

Please send claim form to:
Chartis Europe S.A.
Kalvebod Brygge 45
DK-1560 København V
Tlf +45 33 73 24 00
Fax +45 33 73 24 70
www.chartisinsurance.com



CLAIM FORM - Accident

It is important that you complete this form in as much detail as possible. The more precise the answers to our questions are the sooner we will be able to respond to this form.

If the accident has caused personal injury and there is a medical report from the emergency room please submit it along with this form.

If you have any questions regarding your claim or how to complete this form please do not hesitate to contact our claims department.

Best regards
Chartis Europe S.A.

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Claim no.
(Filled in by Chartis)



CLAIM FORM - Accident

POLICY HOLDER

SE/CVR no.	Policy no.
Company name	Contact person
Address	ZIP code and city

INSURED

Job title	Social security no.
Name	Bank registration and account no.
Address	ZIP code and city
Phone number/cell phone	E-mail

ACCIDENT

When did the accident take place?	Date	Time
Where did the accident take place? At work? <input type="checkbox"/> Yes <input type="checkbox"/> No During leisure time? <input type="checkbox"/> Yes <input type="checkbox"/> No During paid or voluntary work for another ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address	
How did the accident happen? (It is important that the event is described thoroughly)		
What caused the accident to happen?		
What part(s) of your body were injured?		
Were you under the influence of alcohol or any other intoxicating substance when the accident happened? – If yes please provide further information. <input type="checkbox"/> Yes <input type="checkbox"/> No		

Were you completely healthy and fit when the accident took place? If No why not? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your profession?

POLICE REPORT

Do you have a police report? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which department was it reported to?
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OTHER INSURANCE: THIRD PARTY LIABILITY INSURANCE, WORKERS COMPENSATION INSURANCE, ACCIDENT & HEALTH INSURANCE

Has the accident been reported to other insurance companies? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes which?
Company name	Policy/claim no.	What type of insurance?
Are you a member of Health Insurance denmark? Yes/No – if yes , which group? (1,2,5 or 8) <input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL TREATMENT

When did you start receiving medical treatment?	Date	Time
Name of hospital/doctor, address		
Doctor	Name	
	Address	
Hospital	Name	
	Address	
Other	Name	
	Address	
Who is your family Physician?	Name	
	Address	

SIGNATURE

I hereby declare that the information I have specified in this claim form is the truth. I am aware that false information or any suppressions may cause a reduction in the compensation or that no compensation is payable. Chartis may obtain medical information from medical physicians, medical institutions, insurance companies and public authorities that may contribute to a correct assessment of my condition and that Chartis may inform these of the information that I have given Chartis. If the accident has been reported to the police or the Workers Compensation Board I hereby give Chartis permission to obtain information from them.	
City and date	Signature
Employer's signature (Only if the insurance has been paid by the employer).	The insured's signature (If the injured person is under 18 years old the legal guardian/parent shall sign)