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

INJURY REPORT

01/2023 Z54

WARNING: In the case of a co-insured child being injured, it is necessary to submit a copy of the co-insured child birth certificate as an attachment to the Injury report, in order for the insurance compensation claim to be assessed.

THE INSURED, OR CO-INSURED CHILD PARTICULARS

Name and Surname:	Birth registration number:	Phone number:
Permanent address:		ZIP code:
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.		
Occupation (kind of work activity and the employer permanent address):		
Numbers of insurance contracts that insure you against injuries:		

1. INJURY PARTICULARS 1.1. When and where did the injury occur?

Date:	Time:	Place:

1.2. Give a coherent and detail description of the activity, process and circumstances that lead to injury:

1.3. Which body part was injured?

1.4. Was this body part handicapped functionally or otherwise before the injury? yes ☐ no ☐

In what way?

1.5. Address of the medical center,

where you were provided general the first treatment and when:	where you were treated:	Name and address of the practitioner who you belong to as a patient and who keeps your medical records:

1.6. Did the injury occur as a consequence of duty service performance or its direct connection? yes ☐ no ☐

If so, state the particular workplace where the injury occurred, as well as the activity that you were doing at the time:

1.7. Did the injury occur while doing an activity other that duty service? yes ☐ no ☐ If so, tick the correct cause of injury:

- ☐ doing repair and maintenance work; handling machines, tools or material
- ☐ during stay and activity done at home or surrounding area
- ☐ while walking or doing some recreational activities or other activities
- ☐ while travelling or in any connection with traveling
- ☐ at school or an event organized by school
- ☐ own vehicle, own fault
- ☐ doing sports
- ☐ in business
- ☐ doing other activity outside your occupation

1.8. Give a closer description of what was the cause of injury:

1.9. Names and permanent addresses of potential injury witnesses:

1.10. The case was investigated by (body, address, or name):

1.11. If the case is a motor vehicle accident, please state:

Kind and the make of the vehicle:	Vehicle registration plate:
Name and address of the motor vehicle owner:	
Name and address of the driver:	

2. ACKNOWLEDGEMENT OF THE EMPLOYER OR ORGANIZATION

In case the injury occurred as a consequence of work activity or its direct connection:

In ..... on ..... Stamp and signature of the employer (organization)

3. DECLARATION AND AUTHORIZATION (FILLED IN BY THE INSURED PERSON OR HIS/ HER LEGAL REPRESENTATIVE)

I hereby declare to have filled in only one injury report about the injury, in which I stated truthful and complete information. I authorize the insurance company with the right to request any documentation concerning the origin and treatment of my bodily harm and overall medical condition.

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

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ATTENDING PHYSICIAN CASE REPORT

The attending physician certifies to have treated the injured patient who is referred-to on the first page of this declaration, and found bodily harm of the following kind and extent:
The form can fill only specialist physician who is not a relative of an injury affected person specified in this notice.

According to the medical records, when was the first medical attendance provided? On .....at .....o'clock.

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):

Description of X-ray finding:

Does the attended bodily harm and its extent correspond to the accident story described on the first page of this declaration? yes ☐ no ☐

Was the injury a consequence of alcohol use or other toxic substances? yes ☐ no ☐ .....‰ of alcohol detected in blood.

What kind of addictive substance was probably involved?

What symptoms of alcohol intoxication, or other toxic substance intoxication was detected?

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 ☐

What is their probable kind or extent?

Dear physician, in order for the insurance compensation to be assessed and claimed, the information on treatment and medical condition of the insured, or the co-insured child is needed, for disclosure of which we hereby ask you. The written consent of the insured allowing for disclosing the stated information is given on the first page of this form. Provided that the entire form is filled in completely and accurately, and is signed, you may claim for the compensation in the amount of 5,00 € .

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 .....

Name of the physician:

Address:

I declare that I am not a relative of an injury affected person specified in this notice.

.....
Stamp and signature of the attending physician

IBAN:

SWIFT/BIC: