Injury Claim Form

This notice has to be forwarded, one for each victim, completed and signed without undue delay to PANTAENIUS

Policy Holder:

Name/Company:

Address:

Phone: | Fax:

Mobile No.: | Email:

Policy No.: | Customer No.:

Date of claim:

Victim:

Name/Company:

Address:

Phone: | Fax:

Mobile No.: | Email:

Date of Birth: | Profession:

Relationship with the Policy Holder:

Description of the accident:

(Please give detailed description of the date, location, course and cause) if needed, please use a separate sheet.

Number of passengers:

On board at the time of the accident:

Was the vessel chartered at the time of accident?

Yes ○ No ○

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Are there witnesses?

If needed, please use a separate sheet. ◯ Yes ◯ No

Please give names and addresses:

Where was the witness at the time of the accident?

Did the police record the accident?

◯ Yes ◯ No

Please indicate the name and place of the police station:

Who was the skipper/captain at the time of the accident?

Name and address:

Please indicate type and number of the nautical licence:

Which consequences resulted from the accident?

Type and extent of injury:

Was the victim hospitalised?

◯ Yes ◯ No

Please indicate name and location of the hospital:

In case of death:

When and where did the death occur?

Which physician determined the death?

Cause of death?

Please forward the death certificate

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Does the victim suffer from a mental or physical handicap?

○ Yes ○ No

If yes, which?

Name and address of the doctor treating the above mentioned conditions:

Did the victim suffer from a disease or disability before the accident?

(Such as epilepsy, diabetes, dizziness, apoplexy, nervousness, sight or hearing deficiencies…) ○ Yes ○ No

If yes, which?

Name and address of the doctor treating the above mentioned conditions:

Does the insured party hold any further accident, passenger accident, life insurance with accident supplement or insurance e.g. via the employer?

if needed, please use a separate sheet ○ Yes ○ No

Company 1:	Contract No.:

Address:

Sum of indemnity in case of disability:

Sum of indemnity in case of death:

Company 2:	Contract No.:

Address:

Sum of indemnity in case of disability:

Sum of indemnity in case of death:

Does the victim benefit from social security or private health insurance?

○ Yes ○ No

If yes, which?

Name:

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Address:

Explanations and instructions – please read attentively and fill in where required:

Professional secrecy – Discharge declaration

I herewith agree that the Insurer will examine the information and the documents (such as medical certificates etc.) provided/submitted by me and related to the mentioned claim, as well as information given to a hospital or persons belonging to the health and medical care. Thus, I herewith free any person belonging to the health and medical care and/or hospital staff mentioned in the provided information or, who took part in the treatment, from their professional secrecy. I also authorise the release of any medical information to the Insurer or to PANTAENIUS acting on behalf of the Insurer as required to settle all eligible benefits.

I agree when submitting the claim to Pantaenius, that my personal data will be saved and made available to insurers, surveyors, law firms and other authorities etc. in so far Pantaenius deems this necessary in order to handle the claim. After closure of the claim, my data will be saved according to the data protection law currently in force.

I, the undersigned ____ complete and sign the present notice of claim for the Insured of whom I am the legal representative and who cannot judge the meaning of this notice on his/her own (for example for persons under age).

Important

Please be aware that when an accident occur you are obliged to provide us with detailed and correct information about matters which affect the determination of whether the accident is covered by the insurance, the assessment of the benefits, or the claims for cover which the insurer may have against others. We pay your attention to that if you fraudulently dicloses or conceal matters of importance for this, the insurance cover shall be lost.

I acknowledge, being responsible for the content of this notice of claim in case it was not completed by myself.

Date/Place:	Policy Holder's Signature:	Signature of victim (or his/her legal representative):

Germany · United Kingdom · Monaco · Denmark · Austria · Spain · Sweden · USA* · Australia

Skive · Phone +45 9751 3388

pantaenius.dk

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