GENERAL INSTRUCTIONS IN CASE OF AN ACCIDENT POLICY 99 664 990

1. Send this declaration to federations@ag.be or by post to CONCORDIA NV, Sassevaartstraat 46/301 Ghent
2. The medical care costs will be reimbursed as follows:
   - For insured persons who benefit from the intervention of a health insurance fund: 150% of the difference between the NIHDI rates for relevant care and the intervention of the health insurance fund
   - For medical costs not included in the NIHDI rates = up to max. € 500 per accident
3. Accident declaration to be used only for accidents occurring during VVW activities

DETAILS VICTIM

Name:_____ First name:_____

Bank account number: BE_____ Date of birth:_____

Adress:_____ Postal code:_____ Municipality:_____

Tel:_____ E-mail: _____

DEATILS ACCIDENT

Date:_____ Time:_____ Location:_____

Details of the witness (name, address, telephone number): _____

Which discipline were you practicing at the time of this accident: _____

Did the accident happen during competition/exercise/leisure?_____

Causes and circumstances of the accident: _____

_____

ADDITONAL INFORMATION

1. a. Which club are you affiliated with? b. Which sport do you practice at VVW?	_____ _____	
2. Can you benefit from hospitalization insurance in your name? Was it underwritten personally or through your employer?	NO	YES
3. Did you participate as a non-member in a VVW organization with day license: internship or sports camp?	NO	YES
4. Did you participate as a non-member in a sports promotional activity?	NO	YES
5. Does the injured person benefit from "Sickness and Disability" insurance (Health Insurance Fund) as a compulsory (+ free) insured person? Name and address of the Health Insurance Fund:		

Drawn up in: _____

On: _____

Signature of the victim

STATEMENT BY THE PERSON IN CHARGE OF THE CLUB

Undersigned: _____

In the name of: _____

Confirm that the accident occurred during activities arranged with the consent of the VVW.

Drawn up in :_____ On:_____

Signature:

MEDICAL CERTIFICATE (To be completed by the attending physician)

Doctor: Address:	
Victim: name – first name	
Date of accident: Date of first examination	
Identified injuries	
Incapacity arising from the injuries:	COMPLETE (1) – DURATION: _____ PARTIAL: DEGREE:_____DURATION: _____ _____
Predicted consequences:	

Is this injury due to the accident described above: YES / NO

Has the person concerned previously been the victim of a sports accident?: _____

On which date?: _____

What were the injuries suffered then?_____

Does this possibly refer to a relapse?_____

The injured person is taken care of:_____

The treatment applied is as follows:_____

_____

Pre-existing, illness, body defects, which could abnormally aggravate the consequences of the accident are:_____

_____

The intervention of a physician specialist seems to be: REQUIRED/ NOT REQUIRED

A radiography is: REQUIRED/NOT REQUIRED

Hospital care is : REQUIRED/NOT REQUIRED

It is to be expected that the injuries indicated above will leave a permanent disability of _____%

Comments: _____

_____

_____

Drawn up in:_____on_____(date)

Signature and stamp

Doctors are kindly requested not to leave any question unanswered.