COLONNADE
A FAIRFAX COMPANY

DECLARATION OF DAMAGE FROM PERSONAL ACCIDENT INSURANCE FORM

1. PERSONAL DETAILS:

Insurance agreement number (list all your Colonnade agreements):	
Have you claimed damage settlement with Colonnade in the past ❑ yes (list the reference number): ❑ no	
First and last name of the harmed:	Date of birth:
Contact address:	Phone no.: E-mail:
Name of policy holder, if different from the Insured:	ID:
Relationship with the harmed:	
Occupation at the time of accident/disease:	
Description of work activity:	
Current occupation:	

2. DETAILS OF ACCIDENT: (fill this in if you claim insurance benefits due to accident)

Date of accident:	Time:	Place of accident
Circumstances of accident: (state in detail how and during what type of activity the accident happened)		
Which part of body was harmed? For paired body parts: ❑ right ❑ left Had the body part been harmed before the accident? ❑ yes ❑ no How?		
Did the injury occur during an automobile accident ❑ yes ❑ no What kind of accident? Who caused it?		
Were the circumstances of the accident been investigated? ❑ yes ❑ no By whom?		
Names and contact addresses of witnesses:		
Did the injury occur during exercise of profession? ❑ yes ❑ no Was the injury classified as a work accident? ❑ yes ❑ no		
Were you an active sportsperson during the incident? ❑ yes ❑ no What kind of sport? Were you registered with any sport organization? ❑ yes ❑ no Name of the organization: From: to: What kind of sport? Which competitions? Do you (did you) have a professional sport contract ❑ yes ❑ no What kind of sport?		

3. DETAILS OF SICKNESS: (fill this in if you claim insurance benefits due to sickness)

When did the first symptoms of the disease occur?
Circumstances of the disease: (specify by virtue of what kind of sickness you are claiming insurance benefits)
Have you suffered from this disease in the past? When? How and where were you treated?
Was the disease classified as occupational/work-related ❑ yes ❑ no

4. DETAILS OF HEALTH PRACITICIONER/MEDICAL FACILITY:

Where was the first treatment provided? (address of the facility, name of the doctor, date and time of treatment)?
Where were you treated further? (address of the facility, name of the doctor, from - to)?
Your current general practitioner (where you leave your medical documentation):

5. DETAILS OF HEALTH CONDITION:

Have you applied for disability pension?	❑ yes	❑ no	When?	For what reason?
Has your request been confirmed?	❑ yes	❑ no		

From:	to:	❑ full	❑ partial	For what reason?
From:	to:	❑ full	❑ partial	For what reason?

6. DETAILS OF AUTHORIZED PERSON: (fill it in in the case of the death of the Insured)

First and last name:	Relationship with the Insured:	Personal identification no.:
Contact address:		Phone no.:

7. PAYMENT OF INSURANCE BENEFITS:

❑ Send to bank account:											Bank:	Bank code:					Symbol:

Declaration:

I hereby confirm that all listed information is true and complete and am aware of the consequences any incorrect answers might have on the insurance company´s obligation to fulfil its duties. I agree that Colonnade Insurance S.A. has the capacity to request any necessary medical documentation of my treatment and my health condition for the purpose of investigating the insured event.

Pursuant to the law n. 101/2000 Sb. on the protection of personal details, the Insured gives consent to and allows Colonnade Insurance S.A., organizational unit, Na Pankráci 1683/127, 140 00 Praha 4, ID: 04485397 (hereinafter „administrator") the processing of his/her personal details, including intimate information:

- to the extent necessary for the fulfillment of the rights and obligations in the insurance agreement, i.e. the extent to which the Insured makes such information available to the administrator in a declaration of an insured event and any further handling of it (via the form „Declaration of an insured event") and to which the administrator obtains it from the medical facility, pursuant to § 2828 of the law n.89/2012 Sb, of the Civil Code;

- for the purpose of the settlement of claims in case of an insured event in accordance with the mutual rights and obligations listed in the insurance agreement;

- for a duration necessary for the fulfillment of all rights and obligations consequent upon the insurance agreement.

By making available your personal details to Colonnade in connection to an insured event you acknowledge that Your personal details will be collected and processed pursuant to the law n. 101/2000 SB. on the protection of personal details, and in accordance with our Rules for protection of personal details, which you can find at www.colonnade.cz/ochrana-osobnich-udaju.

The processing of personal details will be done by the administrator or by proxy chosen by the administrator. In all cases, all obligations consequent upon the law n. 101/2000 Sb. will be upheld by either the administrator or said proxy, and the Insured will be protected from false intervention into his/her private life. The provision of personal details is voluntary. However, in the case of intimate information, such provision is necessary in order for the insured event to be properly investigated and, consequently, for the claims to be settled based on the investigation results.

The Insured has the right to:

- be given access to personal information that is being processed about him/her,
- request that the insuring party corrected his/her personal information in case it did not reflect the reality,
- require an explanation by the insuring party, or, as the case may be, require that the insurer amended any arisen detrimental situation in case the insurer learned of or suspected that the administrator processed his/her personal information contrary to the protection of private life of the insurer or contrary to the legal enactments,
- in the case of breach of contract by the administrator to turn to the Bureau for the protection of personal details with the request for provision of remedial measures.

In	Date:	Signature:

Send the completed Declaration of damage form along with the Medical report and other required documents (Release note from the hospital, Confirmation of incapacity for work, Statement of facts on motor vehicle accident, Officially verified copy of death certificate, personal identity documentation, etc.) to the following address:

Colonnade Insurance S.A., organizational unit
Department of claims handling
V Celnici 1031/4
110 00 Praha 1, Prague

e-mail: skody@colonnade.cz
Tel: +420 234 108 311
Fax +420 234 108 387

www.colonnade.cz

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MEDICAL REPORT

Where and when (according to the health documentation) the injury happened / When did the first health complications occur? (date and time):			
When did the first medical treatment take place? (date and time, name of the doctor, address of the medical facility)			
Diagnosis and detailed description of physical injury caused by accident / sickness:			
RTG (date, place, description):			
Type of treatment:			
Surgery (date, extent a form of medical intervention):			
Hospitalization (from – to, medical facility, department): (please add a copy of the hospital release note)			
Rehabilitation (from – to, medical facility, type and frequency of RHB):			
Complications (what kind, from – to, treatment method):			
Total time of treatment (incl. complications)	From:		To:
Incapacity for work issued	From:		To:
Period for which incapacity for work would be issued for individuals who have not been issued an incapacity for work note:	From:		To:
Reason why incapacity for work has not been issued:			
Other health disorders before the accident and their connection to the accident:			
The Injured is:	o right-handed		o left-handed
Had the injured body part been negatively affected before the accident?		o yes	o no
In what way?			
Was the injury occurred as a result of alcohol / drug consumption?	o yes	o no	What substances?
Was the patient tested for blood for this purpose?	o yes	o no	
Were there traces of alcohol found in the blood?	o yes	o no	To what extent?
Was intentional self-harm the cause of the injury?	o yes	o no	
Do you anticipate permanent consequences due to the injury?	o yes	o no	
To what plausible extent? (as a percentage formulation)			

Has the Injured suffered from this disease or a related one in the past?: o yes o no What kind? When, how, and where was it treated?
Other comments of the doctor:
I confirm that the data in the MEDICAL REPORT refer to the individual indicated on the opposite side of the DECLARATION OF DAMAGE form In Date: Address of the medical facility, name of the doctor, ID, phone no. Stamp, doctor´s signature