

Accident Report

SJÓVÁ

To be filled out by the injured person

Name of injured person _____	ID no. _____
Address _____	Postcode _____ Town/City _____
Phone (home) _____	Phone (work) _____ Mobile _____ Email _____
Employer _____	Job title _____ How many working hours a week? _____
Trade union _____	Pension fund _____
Name of the insured (if other than the injured) _____	ID no. _____

Accident information	Date of accident _____ Precise time _____ <input type="checkbox"/> Outdoors <input type="checkbox"/> Indoors	Check where applicable: <input type="checkbox"/> Traffic accident <input type="checkbox"/> Leisure-time accident <input type="checkbox"/> Work-time accident <input type="checkbox"/> En route to/from work <input type="checkbox"/> Sports activities <input type="checkbox"/> Other
	Place of accident _____	
	How did the accident happen? (Give details.) _____ _____ _____	
	Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you under the influence of alcohol/other drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is anyone responsible for the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____	

Treatment	When did you first seek treatment for the injury? _____ <input type="checkbox"/> Have not sought physician/treatment.
	Where did you seek first treatment for the injury? _____
	Name of general practitioner _____ Address _____
	Names of other physicians/treatment centres _____ _____

Consequences	Description of injuries and physical consequences (in detail) _____ _____
	Are you unable to work? <input type="checkbox"/> Fully unable <input type="checkbox"/> 75% unable <input type="checkbox"/> 50% unable <input type="checkbox"/> 25% unable <input type="checkbox"/> Fully able to work
	For how long do you expect to be unable to work? _____
	Will the injury affect your income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from what date? _____

Former health	Have you ever sustained injuries or were you suffering from an illness or injury before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Had you previously been hospitalized due to accident/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No Any former disability evaluations? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Details: _____ _____

Informed acceptance and signature	I, the undersigned, do hereby truthfully attest that the above answers and information I have provided herein are to the best of my knowledge correct and that I have not concealed any facts that might be of importance with respect to any decision Sjóvá may make regarding its liability, if any, and the amount of insurance benefits. I am aware that any false or insufficient answers may affect my right to receive insurance benefits.
	I hereby authorize Sjóvá to obtain information from medical doctors, hospitals and other treatment facilities regarding my present state of health and with regard to previous/later illnesses or accidents that may be of importance to Sjóvá when this claim for insurance benefits is signed. Furthermore I authorize Sjóvá to obtain necessary information from the State Social Security Institute, pension funds, trade unions, tax authorities and from other insurance companies as needed for deciding liability and the amount of insurance benefits that result from the accident. This statement entails that I accept the processing of personal data in accordance with Act No. 77/2000, with the proviso that I may revoke this acceptance by written notification to Sjóvá. Sjóvá treats all information it acquires as confidential, but it may be necessary to deliver this form to the above stated parties for data collection.
	Request that benefit payments be deposited into bank account no. _____ - _____ - _____ _____ Town/City and date _____ Signature of injured person