Claims form for Accident insurance for students, who carry out laboratory work at Aalborg University

The completed claims form has to be sent to The Secretariat at Study Service by email to sts-sekretariatet@adm.aau.dk along with any additional information (such as pictures, doctors forms etc.).The Secretariat at Study Service will then forward the accident report to the insurance company.

1. Information about the company

The Policy Holder: Aalborg Universitet	Department:
Contact person – Name and phone number ;	Contact person - e-mail:
Insurance company: If Skadeforsikring	Policy number: SP 1526844

2. Information about the injured party

Name:	Cpr-nr:
Address	Postal code and city:
Phone number :	E-mail:

3. Information about the accident

Date of accident :	Time of accident :	Location of the accident/address:
Where did the accident happen:	Any accident outside of Aalborg University premises, please inform where the accident happened and in what connection you were on the premises?	
Describe how the accident happened and what caused the accident?		
If the accident happened, whilst the injured was carrying out work at the place of internship:	What work did you carry out at the time of the accident?	Has the accident been registered with the place of internships workers compensation insurance?

4. How were you injured, and how have you been treated?

What body part was injured?
How was the body part injured ?
What date did you first receive an examination/ or treatment?

5. Medical Treatment

When did you receive medical treatment (date and time)	
Where did you receive medical treatment?	Name and address of treatment place/ centre
Have you received follow up treatment?	If yes, please detail name and address of treatment place/ centre
Named, address and phone number of your general practitioner:	

6. Information about previous injury or illness

Were you completely healthy at the time of the accident?	(please X the answer) YES ? ☐ NO ? ☐	If NO, please give details:
Do you suffer from a chronic illness or a prolonged period of Illness?	(please X the answer) YES ? ☐ NO ? ☐	If yes, please give details:
Have you previously had an injury, treatment or an illness in the injured body part?	(please X the answer) YES ? ☐ NO ? ☐	If yes, please give details, including dates:

7. Information about accident insurance with another insurance company

Are you accident insured in another insurance company?	If yes, please give details:

8. “Sygeforsikringen Danmark”

Are you a member of Sygeforsikringen Danmark?	If yes, which group level?

9. Signature and consent

If applicable; the compensation should be paid into the below mentioned bank account; Reg. number. / account number.	
I hereby declare that my answers and information are in full accordance with the truth. I am aware that falsified information, concealment of the truth or relevant information can/ and will lead to a decrease or complete denial of any rightful/applicable compensation. I hereby consent that the insurance company (If skadesforsikring) can request information from the doctors, medical treatment centres, insurance companies and public authorities, which can help determine the correct level of the injury. If skadesforsikring can also inform the above doctors, medical treatment centres and other insurance companies, what has been stated by me in this claim form. If the injury has been registered, with the police authority and/or Arbejdsskadestyrelsen, I hereby consent that If Skadesforsikring can request information from the above mentioned parties.	
Date	Full Name and signature