ACCIDENT REPORT

SJÓVÁ

To be filled out by the injured person

GENERAL INFORMATION

Name of injured person _____ ID no. _____

Address _____ Postcode _____ Town/city _____

Phone (home) _____ Phone (work) _____ Mobile _____

e-mail _____

Name of insurance policy holder (if not the injured) _____

ACCIDENT INFORMATION

Place of accident _____ Date of accident _____ Time _____

How did the accident happen? (Give details) _____

_____

_____

Was the police notified? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No If yes, who? _____

Were you under the influence of alcohol/drugs? ☐ Yes ☐ No If yes, describe in more detail _____

_____

Check where applicable:

- ☐ Traffic accident
- ☐ Leisure-time accident
- ☐ En route to/from work
- ☐ Sport activities
- ☐ Other

CONSEQUENCES

Description of bodily injury due to the accident (in detail) _____

_____

Are/were you unable to work due to the injury? ☐ Yes ☐ No

If yes, state the period and the percentage of inability to work. From _____ to _____ Perc. _____%

Will your injury affect your income? ☐ Yes ☐ No If yes, from what date? _____

TREATMENT

When did you first seek treatment for the injury? _____ ☐ Have not sought physician/treatment

Where did you first seek treatment for the injury? _____

Name of general practitioner _____

Address _____

Name of other physicians/treatment centres _____

_____

Address _____

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FORMER HEALTH

Have you sustained other or similar injuries before the accident? ☐ Yes ☐ No

If yes, which? _____

Have you suffered from any kind of illness before the accident? ☐ Yes ☐ No

If yes, which? _____

Have you previously been hospitalised due to any accident/illness? ☐ Yes ☐ No

If yes, when and why? _____

Any former disability evaluations? ☐ Yes ☐ No

If yes, when? _____ Percentage of disability _____%

OTHER INFORMATION

_____

_____

_____

_____

_____

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 information may affect my right to receive insurance benefits.

Bank account information: _____ – _____ – _____ **SSN (Kennitala):** _____

_____ _____

City and date Signature of injured person

CLAIMS REPORT – ACCIDENT

SJÓVÁ

To be filled out by the injured

AUTHORISATION FOR RELEASE OF INFORMATION

I hereby authorise Sjóvá to gather any necessary information and documents from doctors, hospitals, clinics or other treatment centres regarding my state of health as well as prior/later accidents or illnesses the company considers relevant for assessing this claim.

This authorisation includes e.g. Sjóvá´s right to access information in my medical journals if considered necessary. Furthermore, I authorise Sjóvá to obtain any necessary information and documents from The Icelandic Health Insurance and Social Insurance Administration, pension funds, tax authorities, trade union sick-pay funds, AOSH (Administration of Occupational Safety and Health), police and other insurance companies as necessary to determine liability and benefits.

I realise that this authorisation includes consent for processing sensitive personal data in accordance with law 77/2000, and that my concent can be revoked by writtent statement to the company.

All personal information is treated as confidential and access restricted to those who process the claim or have been granted clear permission/authority, I understand that incomplete information may affect my rights to receive benefits.

Date of injury	Signature of claimant
City and date	ID number