DR-WALTER

Accident questionnaire

Policy holder	Policy number
Insured person	

Who suffered the accident?

Name	Date of birth

When and where did the accident take place?

Date of accident	Time	Place of accident

How did the accident take place? (please state details of the event)

Was the accident registered by the police?

☐ Yes	☐ No	Police station	Reference number

Type of accident

Was it a traffic accident?	☐ Yes	☐ No
Was it a work accident or an accident while traveling?	☐ Yes	☐ No
Is there a social accident insurance in place?	☐ Yes	☐ No

Are you a member of an employers' liability insurance association?

☐ Yes	☐ No	If yes, which one?
When did you inform your employers' liability insurance association about the accident?		Reference number

What are the names of the witnesses of the accident and where do they live?

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Who caused the accident?

Name

Address

Does the party responsible for the accident have liability insurance?

☐ Yes ☐ No | If yes, with which insurance company?

Address

Insurance certificate number | Reference number

Are you related or related by marriage to the party responsible for the accident?

☐ Yes ☐ No

Have you already made claims for compensation against the party responsible for the accident?

☐ Yes ☐ No

Has the party responsible for the accident accepted the claims? ☐ Yes ☐ No

Have the consequences of the accident been fully treated?

☐ Yes ☐ No

Are there any outstanding invoices?

Important information / Signature

The policyholder and the insured person are obliged to make a true and comprehensive statement. The company is exempt from the requirement to pay, if the policyholder or the insured person acted intentionally or grossly negligent in making incomplete or false statements or fraudulent misrepresentation. In case of false statements that were given intentionally, this legal consequence is also followed if it neither affects the stipulation or the amount of the benefits that are incumbent on the insurer. In case of a violation caused by gross negligence, the insurer is entitled to reduce the benefits in relation to the seriousness of the fault.

Place, date

Signature of the policyholder | Signature of the injured party

Professional secrecy obligation

for (insured person) | Policy number

I hereby authorize the insurer to collect information at any time about any former illness, disease, consequence of an accident and infirmity and such that occurred until the end of the contract. The same applies for information about any applied for, current or ended personal insurance. For this purpose, the insurer is allowed to ask physicians, dentists, alternative practitioners, any type of hospital, insurance institution and pension office. I hereby exempt them from their professional secrecy and authorize them to provide the insurer with all necessary information.

Place, date | Signature of the insured person