ace europe

Van Ingelgem
Assurances & Finance

ACE European Group Limited FSMA 2312
Av.des Nerviens, 9-31-bte 7
1040 Bruxelles-Belgium

Accident or illness claim form

TO BE COMPLETED BY THE MEDICAL PRACTITIONER IN CHARGE

1. Name and address	
2.Name, first name and address of the insured + district number	
3.**Date** and **time** of the accident/first date: symptoms of the illness	
4. When have you been contacted by the insured?	Date: time
5. Nature of the injury/illness	
6. Do you forsee a permanent disability? Which one and for which reason?	
7. Did you notice any disability or illness from which the insured suffers, besides the injury related to the accident? Which one?	
8. In which way could the disability or illness impact on the healing process?	
9. Is it required for the insured to keep in bed or confined his room ? For which period?	
10. Is the insured able to perform his occupation partially?	
11. Do you think the insured requires treatment in a hospital? For which reason? Anticipated duration?	
12. Evolution of the degree of disability Anticipated duration of the medical treatment	From to % From to % From to %
13. Anticipated date of healing	
14. Additional information	

Made out at

Stamp and signature of the medical practitioner

Important message: we specifically ask the medical practtioner to provide an answer to all questions stated hereabove. We likewise invite them to transmit confidential information to our medical team under a sealed envelope