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Client Questionnaire/Vehicle accidents

PERSONAL DETAILS:
1. Client's Name:____ Profession:__________
2. Client's Address:_______________________________________ Phone:______________
3. Fax:________________________
4. Driver's Name:_____________________________________
5. Driver's Address:___________________________________

OPPONENT`S DETAILS:
1. Opponent's Name:_________________________________
2. Opponent's Address:________________________________ Phone:_______________
3. Insurance Company:___________________________________ Policy Nr.:____________
4. Registration Number:_________________________________
5. Driver's Name:____________________________________
6. Driver's Address:__________________________________ Phone:_______________

THE ACCIDENT:
1. Location:______________________________ Date:_______________ Time:_______
2. Describe in detail how the accident occurred, if necessary draw a diagram (on a separate page or on page 2):

3. Witnesses Names, Addresses and phone numbers:_________________________________
____
4. Police Department investigating the accident:_____________________________________
record token:___________________________

CLAIMS DUE TO ACCIDENT
1. What got damaged? ____
2. Who is its owner, if different:____
3. Input Tax? □ Yes □ No
4. Estimated costs due to the accident (expertise, bills, opinion etc.)
5. Damaged thing can be seen at:_________________________________ Phone:__________

CLAIMS DUE TO VEHICL ACCIDENT
1. Vehicle Type:____________________ Registration Date:___________________
Km:________
Chassis Number:_________________ Vehicle Identification Number:____________
Registration-Number:__________________
2. When the accident occurred, the **vehicle** was insured (your responsible insurance):
Indemnity Insurance:
Insurance Company (Office):____________________________ Policy Nr.:______________

Comprehensive collision coverage:
Insurance Company (Office):______________________________ Policy Nr.:_______________
Retention: €_______________

Comprehensive coverage excluding collision:
Insurance Company (Office):______________________________ Policy Nr.:_______________
Retention: €_______________
Legal Protection Insurance:
Insurance Company (Office):______________________________ Policy Nr.:_______________

CLAIMS FOR PERSONAL DAMMAGES:
1. Name and Address of injured person:____
2. Date of Birth:_________________________ Number and age of kids:_______________
3. Profession:___________________________ self employed: □ Yes □ No
Monthly net income:______________ €
4. Name and Address of employer:____
5. The injured person gets a pension (because of an other incident than this accident)?
□ Yes □ No From whom?____________________ monthly:_________€

6. State all injuries known or believed by you to have been received as a result of this accident: ____
____
7. Hospitalizations, Name and Address of hospital:_______________________________________
Date admitted:____________________________ Date discharged:______________________
8. Medical treatment out of hospital, Name and Address of doctors:______________________
____
9. Period of disability: from___________________ to_________________________
10. Health Insurance Company of injured person:_____________________________________
11. Occupational accident, or did the accident happen on the way to work?
□ Yes □ No
12. Employers` Liability insurance association: _______________________________________

The injured person authorizes his doctors to pass on information to the involved insurance companies: □ Yes □ No

____
(City, Date, Signature)

Diagram of the accident: