Accidental Death or Disability Insurance

Notification for lump-sum payments

This form must be completed by the insured person or the insured person's legal representative. You can find all the information about the product and the required form at css.ch/add. Please complete the form in full and send it to us as quickly as possible to the address shown on the last page. Without your information, we are unable to review your entitlement to benefits. Thank you for your cooperation.
If you are reporting a death, please ignore points 3.1 and 3.2.
Questions 3.1 and 3.2 do not need to be answered for children younger than 15.
Any questions? Our Contact Center will be happy to help on 0844 277 277.

Client number

☐ Disability ☐ Death

1 General information

1.1 Details of insured person

First name | Surname | Date of birth | Street address

Postcode / town | E-mail | Phone | Available at (time)

1.2 Details of person making report

First name | Surname | Date of birth | Street address

Postcode / town | E-mail | Phone | Available at (time)

2 Circumstances of accident

2.1 When, where and how did the accident happen?

Date | Time

Location of accident | Country

Please describe how the accident happened (what you were doing, weather conditions, and the persons, vehicles, animals or machines, etc. involved)

2.2 Did the police file an accident report?

☐ Yes ☐ No

If yes, by which precinct?

3 Insurance

3.1 Who was your employer at the time of the accident?

Name of employer | Street address

Postcode / town | Number of hours per week

3.2 Do you know the name of your employer's accident insurance company?

☐ Yes ☐ No

If yes, name of insurance company?

Name of insurance company

Claim number

4 Injuries

4.1 What injuries did you suffer?

Nature of injury

Part of body

☐ Right ☐ Left

4.2 Who treated you first (doctor / hospital / dentist)?

Name

Postcode / town

4.3 Do you have any other accident insurance cover?

☐ Yes ☐ No

If you have other accident cover, please include a copy of your policy.

Name of insurance company

Name of agency

Policy number

5 Remarks

Please confirm these details with your signature. Many thanks for your support.

The undersigned person hereby confirms that he or she has answered all questions in this form truthfully and in full.
The undersigned person hereby assigns to CSS any liability claims arising from the accident referred to above up to the amount in benefits it has paid and acknowledges that CSS may assert its claims against third parties.
By signing the accident report, the applicant authorises CSS to share information and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover, while respecting statutory provisions on data protection.
In such cases, all parties involved are released from the obligation to maintain professional or patient confidentiality with respect to CSS.

The undersigned person is entitled to request information about the data pertaining to him or her that is being processed. Consent to the processing of data may be revoked at any time.

Legal entity for basic insurance (KVG): CSS Kranken-Versicherung AG or Arcosana AG, legal entity for supplementary insurance (VVG): CSS Versicherung AG

Place

Date

Signature of the insured person or his or her legal representative

Please return to:
CSS Versicherung AG
Special Insurance Competence Center
P. O. Box 2568
6002 Lucerne

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