

Reporting a case

Legal expenses insurance for patients or Legal expenses insurance while abroad

As the insured person or their legal representative, please complete the form in full and send it to the address given on the last page.

Only then can we verify your entitlement to benefits.

Any questions? Our Customer Service Centre will be happy to help on 0844 277 277. Thank you.

Client number

1 General information

1.1 Insured person

First name

Surname

Date of birth

Street, house number

Postcode/town

1.2 Contact

Private Phone

Mobile

Business phone

What is the best time to reach you?

Where?

Private

Mobile

Business

Email

Contact person for questions

1.3 Information about the insurance cover (will be filled out by CSS)

CSS Versicherung AG:

- myFlex Outpatient insurance including Legal expenses insurance for patients (Orion PRS policy no. 1.248.851)
- myFlex Outpatient insurance including Legal expenses insurance while abroad (Orion ARS policy no. 1.248.852)
- Legal expenses insurance for patients (Orion policy no. 1.262.223)
- Legal expenses insurance while abroad as part of Travel insurance (Orion policy no. 1.262.224)
- Legal expenses insurance for patients ex INTRAS (Orion policy no. 1.245.965)
- Outpatient insurance including Legal expenses insurance for patients ex Sanagat (Orion PRS policy no. 1.262.225)
- Outpatient insurance including Legal expenses insurance while abroad ex Sanagate (Orion ARS policy no. 1.262.226)

1.4 Information about the claim

If the claim relates to **Legal expenses insurance for patients**, please complete, **sections 2, 4, 5 and 6**.

If the claim relates to **Legal expenses insurance while abroad**, please complete, **sections 3, 4, 5 and 6**.

2 Legal expenses insurance for patients

2.1 Information about the service provider

Where were you treated?

Hospital

Practice

Other

Name and address of the service provider (hospital, doctor, etc.)

| | | |
|------------|---------|-------|
| First name | Surname | Phone |
|------------|---------|-------|

| | |
|----------------------|---------------|
| Street, house number | Postcode/town |
|----------------------|---------------|

Name of the person who in your opinion made the error in treatment/committed malpractice:

| | | |
|------------|---------|-------|
| First name | Surname | Phone |
|------------|---------|-------|

| | |
|----------------------|---------------|
| Street, house number | Postcode/town |
|----------------------|---------------|

2.2 Information about the claim

When was the incorrect treatment carried out?

Date

In your opinion, what did the incorrect treatment/malpractice consist in?

Precise description

What health problems have you suffered since the treatment?

Precise description

Are you unable to work? Yes No

3 Legal expenses insurance while abroad

3.1 What happened?

3.1.1 When did the event take place?

Date

3.1.2 Where did the event take place?

Place, Country

3.1.3 What happened? (Please provide a full and accurate description of what happened, including sketches and photos etc.)

(Please use another sheet of paper if you run out of space.)

3.1.4 What do you disagree with and what do you want to achieve?

[Empty text box for 3.1.4]

3.1.5 Against whom would you like legal support?

[Empty text box for 3.1.5]

3.2 Description of the damage suffered

3.2.1 Was anyone injured?

Yes No

If yes: Who?

First name

Surname

[Text box for First name]

[Text box for Surname]

Nature of injury

[Text box for Nature of injury]

Attending doctor/hospital

[Text box for Attending doctor/hospital]

Accident insurance with SUVA

Yes No

Other accident insurance

Name of insurance company

Policy no.

[Text box for Name of insurance company]

[Text box for Policy no.]

General health insurance company

Name of general health insurance company

Policy no.

[Text box for Name of general health insurance company]

[Text box for Policy no.]

3.2.2 Was any property damaged?

Yes No

If yes: Nature of damage/loss?

Precise description

[Large text box for 3.2.2 description]

Approximate amount of damage caused

CHF

[Text box for CHF amount]

When and where can the damaged property be inspected?

Precise description

[Large text box for 3.2.2 inspection details]

Insurance policies of your own which may be liable:

Name of insurance company

Policy no.

[Text box for Name of insurance company]

[Text box for Policy no.]

Name of insurance company

Policy no.

[Text box for Name of insurance company]

[Text box for Policy no.]

3.3 Traffic accident or breach of road traffic regulations

3.3.1 Vehicle data of the vehicle you were using:

| | |
|---|--------------------------------|
| First name of the registered user | Surname of the registered user |
| <input type="text"/> | <input type="text"/> |
| Street, house number | Postcode/town |
| <input type="text"/> | <input type="text"/> |
| Registration plate | |
| <input type="text"/> | |
| Name and address of the liability insurance company of the vehicle used | |
| <input type="text"/> | |

3.3.2 If your vehicle was damaged:

Does it have fully comprehensive insurance cover? Fully comprehensive Partial No

If yes:

Name and address of the company providing fully comprehensive insurance

Has the claim already been reported? Yes No

Has your vehicle already been repaired? Yes (please enclose the invoice) No

Has an expert opinion been sought? Yes No

If yes:

Name, address

3.3.3 Driver of the vehicle: (only to be completed if not the same as the policyholder or registered user entered in section 1)

| | | |
|----------------------|----------------------|----------------------|
| First name | Surname | |
| <input type="text"/> | <input type="text"/> | |
| Street, house number | Postcode/town | |
| <input type="text"/> | <input type="text"/> | |
| Private phone | Mobile | Business phone |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Email | | |
| <input type="text"/> | | |

3.3.4 Was the driver of your vehicle in possession of a valid driver's licence? Yes No

3.3.5 Was an accident statement form completed? Yes No

If yes, by whom? Police Drivers involved Other

4 Documents and other evidence

Contracts, correspondence relating to the case

Date on which the decision was communicated

Rulings/decisions from the authorities

Any appeals submitted against such rulings/decisions

Accident statement

Police report

Medical certificate (in the event of work incapacity)

Invoices from doctors and hospitals

Photographs

Repair bills, receipts and other documents relating to the damage suffered

Copies of claims reported to other insurers (e.g. liability or fully comprehensive)

Witnesses

Name, address

Other/enclosures

5 Additional information

Do you / does the insured person have further legal protection insurance policies?

Yes No

Name of insurance company

Policy no.

Name of insurance company

Policy no.

6 Authorising signature

Orion Rechtsschutz-Versicherung AG, CSS Kranken-Versicherung AG and CSS Versicherung AG process the data disclosed to them by the undersigned person and which they obtain from third parties with the consent of the undersigned person to the extent necessary for handling claims. The undersigned person authorises the aforementioned insurers to inspect any documents required by the aforementioned insurers in dealing with this legal case, to share information if necessary, and to take any legal steps that they deem useful or necessary. Moreover, the undersigned person releases the relevant lawyers, doctors and medical advisors of the aforementioned insurers from their mutual obligation to maintain professional secrecy in connection with the reported case.

The privacy policy of CSS Versicherung AG at css.ch also applies.

Town

Date

Signature of the insured person or his/her legal representative

Address of the insurer:

CSS, Special Insurance Competence Centre, P.O. Box 2568, 6002 Lucerne