wüstenrot

W DOBROM AJ V ZLOM

Nevpisujte text - miesto pre podateľňu

Nevpisujte text - miesto pre čiarový kód

Wüstenrot poisťovňa, a.s. (Insurance company)
Digital Park I, Einsteinova 21
851 01 Bratislava, Slovakia
Company Registration Number: 31 383 408,
Commercial Register of the District Court,
Bratislava I, Section Sa, entry No. 757/B
www.wuestenrot.sk

01/2023 Z54

ATTENDING PHYSICIAN CASE REPORT
LASTING EFFECTS FROM THE INJURY (one year after the date of accident)

The form can fill only specialist physician who is not a relative of an injury affected person specified in this notice.

THE INSURED, or CO-INSURED CHILD PARTICULARS **DATE OF THE INJURY:**

Name and surname:	Birth registration number:	Phone number:
Permanent address:		ZIP code:
Numbers of insurance contracts that insure you against injuries:		
Are you politically exposed person under the Act. 297/2008? ☐ Yes ☐ No If so, please specify in what position: If the injury occured to the co-insured child particular, answer the questions in the part Declaration of the legal representative.		

I certify the Wüstenrot Insurance Company, Inc. to inquire about the entire medical documentation of mine and I release the health professionals to disclose my medical information.

Insurance coverage to be remitted to:

☒ **to bank account:**

IBAN:

SWIFT/BIC:

Declaration of the legal representative in case a juvenile insured person is involved:
I hereby certify my authorization to represent my child and administer all the matters of hers/ his, and I recognize my responsibility for all the consequences in case this declaration was not truthful.

Name of the legal representative:	Birth registration number:
Are you politically exposed person under the Act. 297/2008? ☐ Yes ☐ No If so, please specify in what position:	
In ..... on ..... **Signature of the insured person/ legal representative of the insured juvenile**	

The attending physician certifies to have treated the above mentioned person afflicted with injury, and found bodily injuries of the following kind and extent:

Injury **diagnosis**:
Detail description of the bodily harm caused by the injury, including its extent assessment:
Manner and kind of the treatment administered (provide a detail description):
X-ray finding in description:

Was the injured limb or organ in any way functionally handicapped before the injury? yes ☐ no ☐ In what way?

At what extent?

Did the injury have lasting effects? yes ☐ no ☐

Of what kind and extent?

All the other medical reports of the attending physician:

Dear physician, in order for the insurance compensation to be assessed and claimed, the information on treatment and medical condition of the insured is needed, for disclosure of which we hereby ask you. The written consent of the insured allowing for disclosing the stated information is given in the top part of this form. Provided that the entire form is filled in completely and accurately, and is signed, the compensation in the amount of € 5,00 may be claimed.
Warning: In the case of inaccurate or incomplete information provided, or of a failure to attach all the documentation required, no claim for the above-described compensation may be asserted.

In ..... on	I declare that I am not a relative of an injury affected person specified in this notice.
Name of the physician:	
Permanent address:	..... Stamp and signature of the attending physician

IBAN:

SWIFT/BIC: