ARGOS GROUP
Route des Avouillons 30 - 1196 Gland
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Company / Claim Service / Address

NOTICE OF CLAIM ACCIDENT OR ILLNESS INDIVIDUAL

◯ Accident
◯ Illness
◯ Assistance

Location: _____ , on _____

Insurance Holder: _____ Policy No.: _____

Person insured: _____ Date of Birth: _____ AVS No.: _____

Address: _____ Relationship to the Insurance Holder: _____

Contact person: _____ Tel: _____ Fax: _____ E-mail: _____

Date of Event: _____ Place of Event: _____

Is the person insured subject to UVG ? ◯ Yes ◯ No Does the person insured work more than 8 hours per week ? ◯ Yes ◯ No

Circumstances:

Did the accident take place on the way to work ? ◯ Yes ◯ No

Was anyone responsible ? ◯ Yes ◯ No If yes, name and adress: _____

Police report: _____ Police station: _____

Witnesses: _____ (Attach police report or complaint filed)

Damages

Onjuries or ailment: _____ Part of body affected: _____

1st doctor: _____ Continuation of treatment: _____

Incapacity to work: ◯ Yes ◯ No If yes, since: _____ (Attach Certificate of Incapacity to Work)

Monthly AVS salary or conventioal: _____

Other insurances (accidents or illness): _____ Company: _____ Policy No.: _____

Indemnity to be paid to:

◯ Care provider (attach CCP payment slip)
◯ Insurance Holder

CCP No.: _____

IBAN: ____ - ____ - ____ - ____ - ____ - __

Bank: _____ Place: _____

Account Holder: _____

Enclosures:

Signature: _____

Send to Agent | Erase | Print