ASSOCIATION D'ASSURANCE ACCIDENT

DECLARATION OF AN ACCIDENT AT WORK / A COMMUTING ACCIDENT

The declaration must be completed, according to the instructions, **by the employer or his representative.**

1. EMPLOYER

1.01 Name of the company, the administration or first and last name of the employer

1.02 Address

1.03 Employer's social security number

2. INSURED

2.01 First and last name of the insured

2.02 Social security number of the insured

2.03 Address

2.04 Temporary worker? ☐ Yes ☐ No

If applicable, name of the temporary employer

If applicable, social security number of the temporary employer

2.05 The insured works : ☐ Full-time ☐ Part-time

Please indicate the regular number of hours worked per week ____ hours / week

2.06 Insured's occupation (e.g. painter, teacher, accountant)

3. INFORMATION CONCERNING THE ACCIDENT

3.01. Date and time of the accident

day / month / year H : m

3.02. Date and time of reporting to the employer or his representative

day / month / year H : m

3.03 Hours during which the insured worked or should have worked the day of the accident

morning from / to H : m / H : m

afternoon from / to H : m / H : m

3.04 Did the accident occur :

☐ at the regular workplace

☐ at an occasional or mobile workplace

☐ while commuting

Please indicate the address of the workplace if different from 1.02 :

In case of a road accident :

- was the insured in : ☐ a company car ☐ a private car ☐ other
- was the insured : ☐ the driver ☐ the passenger ☐ other
- was a friendly accident report filled out? ☐ Yes ☐ No
- was a police report established? ☐ Yes ☐ No

3.05 Detailed description of the **location or the insured's workplace when the accident occured** (in case of a road accident, please specify the exact location: e.g. locality, street, motorway exit, etc.) In case of an accident abroad, please indicate the country.

3.06 Detailed description of the activity or task the insured was performing at the moment of the accident.

3.07 List of objects involved in the accident (e.g. tools, machines, equipment, materials, instruments, substances, etc.).

3.08 Description of events that deviated from the normal process and led to the accident (e.g. wet or slippery floor).

3.09 If applicable, please specify the public authority (e.g. Police, ITM, CGDIS, ...) which was notified / was on site of the accident :

3.10 Was(Were) there any eyewitness(es) ? ☐ Yes ☐ No If applicable, name(s) and address(es) of the witness(es)

3.11 Name, address and function of the first person notified in the company

4. PREVENTIVE MEASURES

4.01 Which preventive measures were in place when the accident occurred?

4.02 Which preventive measures have been taken or should be taken in order to avoid a similar accident in the future?

5. CONSEQUENCES OF THE ACCIDENT ACCORDING TO THE INSURED'S INFORMATION

5.01 ☐ **No injury**, only material damage to the vehicle -> **Please continue with point 6.**

5.02 **In case of injury**, please indicate the **nature** of the injury(ies)

- ☐ Superficial wounds and injuries
- ☐ Bone fractures
- ☐ Dislocations, sprains and strains
- ☐ Concussions and internal trauma
- ☐ Other injury(ies), please specify:
- ☐ Effects due to noise, vibration and pressure
- ☐ Effects due to extreme temperature, light or radiation
- ☐ Shock (emotional / psychological)
- ☐ Burns and frostbites

5.03 Please indicate the **location** of the injury(ies)

☐ Head	Eye(s)	☐ left	☐ right
☐ Neck	Shoulder(s)	☐ left	☐ right
☐ Back	Arm(s), including elbow(s)	☐ left	☐ right
☐ Chest	Hand(s)	☐ left	☐ right
☐ Stomach, pelvis	Leg(s), including knee(s)	☐ left	☐ right
	Foot / feet	☐ left	☐ right

☐ Other injured body part(s), please specify:

5.04 If applicable, name and address of the first attending physician

Date of consultation : day / month / year

Doctor code (if known) : ☐☐☐☐☐☐ - ☐☐

5.05 If applicable, name of the hospital attended

5.06 Consequences of the injuries

- ☐ Death of the insured
- ☐ The insured did not interrupt his work
- ☐ The insured left work on

day / month / year at ☐☐ H : ☐☐ m

The insured :

- ☐ resumed work on day / month / year
- ☐ did not resume work

Please indicate the end of the expected disability on the certificate of work incapacity (if known) day / month / year

6. SIGNATORY (EMPLOYER OR REPRESENTATIVE)

6.01 First and last name of the employer or his representative

6.02 Function of signatory

6.03 Telephone number

6.04 ☐ By checking this box, I wish to express my doubts regarding the truth of the facts. **I am required to attach a detailed statement of doubt.**

6.05 Place and date

, the day / month / year

6.06 Signature of the employer or his representative

Please fill out all the sections before sending this form **by computer** or if it is filled by hand with **black ink in capital letters**.

Any incomplete form will be returned !

The declaration must be sent to **Association d'assurance accident**,
either to the postal address L-2976 Luxembourg,
by fax to the number +352 495335 or
by e-mail (**PDF format**) to the address
declaration.aaa@secu.lu