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INCIDENT REPORTING accident notification

Insured			
Name		**Policy number**	1110025473
Address		**City**	
Phone number		**Country**	
E-mail		**Identification number**	

Accident description (filled in by the insured, or legal representative for a minor insured)			
Date of injury	**Hour of injury**	**Place of injury**	
The first treatment was given on (date)			
Description of the accident (what activity was performed at the time of the accident, the cause of the accident)			
Was the ski equipment damaged in connection with the accident? Describe			
Description of injury			
Did the injury happen during a sport activity? ☐ **yes** ☐ **no**		**Do you practice sports competitively or under registration in a sports club?** ☐ **yes** ☐ **no**	
Name and address of the organization, or sports club		**Since when?**	
Was this part of the body already functionally impaired (injury, disease)? ☐ **yes** ☐ **no**	**When?**	**What injury?**	
Address of the doctor, medical facility where you were treated, where the complete medical documentation is stored			**Phone number**
Did the police investigate the accident? ☐ **yes** ☐ **no**	**Police address**		

Instructions for the payment (to be completed by the insured or the legal representative for the minor insured)	
I would like to show the insurance payment:	
to the account (IBAN)	**Name of the bank**
☐ **yes, I declare that I am the owner of the mentioned account**	☐ **no, the account belongs to a spouse or close relatives, please state the owner of the account and the relationship**

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Declaration of the legal representative of the minor insured (completed by the legal representative of the minor insured)		
Surname of the legal representative	**Name, title**	**Identification number**
Relationship to a minor		**Phone number**

I honestly declare that I am authorized to represent and manage the minor's affairs and I am aware of the consequences if I provide false information in the declaration.
I acknowledge that PREMIUM Poisťovňa, pobočka poisťovne z iného členského štátu, processes the personal data mentioned in this notice in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27, 2016 on the protection of natural persons in the processing of personal data and on the free movement of such data, which repeals Directive 95/46/EC (General Data Protection Regulation) and relevant Slovak legislation. At the same time, the insurance company informs the affected person that information on the processing of personal data can be found at: www.premium-ic.sk

Consent to the processing of personal data

I declare that I have answered truthfully, completely and the given data correspond to reality.
I acknowledge that PREMIUM Poisťovňa, pobočka poisťovne z iného členského štátu, processes the personal data listed in this notice as well as other personal data provided in connection with the insurance contract in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27 2016 on the protection of natural persons in the processing of personal data and on the free movement of such data, which repeals Directive 95/46/EC (General Data Protection Regulation) and relevant Slovak legislation. At the same time, the insurance company informs the affected person that information on the processing of personal data can be found on the website www.premium-ic.sk
I agree that the company PREMIUM Poisťovňa, pobočka poisťovne z iného členského štátu, processes my personal data regarding my state of health by finding and checking them (and subsequently processing these data) in all medical facilities providing health care and with all doctors, as well as obtaining extracts from medical documentation and borrowing medical documentation for the purpose of ascertaining the veracity of the information provided by me in the insurance contract and assessing the insurance event. At the same time, to the extent mentioned, I release all doctors from confidentiality towards the Company in matters related to my state of health.
I note that I can revoke my consent to the processing of personal data at any time by sending a written appeal to the address of the Company's registered office.

☐ YES, I CONSENT ☐ NO, I DO NOT CONSENT

Signature of legal representative

In	Date	Signature of the insured or legal representative of the insured	Identity document number

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ATTENDING DOCTOR'S REPORT

The costs associated with filling out the form for the insurance company are borne by the insured, or authorized person for the payment of insurance benefits.

Name and surname of the attending physician					
Name and address of the medical facility					ZIP Code
Phone number			E-mail		
The attending physician confirms that the insured: Name and surname of the insured					Identification number
☐ treated the injured insured and discovered physical damage caused by the accident ☐ prepared an accident report based on health. documentation from the treatment of the insured's injury issued by the medical facility:					
The first medical treatment of the injury (according to the medical documentation) was:			date		hour
in a medical facility					Phone number
A detailed description of the physical damage caused by the accident, specifying its extent and cause					
Injury diagnosis (Slovak - Latin, International classification of diseases)					
The extent of physical damage corresponds to the accident event listed on the front of the form? ☐ yes ☐ no Why:					
Method and type of treatment (description of treatment, in case of rehabilitation, state the frequency, duration and its results)					
Description of findings –	RTG,	MR,	CT,	Sono, other... (indicate always if the given examination was performed)	
An operation was performed? ☐ no ☐ yes				What kind??	
Was the insured hospitalized? ☐ no ☐ yes	from		to	Where?	
Reason for hospitalization					
Actual time of necessary injury treatment (including complications)			from	to	Number of weeks
Incapacity for work due to the treatment of the injury lasted			from	to	Number
Name and surname of the doctor, address of the medical facility that issued the incapacity for work					
Has there been an increase in the average time of injury treatment? ☐ no ☐ yes			State the cause and type of complications (infection, inflammation, etc.)		
Do you assume that the injury will leave permanent consequences? ☐ no ☐ yes			Briefly describe what kind and scope?		
Was the injured part of the body already functionally disabled before the accident? ☐ no ☐ yes			How and to what extent?		
Was there an accident under the influence of alcohol? ☐ no ☐ yes			Alcohol detected in the blood ‰		
Did the injury occur under the influence of narcotic or toxic substances or drugs? ☐ no ☐ yes			What kind?		

I declare that the given data are true, complete and correspond to reality.	In Date	Stamp and signature of the attending physician