



# Accident Insurance

For horse riders/carers of horses

## Claim notification form

### Obligatory in the event of a claim:

In the case of **death**, the insurers should be notified by **telephone, fax or e-mail** at the latest **within 48 hours** of the accident.

Written notification should be given at the latest **within eight (8) days** of the accident in the event of the possibility of **permanent disablement**

#### Policy number

\_\_\_\_\_

#### Horse involved

Name of horse: \_\_\_\_\_

Chip number / studbook number: \_\_\_\_\_

Horse Insurance policy number: \_\_\_\_\_

#### Personal details

Name of the person concerned: \_\_\_\_\_

Address, postcode and town/city: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Sex:

male

female

BSN-number (formerly "sofi" number): \_\_\_\_\_

Civil status:

married

unmarried

Profession: \_\_\_\_\_

fulltime

parttime

Telephone no. (work): \_\_\_\_\_

Mobile Phone no.: \_\_\_\_\_

Telephone no. (home): \_\_\_\_\_

Bank account no.: \_\_\_\_\_

E-mailaddress: \_\_\_\_\_

How many horses do you currently own: \_\_\_\_\_

#### 1. The incident

Where did the accident happen?

(full address) \_\_\_\_\_

When did the accident happen?

Date: \_\_\_\_\_

Time: \_\_\_\_\_

In which municipality? \_\_\_\_\_

#### 2. Explanation

Detailed description of the occurrence leading to a claim and mention of the cause of the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### 3. Outcome

Nature of injury: \_\_\_\_\_  
\_\_\_\_\_

Cause of death: \_\_\_\_\_  
\_\_\_\_\_

#### 4. Vehicle involved

Make of car / motorcycle / moped: \_\_\_\_\_

Distinguishing features: \_\_\_\_\_

Make of bicycle: \_\_\_\_\_

#### 5. Questions concerning the incident

The accident occurred during:

Riding

Care

Other, viz.:

The horse belongs to the insured person:

Yes

No

A riding cap was being worn at the time of the accident:

Yes

No

N/a

#### 6. Police

Was a report drawn up?

Yes

No

If so, who was the officer recording the \_\_\_\_\_

details?  
 At which police station was this done?

**7. Witnesses**  
 Names and addresses of any witnesses:

**8. Use of medical adviser**  
 Name, address, place of residence and telephone number  
 - of general practitioner:  
 - of specialist(s):

On what day, at what time and by which doctor was first medical assistance provided?  
 Is the person concerned still undergoing regular medical treatment?  Yes  No  
 What is the (estimated) duration of the treatment?  
 On what date did the person concerned cease work?  
 Where and when can the insurers' supervising physician visit the person concerned?

**9. General**  
 What other details can you provide that may be of importance for the assessment of this accident?  
 Is the accident attributable to the fault of third parties?  Yes  No  
 If so, who? \_\_\_\_\_  
 Does the person concerned also have an accident Insurance with another company?  Yes  No  
 If so, with which company? \_\_\_\_\_  
 How is the claim identified at this institution? Policy number: \_\_\_\_\_  
 Claim number: \_\_\_\_\_

**Declaration** The undersigned hereby declares that the information given above has in all respects been provided truthfully and without reservation.

**Signature**

Date:	Signature of the person concerned/interested party	Signature of the policy holder:
Town/City:	(in case of minors: parent/guardian)	