

Bodily injury damage claim

(excluding work-related accidents)

POLICY NUMBER

POLICYHOLDER

Surname (or name of institution) and address

INTERMEDIARY

Name and address (or stamp)

Agent's number

File number

FSMA number

VICTIM

Surname and first name

Street and number

Postcode

Town/city

Date of birth

____/____/____

Telephone number

E-mail

Payment via account*

Held in the name of*

IBAN* _____

BIC _____

Relationship to the policyholder

Parent child grandchild other family member apprentice volunteer staff member unpaid helper

Other: _____

Only for traffic accidents: in what capacity was the victim injured

pedestrian cyclist passenger moped driver motorcycle driver (≥ 50 cc) driver of vehicle

ACCIDENT

Town/city

Day(s) _____ Hour(s) _____:_____ Date ____/____/____

Police report Yes No Police report number _____ Date ____/____/____

Alcohol test: Yes No Result: _____

Bodily injury damage claim

(excluding work-related accidents)

Precise description of cause and circumstances

Accident filed under another policy Yes No

If 'Yes', Type of policy: hospital legal assistance other bodily accident industrial accident
 other: _____

Policy number _____ Company _____

LIABILITY

Possible liable third party – name and address

Insurance company

Number of the third-party liability insurance policy

KBC Insurance NV, Professor Roger Van Overstraetenplein 2, 3000 Leuven, will use the medical details that you as the party concerned (policy holder, insured party, member or beneficiary) provided in this form to conclude, manage or implement your personal insurance contracts.

Medical details are defined as any personal details relating to the past, present or future physical or psychological state of health of the person concerned that are directly related to that person's state of health. Access to medical details is restricted to those categories of persons who need them for the purposes stated. You can receive a list upon request. You are also entitled to ask KBC Insurance for your medical details. If, despite everything, these details are inaccurate, you may of course ask to have them corrected. In all cases, you should send your request in writing to the Privacy Department of KBC, Brusselsesteenweg 100, 3000 Leuven. Please send this form to the consulting physician of KBC Insurance.

For general questions concerning privacy, please contact the Privacy Commission (www.privacycommission.be).

The undersigned hereby declares that, based on the information, they grant permission in writing to KBC Insurance to use their medical details in accordance with this privacy clause. Legal representatives are acting on behalf of the legally incompetent person (such as a minor) they are representing.

Drawn up in _____ on ____/____/____

I agree to submit the claim. I have read and accept the privacy clause.

Party introducing the claim

The intermediary

Party introducing the claim

Medical certificate

POLICY NUMBER

FIRST NAME AND SURNAME

DOCTOR

Name and address (or stamp)

VICTIM

Name

Date of the accident

____/____/____

NATURE OF THE INJURIES

DID THE VICTIM ALREADY SUFFER FROM INJURIES OR ILLNESSES WHICH MIGHT HAVE WORSENERED THE SITUATION?

Yes No

Which injuries or illnesses?

Since when?

WHEN WAS THE DOCTOR'S ASSISTANCE FIRST REQUESTED?

Date ____/____/____

Doctor's name and address

Medical certificate

THE VICTIM IS:

able to continue working as normal

wholly unfit for work starting date ____/____/____ anticipated end date ____/____/____

partially unfit for work

_____ % starting date ____/____/____ anticipated end date ____/____/____

_____ % anticipated starting date ____/____/____ anticipated end date ____/____/____

IS FULL RECOVERY POSSIBLE?

Yes, please specify when _____

No, please specify future outcome (e.g., death or permanent work disability, etc.)

Drawn up in _____ on ____/____/____

Doctor (signature and stamp)