W DOBROM AJ V ZLOM

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

INJURY REPORT

06/2023

Z54

report, in order for the insurance compensation cla		abmit a copy of the co-insure	a chila birth certifi	cate as an attachment to the injury					
THE INSURED, OR CO-INSURED CHILD PARTIC									
Name and Surname:	·								
Permanent address:	ZIP co	P code:							
Are you politically exposed person under the Act. 2 If the injury occured to the co-insured child particular		If so, please specify in wha n the part Declaration of the l		re.					
Occupation (kind of work activity and the employe	<u> </u>								
Numbers of insurance contracts that insure you ag	ainst injuries:								
1. INJURYPARTICULARS 1.1. When and where	e did the injury occur?	Date: Time:	Place:						
1.2. Give a coherent and detail description of the ad	tivity, process and circums	tances that lead to injury:							
1.3. Which body part was injured?	1 / Was this	body part handicapped func	tionally or othorwi	ise before the injury? ves 🗌 no 🗌					
1.3. Which body part was injured:	In what wa	7 1 11	donally of otherwi	ise before the injury: yes in the in-					
1.5. Address of the medical center,	III WIIAL WA	y:							
where you were provided general the first treatr	nent where you were trea	ated:	Name and addr	ess of the practitioner who you					
and when:	,		belong to as a pa	tient and who keeps your medical					
			records:						
1.6. Did the injury occur as a consequence of duty s			no						
If so, state the particular workplace where the inju	· ·								
1.7. Did the injury occur while doing an activity othdoing repair and maintenance work; handling		□ no □ If so, tick the corr□ while travelling or in any		: doing sports					
or material	macinics, tools	traveling	, connection with	uoning sports					
during stay and activity done at home or surro		at school or an event org	anized by school	in business					
while walking or doing some recreational activ	ities or other activities	own vehicle, own fault		doing other activity outside your occupation					
1.8. Give a closer description of what was the				your occupation					
cause of injury:									
1.9. Names and permanent addresses of poten- tial 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 registration plate:					
picase state.	Name and address of the								
	Name and address of the	driver:							
2. ACKNOWLEDGEMENT OF THE EMPLOYER OF									
In case the injury occurred as a consequence of wo	rk activity or its direct con	nection:							
In	on	Stamp a	and signature of th	ne employer (organization)					
3. DECLARATION AND AUTHORIZATION (FILLE	D IN BY THE INSURED P	ERSON OR HIS/ HER LEGAI	L REPRESENTATI	VE)					
I hereby declare to have filled in only one injury repo	ort about the injury, in which	ch I stated truthful and compl	ete information. I	authorize the insurance company					
with the right to request any documentation conce	rning the origin and treatn	nent of my bodily harm and o	overall medical cor	ndition.					
Insurance coverage to be remitted to:									
to bank account: IBAN:									
SWIFT/BIC:									
		aland thambar eff	ul						
Declaration of the legal representative in case a juve matters of hers/ his, and I recognize my responsibile.	enile insured person is inve	oived: I nereby certify my aut s in case this declaration was	inorization to repr	esent my chiid and administer all the					
Name of the legal representative:	ity for all the consequence	o in case tins accidiation was	Birth registration	on number:					
Are you politically exposed person under the Act. 2	297/2008? Yes No	If so, please specify in wha							
, , , , , , , , , , , , , , , , , , , ,		,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,	<u> </u>						
In	on	Signature of the insure	ed person/legal re	presentative of the insured juvenile					



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 record	rding to the medical records, when was the first medical attendance provided?									d?	Onat .								t		0′	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 Was the injury a consequence of	falco	hol ι	use c	or ot	ther to	oxic s				story		escribed yes 🔲 I		-		e of th				,		no 🗆			
What kind of addictive substance		•		•																					
What symptoms of alcohol into							tan	ce into	xicat	ion \	was	s detecte	ed?												
Was the injured limb or organ handicapped before the injury?	n in	any	way	/ fur	nction	nally		yes	_ no)	li	n what v	vay?												
At what extent?																									
Did the injury have lasting effec					yes	no																			
What is their probable kind or	exte	nt?																							
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.																									
<u>.</u>												I doclar	that	l am n	ot :	a rolat	ve of	an ini	ırv əfi	focto	d nar	con c	nacif	iad in	
Inonon								I declare that I am not a relative of an injury affected person specified in this notice.																	
Address:																									
Auuress.														S	 tan	np and	signa	ture o	f the a	atter	ndina	phys	 ician		
IBAN:		T				T									ī		Ţ								
SWIFT/BIC:		\dagger	П	Т	\top	\dagger		\top																	