

Accident Notification Form

Mandatory healthcare insurance (KVG) and supplementary insurance plans (VVG)



This form must be completed by the insured person or the insured person's legal representative. You can also complete this document online on our website, www.css.ch (search for «claim notification form»). Please send us the form as quickly as possible to the address indicated on the last page. Without your information, we are unfortunately unable to review your entitlement to benefits. Please return the form even if no accident has happened, and include a note to this effect in the «Remarks» field at the end of the form. Questions 1.2, 1.3, 1.5 and 3.6 do not need to be answered for children younger than 15.

If you have any questions, our Contact Center will be happy to help on 0844 277 277. Thank you.

Client number

1 General information

1.1 First Name Surname Date of birth Street address
 Postcode/town E-Mail Phone Available at (time)

1.2 Who was your employer at the time of the accident?

Name of employer Street address Postcode / town Number of hours per week

1.3 Do you know the name of your employer's accident insurance company?

Yes No Name of insurance company Claim number

1.4 If you were not in a relationship of employment: why?

Self-employed* Homemaker* Pensioner* Do not work* Child
 *Who was your last employer? From to Never been an employee
 Name of employer Street address Postcode / town

1.5 Do you receive or have you received unemployment benefit?

Yes No From to

2 Circumstances of accident

2.1 When, where and how did the accident happen?

Date Time
 Accident location Country
 The accident occurred While at work On the way to work During leisure hours
 Please describe how the accident happened (what you were doing, weather conditions, involved persons, vehicles, animals, machines etc.)

2.2 Did the police file an accident report?

Yes No By which precinct

2.3 Was a third party involved in the accident?

Yes No

First Name/Surname	Phone
<input type="text"/>	<input type="text"/>
Street address	Postcode / town
<input type="text"/>	<input type="text"/>
Name of third party's liability insurance	Policy number / claim number
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Third party's liability insurance not known	<input type="checkbox"/> The third party does not have liability insurance

2.4 Was the accident the fault of this third party?

Yes No

2.5 Are there any witnesses to the accident?

Yes No

First Name/Surname	Phone
<input type="text"/>	<input type="text"/>
Street address	Postcode / town
<input type="text"/>	<input type="text"/>

3 Injuries

3.1 What injury did you suffer?

Nature of injury	Part of body	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="text"/>	<input type="text"/>		

3.2 Did your complaint begin immediately after the event?

Yes No

3.3 Was the pain or the injury triggered by an uncontrolled or sudden movement?

Remarks
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>

3.4 Who treated you first (doctor / hospital / dentist)?

Name	Postcode / town
<input type="text"/>	<input type="text"/>

3.5 Did anyone else provide further treatment?

Name	Postcode / town
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="text"/>

3.6 Are or were you unable to work as a result of the injury?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Degree of incapacity to work <input type="text"/> %	From <input type="text"/> to <input type="text"/>
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4 Other insurances

4.1 Do you have any other accident insurances cover?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Supplementary insurance to mandatory accident insurance	<input type="checkbox"/> TCS ETI insurance card
Name of agency	Policy number	
<input type="text"/>	<input type="text"/>	
Name of insurance company	<input type="text"/>	

If you have other accident cover, please include a copy of your policy.

Please note: the following questions are to be answered *only in the case of road traffic accidents*.

5 Vehicles involved

5.1 Which vehicles were involved in the accident?

Your vehicle	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Moped	<input type="checkbox"/> Car	<input type="checkbox"/> Other	<input type="text"/>
Third party's vehicle	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Moped	<input type="checkbox"/> Car	<input type="checkbox"/> Other	<input type="text"/>

5.2 To whom does the vehicle belong (keeper / owner)?

	First Name / Surname	Postcode / town	Number plate / make
Your vehicle	<input type="text"/>	<input type="text"/>	<input type="text"/>
	First Name / Surname	Postcode / town	Number plate / make
Third party's vehicle	<input type="text"/>	<input type="text"/>	<input type="text"/>

5.3 Who was driving the vehicle at the time of the accident?

<input type="checkbox"/> The keeper / owner was driving	First Name / Surname	Postcode / town
	<input type="text"/>	<input type="text"/>

5.4 With which insurance company do you/does the third party hold liability insurance?

Your vehicle	<input type="checkbox"/> Not known	Name of insurance company	Policy number
		<input type="text"/>	<input type="text"/>
Third party's vehicle	<input type="checkbox"/> Not known	Name of insurance company	Policy number
		<input type="text"/>	<input type="text"/>

5.5 With which insurance company do you/does the third party hold passenger insurance?

Your vehicle	<input type="checkbox"/> Not known	Name of insurance company	Policy number
		<input type="text"/>	<input type="text"/>
Third party's vehicle	<input type="checkbox"/> Not known	Name of insurance company	Policy number
		<input type="text"/>	<input type="text"/>

6 Remarks

Please confirm these details with your signature. Many thanks for your support.

The undersigned person hereby confirms that he or she has answered all questions in this form truthfully and in full.

The undersigned person hereby assigns to CSS Insurance any liability claims arising from the accident referred to above up to the amount in benefits it has paid and acknowledges that CSS Insurance may assert its claims against third parties. By signing the accident report, the applicant authorises CSS Insurance to share information and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover, while respecting statutory provisions on data protection. In such cases, all parties involved are released from the obligation to maintain professional or patient confidentiality with respect to CSS Insurance. The undersigned person is entitled to request information about the data pertaining to him or her that is being processed. Consent to the processing of data may be revoked at any time.

*Legal entity for basic insurance (KVG): CSS Kranken-Versicherung AG, INTRAS Kranken-Versicherung AG or Arcosana AG

*Legal entity for supplementary insurance (VVG): CSS Versicherung AG or INTRAS Versicherung AG

*Your legal entity for basic insurance (KVG) and supplementary insurance (VVG) is shown in your insurance policy.

Place	Date	Signature of the insured person or his or her legal representative
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address of the insurer:
 CSS Insurance, P.O. Box 2550, 6002 Lucerne