CAISSES SOCIALES DE MONACO

C.C.S.S. - C.A.M.T.I.

ACCIDENT REPORT

VICTIM

C.C.S.S. ID number: .... *of the insured if the victim is not the insured person*	**C.A.M.T.I. ID number:** .... *of the insured if the victim is not the insured person*
SURNAME:	First Name: ....
Maiden name:	Date of birth: ....

Address: ....

....

Email address: ....

Telephone:	Mobile : ....
Employer name:	Employer telephone: ....

ACCIDENT

Nature (please tick)

- ☐ traffic accident
- ☐ assault and battery (assault)
- ☐ animal bite
- ☐ sporting accident
- ☐ accident at school
- ☐ other (please specify, e.g. fall...) ....

Exact circumstances of the accident .... on ..../......./.......

....

....

....

....

....

....

Did this accident occur:

☐ during **work** ☐ during the **journey to or from work**

☐ **outside** the work environment

In this case, can liability for the accident be attributed to a third party (natural person or legal entity, for example: company, store, etc.)? (please tick)

☐ Yes ☐ No

If yes, please read the back of this form, complete it and attach:

→ The medical certificate recording the injuries,

→ A copy of the accident statement.

Description of the injuries:

....

....

....

....

Drawn up in .... Signed:

on ....

"In accordance with Law no. 1165, as amended, you have the right to access and amend the personal information relating to you. For more information on the processes implemented, you can consult the "Data Protection" section on the www.caisses-sociales.mc website."

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INFORMATION	
	Information about the person responsible for the accident: SURNAME: .... First Names: .... Adress: .... Name of the insurance company covering the risk (civil liability, car insurance, etc.) : .... **Full** address of the agency: .... Claim no.: .... Policy no.: .... In the event of a traffic accident, vehicle registration no.: ....
	Information about the victim: Name of the insurance company covering the risk (civil liability, car insurance, etc.) :ⓘ .... **Full** address of the agency: .... Claim no.: .... Policy no.: ....
	If the victim was a passenger in a vehicle involved in an accident: Surname, first name and address of the driver: .... Name of the driver's insurance company for the vehicle: .... **Full** address of the agency: .... Claim no.: .... Policy no: ....

ⓘ **Important** :

In your interest and to prove the expenses incurred by your accident to the third party responsible, we recommend that you:

➲ *check that the information given by your doctor or medical auxiliary on your treatment form under the "conditions treated for the person receiving the care" section, expressly states whether or not the treatment for which reimbursement is claimed relates to an accident caused by a third party, and gives the date of this accident.*

➲ *take photocopies of all the medical expenses claim forms and invoices that you send to the fund for reimbursement.*

➲ *keep the itemised statements that will be sent to you as a single copy by the fund with each reimbursement.*

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