CLAIM FORM – COLLECTIVE ACCIDENT INSURANCE

Gouda
En del af Gjensidige

Please fill out all fields and enclose original documentation.

Processing your claim cannot begin before we have received all relevant information.
Please fill out all fields in the claim form, otherwise the claim handling will be prolonged.

Remember to specify your claim and enclose original documentation. To be forwarded to:
Gouda Rejseforsikring, A.C. Meyers Vænge 9, DK-2450 København SV.

1. PERSONAL INFORMATION		
Name:	Policy number:	Claim number: *(Completed by Gouda)*
Civil registry no.:	E-mail:	
Address:	Postal code:	City:
Company name:	Phone no. (work):	Phone no. (private):

2. NATURE OF DAMAGE		
Death	Permanent disability	Dental damage

3. DESCRIPTION OF THE ACCIDENT							
When did the accident occur (dd/mm/yy)?			Time:				
Where did the accident occur?							
How did the accident occur? (It is important that the questions below are answered accurately and detailed to enable Gouda to get a clear picture of what happened).							
What happened immediately before the accident?							
How did the accident occur?							
What was the direct cause of the accident?							
Description of the damage:							
Has a police report been made?	Yes:	No:	Police station:	Was the injured influenced by alcohol?	Yes:	Tested:	No:
Were there any witnesses to the accident?	Yes:	No:	Who:				
Was anyone to be blamed for the accident?	Yes:	No:	Counterpart:	Registration number:			
Insured by:				Policy no.:			
Did the accident occur:	In spare time	While working for others		During independent work	While driving a motorcycle		

4. TREATMENT				
Date and time of 1st consultation (dd/mm/yy):	Name of the claimant's own doctor:			
For how long time is the work incapacity estimated to last? Approx. no. of weeks/months:				
Were you hospitalised or did you receive ambulant treatment at a hospital?	Yes:	Which hospital:		No:
Is the claimant covered by the public health insurance?	Yes:	No:	Group 1:	Group 2:

5. OTHER COMPANIES				
Has the accident been reported to the compulsory Workmen's Compensation Insurance?	Yes:	No:		
Is the claimant covered by the health insurance "danmark"?	Yes:	Membership no.:		No:
Is the claimant insured by any other insurance company?	Yes:	Company:	Policy no.:	No:

6. CLAIMANT'S OCCUPATION		
Is claimant's occupation entirely office work?	Yes:	No:
If no, which occupation:		
Is the claimant's occupation entirely domestic work?	Yes:	No:
Other occupation:		

7. FURTHER INFORMATION				
Were you completely well at the time of the accident?	Yes:	No:	If no, what kind of disease did you suffer from?	
Have you previously been ill?	Yes:	No:	If yes, what kind of disease did you suffer from?	
Did you previously have other accident incidents?	Yes:	No:	If yes, when?	Which part of the body?
And did you receive any compensation?	Yes:	No:	If yes, in which insurance company?	
			Claim no.:	Injury percentage:

8. BANK- GIRO ACCOUNT *If you require any compensation placed in deposit at your bank account, please note:*		
Bank:	Registration no.:	Account no.:
Transfer to a bank outside Denmark:		
Bank:	IBAN no.:	Swift code:

9. SIGNATURE	
I, the undersigned, solemnly declare that the above information is correct, and authorise Gouda Travel Insurance to obtain medical information about any present and previous illness or treatment, insofar as this information is relevant to the handling of the claim. At the same time I give my consent to Gouda to obtain information from doctors, other health institutions or insurance companies and also inform them of the facts given to Gouda. If the accident is reported to the police or Arbejdsskadestyrelsen (National Board of Industrial Injuries) or if I have applied for pension from the public authorities, I also authorise Gouda to procure information from these authorities. In case of signature by someone else than the claimant, please advise name, address and relationship with to the claimant.	
Date:	Signature: