

Name of policyholder _____ ID no. of policyholder _____
Address _____ Postal Code _____ City _____
Email _____ Phone _____

Name of injured person _____ ID no. _____
Job title _____ Phone _____ Email _____

Did the accident happen on route to/from work? No Yes

Place of accident _____

When did the accident happen? Date _____ Month _____ Year _____ Time _____

How did the accident happen (detailed description) _____

Were there any witnesses? No Yes, who? _____

Was the police notified? No Yes Did the police arrive to the scene of the accident? No Yes

Description of the injuries and consequences (detailed description) _____

When did you first seek medical treatment for the injury? _____

Were you of good health and able to work before the accident? No Yes

If no, what injuries/sickness did you suffer from? _____

Were you under the influence of alcohol/drugs? No Yes

Any former disability evaluations? No Yes

If yes, state the reason, who performed the evaluation and the outcome in % _____

Should compensations be deposited please provide bank account no _____ / ____ / _____ ID no. _____

Since VÍS is legally obliged to withdraw income tax from paid daily benefits, claimant has to turn in his tax card in order to use potential personal tax credit

I, the undersigned, do hereby truthfully attest that the above answers and information I have provided herein are to the best of my knowledge correct. I have not concealed any facts that might be of importance with respect to any decision VÍS may make regarding its liability in the above mentioned event.

Town/city and date

Signature of injured person

Informed consent

To be filled out by the claimant

Vátryggingafélag Íslands hf
Ármúla 3, 108 Reykjavík, 560 5000
kt. 690689-2009, www.vis.is



Date of the accident _____

Informed consent

I hereby authorize VIS, ID no. 690689-2009 to obtain information from medical doctors, hospitals and other treatment facilities regarding my present state of health and with regard to previous/later illnesses or accidents that may be of importance to VIS when this claim for insurance benefits is processed.

Furthermore I authorize VIS to obtain necessary information from the State Social Security Institute, pension funds, trade unions, tax authorities, as well as reports from the Administration of Occupational Safety and Health and information from other insurance companies as needed for deciding liability and the amount of insurance benefits that result from the accident.

VIS treats all information it acquires as confidential.

This statement entails that I accept the processing of personal data in accordance with Act No. 77/2000, with the proviso that I may revoke this acceptance by written notification to VIS.

Town/city and date

ID no. of injured person

Witness 1 - Signature and ID no.

Witness 2 - Signature and ID no.