☐ no

If yes, with whom?

☐ employer (UVG insurance)

☐ other (quote name of insurance company and policy no)

_____

Accidents with motor vehicles

	Vehicle used by you	Vehicle involved in collision
Vehicle type (e.g. cycle, motorcycle, passenger car) and make, type		
Name and address of the driver		
Registration plate		
Civil liability insurance **Name**		
Agency		
Claim no.		
Occupants' insurance	☐ yes ☐ no	☐ yes ☐ no

The **undersigned person** confirms the accuracy of the details given above and **authorises Aquilana Versicherungen** to seek the necessary information from medical personnel, medical establishments, official bodies and other insurance providers or insurers needed to assess the obligation to provide benefits and specifically releases such persons from professional secrecy or from the obligation of discretion in relation to Aquilana Versicherungen.

Place, date

Signature of the insured person or his/her legal representative