Please send claim form to:

anmeldelse@aig.com

AIG Europe S.A.
Bryggernes Plads 2
DK-1799 København V
TLF +45 91 37 53 00

www.aig.dk

CLAIM FORM – Accidental Death

It is important that you complete this form in as much detail as possible. If this claim form has been completed correctly we will be able to settle the claim faster.

If you have any questions regarding your claim or how to complete this form please do not hesitate to contact our claims department.

Best regards
AIG Europe S.A.

anmeldelse@aig.com

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Claim form – Accidental Death

POLICY HOLDER

Job title	Policy no.
Name	Social Security no./
Address	ZIP code and city

DECEASED

Job title	Social security no. /CPR
Name	
Address	

DESCRIPTION OF THE ACCIDENT

When did the accident occur?	Date	Time
Where did the accident take place?		
How did the accident occur? (It is important that the event is described thoroughly in order for us to understand correctly what happened)		
1. What happened just before the accident occurred?		
2. How did the accident happen?		

MEDICAL INFORMATION

When did the deceased receive initial medical treatment?	Date	Time
Name & address of the medical physician/hospital?		
Were the deceased – to your knowledge - completely healthy and fit when the accident occurred? ☐ Yes ☐ No	If No was the deceased injured/ill?	

OTHER INFORMATION

Did the accident occur during leisure time? ☐ Yes ☐ No		Did the accident occur during transport to work? ☐ Yes ☐ No	
Did the accident occur during self-employment including farming? ☐ Yes ☐ No		Did the accident occur during military service or during work for another party (including voluntary work in a club or the like)? ☐ Yes ☐ No	
Did the accident occur during work? ☐ Yes ☐ No			
If yes who was the deceased working for?			
Has the accident been reported to the Workers Compensation Insurance? ☐ Yes ☐ No			
If yes, for which company?			
Claim no. /policy no.?			

POLICE REPORT

Was the accident reported to the police? ☐ Yes ☐ No	If yes, which department was it reported to?
Do you know if a blood alcohol test was made? ☐ Yes ☐ No	

TRAFFIC ACCIDENT

Was the accident a road accident? ☐ Yes ☐ No	
Was the deceased driver or passenger in a car? ☐ Dri- ☐ Passenger	Was the deceased driver or passenger on a motor cycle? ☐ Dri- ☐ Passenger

OTHER INSURANCE

Did the deceased have any other health or accident insurance? ☐ Yes ☐ No	If yes which?	Policy no.
Has the accident been reported to other insurance companies ? ☐ Yes ☐ No	If yes, which date?	

BEREAVED SPOUSE

I, spouse to the deceased hereby certify the above to be the truth. As I submit our marriage certificate I solemnly declare that my marriage to the deceased was not invalid due to separation or and divorce but that the deceased and I were married until his/her death.	
Date	Signature

IF THE DECEASED DID NOT LEAVE A SPOUSE BUT CHILDREN

If the deceased has not left a spouse but children please specify names, date of birth, date of death. (This applies to children – alive or dead, born both in and out of wedlock and adoptive children but not step children) If one or more children are deceased, names, addresses and CPR for these children must be specified under "additional relevant information" as these children may inherit from the insured. Please submit birth or		
Name	**Social security no.**	**Date of death**
Address		
Name	**Social security no.**	**Date of death**
Address		
Name	**Social security no.**	**Date of death**
Address		
Name	**Social security no.**	**Date of death**
Address		
Child/guardian:		
Additional relevant:		

SIGNATURE

I hereby declare that the above information is correct. I agree that AIG may obtain medical information about the deceased and information relevant to the assessment of the event and the claim. This consent is only applicable from the time the insurance commenced until the time of the final assessment of the claim. For additional medical information another special form must be used if AIG determines it. AIG may obtain information from authorised medical physicians/nurses, hospitals, other health institutions or clinics, public authorities, pension funds and insurance companies. Other insurance companies, pension funds, The Workers Compensation Board, and other authorised persons who become involved in the claim may receive relevant information as well. I also permit AIG to obtain a copy of the autopsy report.	
The signer's family connection to the deceased	
Name	
Address	
ZIP code/City	**By**
Telephone number daytime	**Telephone number night-time**
Date	**Signature**