Please send claim form to:

anmeldelse@aig.com

AIG Europe S.A.
Bryggernes Plads 2
DK-1799 København V
TEL +45 91 37 53 00
www.aig.dk

CLAIM FORM – ACCIDENT

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.

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CLAIM FORM - Accident

POLICY HOLDER

SE/CVR no.	Policy no.
Company name	Contact person
Address	ZIP code and city

INSURED

Job title and date of employment	Social security no.
Name	Bank registration and account no.
Address	ZIP code and city
Phone number/cell phone	E-mail

ACCIDENT

When did the accident take place?	Date	Time
Where did the accident take place? At work? ☐ Yes ☐ No During leisure time? ☐ Yes ☐ No During paid or voluntary work for another ? ☐ Yes ☐ No	Address	

How did the accident happen? (It is important that the event is described thoroughly)

What caused the accident to happen?

What part(s) of your body were injured?

Were you under the influence of alcohol or any other intoxicating substance when the accident happened? – If yes please provide further information. ☐ Yes ☐ No

Were you completely healthy and fit when the accident took place? If No why not?	☐ Yes ☐ No
What is your profession?	

POLICE REPORT

Do you have a police report? ☐ Yes ☐ No	If yes, which department was it reported to?

OTHER INSURANCE: THIRD PARTY LIABILITY INSURANCE, WORKERS COMPENSATION INSURANCE, ACCIDENT & HEALTH INSURANCE

Has the accident been reported to other insurance companies? ☐ Yes ☐ No	If yes which?	
Company name	Policy/claim no.	What type of insurance?
Are you a member of Health Insurance denmark? Yes/No – if yes , which group? (1,2,5 ☐ Yes ☐ No		

MEDICAL TREATMENT

When did you see hospital/doctor first time?	Date	Time
Name of hospital/doctor, address		
Doctor	Name	
	Address	
Hospital	Name	
	Address	
Other	Name	
	Address	
Who is your family Physician?	Name	
	Address	

EMPLOYER'S SIGNATURE

I confirm that the employee was employed at the date of the incident.

City and date	Employer's signature

SIGNATURE

Accident and sickness insurance
With my signature, I consent to AIG collecting, using and disclosing, in connection with the consideration of my case, the information relevant for the company's consideration of my case.

AIG collects information to be able to assess whether my injury is covered by the accident insurance and whether I have suffered a permanent injury and, if so, the degree of permanent injury. In this connection AIG may disclose information that identifies me (such as my civil registration number) and relevant information about my insurance case and my health to the parties from which the company collects information. AIG will specify to the parties from which information is collected what information is relevant.

From whom can information be collected?
With this consent, AIG may for one year from the date of my signature collect relevant information from the following parties:

- My current and former general practitioner.
- Public and private hospitals, clinics, centres and laboratories.
- Medical specialists, dentists, physiotherapists, chiropractors and psychologists.
- Labour Market Insurance (https://aes.dk/).
- Other insurance companies to which I have reported my injury.
- The police.
- Others (state the name and other relevant contact information).

With this consent, the specified parties may for one year from the date of my signature disclose the relevant information to AIG.

To whom may relevant case information be disclosed?
With this consent, AIG may disclose relevant case information to the following parties in connection with the consideration of my case:

- Labour Market Insurance (www.aes.dk).
- Medical specialist who is to fill in or prepare a medical specialist’s certificate.
- Other insurance companies to which I have reported my injury.
- Sygeforsikringen "danmark" (Health Insurance "danmark") if I receive any reimbursements for the treatment covered.
- Others (state the name and other relevant contact information).

What types of information may be collected, used and disclosed?
The consent covers collection, use and disclosure of the following categories of information:

- Medical information, including information about illnesses, symptoms and contacts to the health services.
- Police reports, form with description of the accident and notification of the police.
- Decisions made by Labour Market Insurance in cases relevant to my current accident insurance case.

For what period of time may information be collected?
The consent covers information for a period of 5 years prior to the date of occurrence or the time of onset of the illness and until the time when AIG has considered my case. If the information for that period so warrants, AIG may, providing a specific reason, also collect information relating to the time before that period.

Withdrawal of consent
I can withdraw my consent at any time with effect for the future. The withdrawal may affect the ability of AIG to consider my case.

Date: …… **Signature: ……** **Social Security no.: _ _ _ _ _ _ - _ _ _ _**