

Claim Form Children's accident in Dental injury

Please avoid using staples – use a paper clip instead! We will scan any enclosures

Policyholder

Name
Address
Postal code
Town/city

Claim no.

(to be completed by Privatsikring)

Policy no.
Tel. (home)
Tel. (work)
Social Security no.

Signature

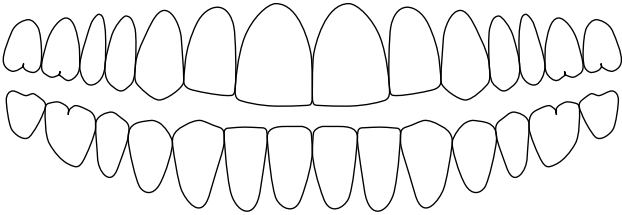
Declaration relating to information

I hereby declare that the statements and information given are true in every respect. I am aware that any misrepresentation and non-disclosure may result in the compensation being reduced or not being paid.

Privatsikring's assessment of your information

Privatsikring will retain your information. Privatsikring may obtain additional information about you and your injury through publicly available media, sources and witnesses etc. in order to assess your claim. Privatsikring will retain the information for as long as it may be necessary in relation to your insurance and the claims made.

Date	Policyholder signature
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Email	If you prefer to communicate via email, please state your email address here	
Injured child	Name	
	Parents' names (if none of the parents is the policyholder)	
	Address	
	Postal code	Town/city
Details about the injury	When did the accident occur (day/month/year)?	Where did the accident occur (address)?
	Was the accident reported to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of police station
	Did the accident occur during work performed by the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of employer
	Has personal accident insurance been taken out for the child with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of insurer and policy no.
	How did the accident occur? (a description must be given even if the accident was reported to the police)	
Which teeth were injured?	Mark the injured teeth with an X. Set of teeth viewed from the front	
		
	The injured teeth are (please tick box) <input type="checkbox"/> Milk teeth <input type="checkbox"/> Permanent teeth	