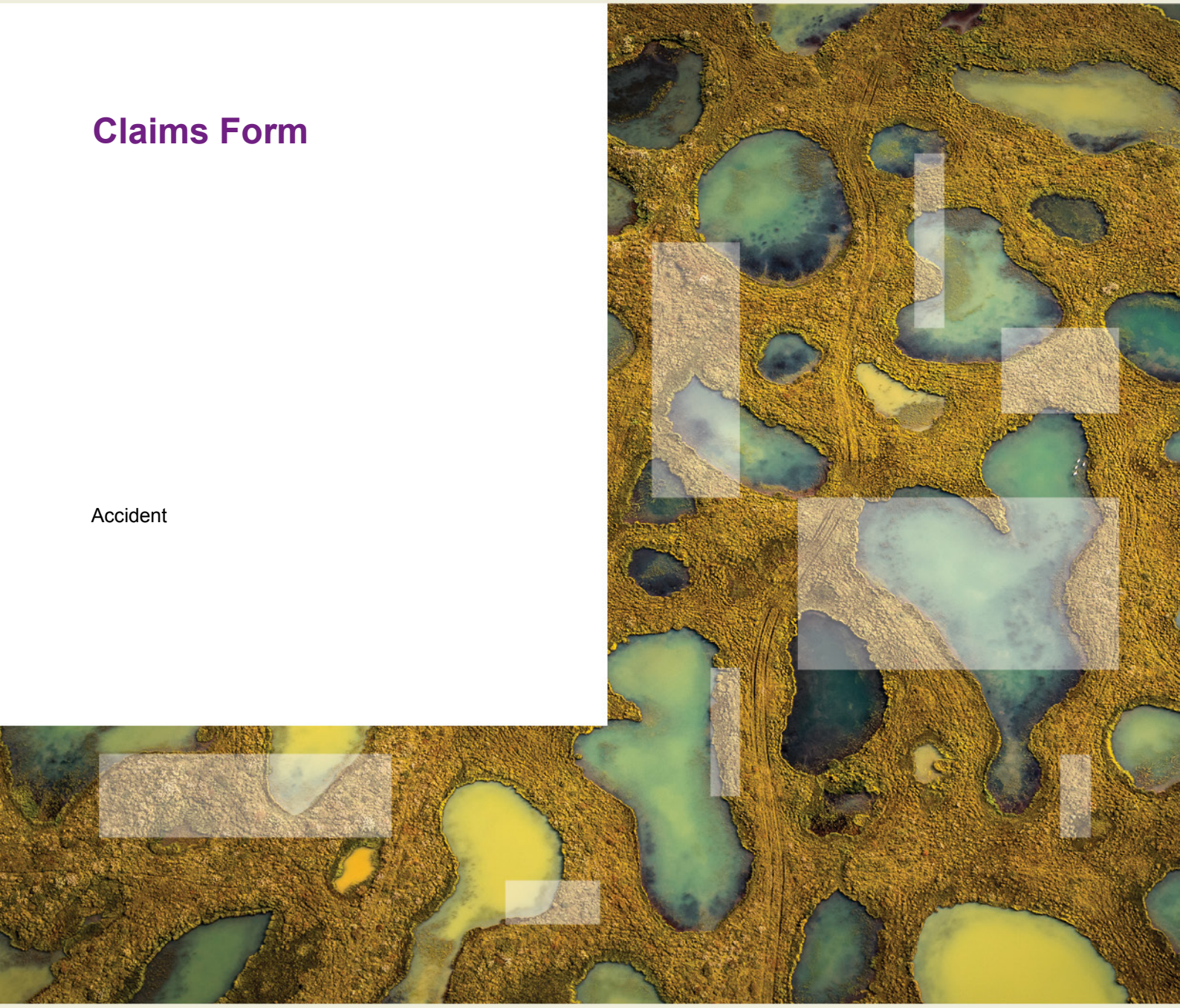
Willis Towers Watson

Claims Form

Accident



Please fill in the form clearly in capital letters.

The filled in claims form should be sent via e-mail with the relevant documents attached to your usual contact person at Willis Towers Watson. Your contact person will subsequently file the claim with the insurance company.

1. Company Information

Policy Holder / Company Name			
Contact Person	Name	Phone Number	E-mail
Insurance Company		Policy no.	

2. Information on Aggrieved Party

Name	CPR Number
Address	Postal Code and Town/City
Phone Number	E-mail
What is your daily work	

3. Information about the Accident

Date of Damage	Time of Incident	Place of Incident / Address	
When did the accident occur?	☐ During my spare time ☐ At work (paid/unpaid)	If the accident occurred at work, state the employer's name and address.	
Describe how the accident occurred and its cause.			
If the incident occurred at work	Which type of work were you carrying out, when the accident occurred?		
	☐ The incident has been filed as an occupational injury		
	If 'x' was marked above, state the name of the insurance company and policy no.		

4. Injury and Treatment

Which body parts were injured?
In which way are the body parts injured?
On which date were you first examined/treated?

5. Information on Previous Injuries or Illness

Were you completely well, when the incident occurred?	☐ Yes ☐ No	If no, describe why not
Do you suffer from any chronic or prolonged illness?	☐ Yes ☐ No	If yes, which one
Have you previously had injuries, discomforts requiring treatments, or illness connected to the body part, which is now damaged	☐ Yes ☐ No	If yes, write a description and indicate when
If you answer yes to the above-mentioned, indicate when and what the consequences have been.		
Was a claim submitted at that time to an insurance company?	☐ Yes ☐ No	If yes, indicate the policy no./name of insurance company

6. Medical Treatment

When did you receive medical treatment? Date		Time
Where did the treatment take place?	☐ Physician ☐ Hospital ☐ Other	Name and Address of the Treatment Facility
Has there been subsequent treatment?	☐ No ☐ Physician ☐ Hospital ☐ Other	Name and Address of the Treatment Facility
Information about your G.P. Name	Address	Phone Number

7. Information about Insurance in Another Insurance Company

Do you have accident insurance in another insurance company?	☐ Yes ☐ No	If yes, state insurance company and policy no. below
Insurance Company		Policy no.

8. In Case of Traffic Accident

Were you	☐ Driver ☐ Passenger	If "x" in "Driver", a copy of your driver's license must be attached
In which vehicle did the accident occur	☐ Car ☐ Motorcycle ☐ Moped 30 ☐ Moped 45 ☐ Other	If "x" in "Other", indicate vehicle type
Has the accident been reported to the motor third party insurance?	☐ Yes ☐ No	If yes, state insurance company and policy no. below
Insurance Company		Policy no.
Is there a counterparty?	☐ Yes ☐ No	If yes, indicate counterparty's data below
Counterparty's name		Address
Insurance Company		Policy or Vehicle Registration Number

9. Police Report

Has a police report been filed?	☐ Yes ☐ No	If yes, name of police station

10. Sygeforsikringen Danmark

Are you member of Sygeforsikringen Danmark?	☐ Yes ☐ No	If yes, indicate your group

11. Signature

Compensation can be paid into the bank account stated below Bank Code No. Account No.
I hereby declare that my answers and information submitted are in full accordance with the truth. I am aware that false information or non-disclosure may have the consequence that the compensation is reduced or completely voided. I consent to THE INSURANCE COMPANY contacting me, should they need my consent in order to obtain further information from physicians, medical institutions, insurance companies, and public authorities, which may contribute to a correct assessment of my condition. Date Name in capitals and signature