

# Traffic Accident Claim Form



Name of the injured party \_\_\_\_\_ ID No. \_\_\_\_\_

When did the accident occur? Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Time \_\_\_\_\_

Where did the accident occur?  During leisure time  During working hours  Travelling directly to/from work

Location of accident \_\_\_\_\_

Vehicle registration no. \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Were the police called to the scene?  Yes  No      Were there witnesses to the accident?  Yes  No

If so, specify name(s) and ID No/s. \_\_\_\_\_

Where did the injured party receive medical assistance? \_\_\_\_\_

Name of physician / treatment centre in Iceland \_\_\_\_\_

Description of injury/illness. \_\_\_\_\_

Was the injured party healthy and fit for work prior to the accident?  Yes  No

If no, what illness/injury was involved? \_\_\_\_\_

Has the injured party been in an accident before?  Yes  No

Has the injured previously been assessed for disability?  Yes  No

If yes, specify injury/disease, who performed the assessment and the disability in %. \_\_\_\_\_

Which physicians have treated the injured party before and after the accident? Specify name/s of the treating physician/s. \_\_\_\_\_

If my claim is approved, I request that compensation be deposited into my bank account No. \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ ID no. \_\_\_\_\_

VIS Insurance Ltd is under legal obligation to deduct withholding tax from per diem payments paid and return to the Treasury. Therefore, the claimant must return the tax card to VIS Insurance Ltd in order to use the personal tax allowance.

I hereby declare that I have answered all questions truthfully and according to the best of my knowledge. I have not withheld any information that might be of importance to VIS in connection with determining and assessing the liability for compensation as regards the above event.

\_\_\_\_\_  
Date and place

\_\_\_\_\_  
Signature

# Informed consent



To be completed by claimant

Date of loss, damage or injury \_\_\_\_\_

## Informed consent

I authorise VÍS, ID no. 690689-2009 to gather information and supporting documentation from physicians, hospitals, healthcare centres and other medical treatment institutions/treatment entities about my current health as well as information about previous/more recent illnesses and accidents that are important for the assessment of the liability to pay and the indemnification claim.

Furthermore, I authorise VÍS to gather any necessary information and supporting evidence about income/payments and entitlements from Tryggingastofnun Ríkisins (The State Social Security Institute), pension funds, unions, employers and tax authorities as necessary for determining the amount of the compensation claim. Likewise, I authorise VÍS to submit inquiries to my former/present employer about any period(s) of inability to work that may be attributed to the above event.

VÍS may also obtain reports and statements from the Administrator of Occupational Safety and Health concerning the accident for which this claim form is being filed. Finally, VÍS may gather any necessary information and supporting evidence about earlier claims for other insurance companies as may be necessary for determining liability to pay compensation and the amount of the compensation claim with respect to the above occurrence.

All information will be treated as confidential. The above statement entails an approval to process personal data pursuant to Act No. 77/2000. This approval may be revoked at any time by written notice to VÍS.

\_\_\_\_\_  
Date and place

\_\_\_\_\_  
Signature and ID. no of claimant

\_\_\_\_\_  
Signature and ID. no of witness 1

\_\_\_\_\_  
Signature and ID. no of witness 2