Annex 4

A close relative has died following an accident

GENERAL INFORMATION

Claim-file reference (as detailed in accompanying letter): ……
Date, location and time of the accident: ……

1. Personal details of the victim

First name(s) and last name of the ased: ……
Date of birth: ……
Address: ……

2. Personal details of the declarant

First name(s) and last name: ……
Date of birth:……
Address: ……
Home telephone:…… Mobile telephone: ……
E-mail address: ……
Link with the victim: ……

3. Family status of the victim

Marital status: single – married – cohabiting (de facto cohabitation) – cohabiting (legal cohabitation) – widow(er) – separated – divorced

Name of spouse/partner ……
Date of birth: ……/……/……
Working status of spouse/partner:

□ full time
□ part time: …… hours/week

Household composition of the deceased:

	First name, last name	Date of birth	Dependent	Cohabiting
Spouse/partner			□ Yes □ No	□ Yes □ No
Child(ren)			□ Yes □ No	□ Yes □ No
			□ Yes □ No	□ Yes □ No
			□ Yes □ No	□ Yes □ No
			□ Yes □ No	□ Yes □ No
			□ Yes □ No	□ Yes □ No
Parent(s)			□ Yes □ No	□ Yes □ No
			□ Yes □ No	□ Yes □ No

Is there any kind of relationship with the perpetrator(s) of the accident (family ties or other)?

□ Yes □ No

If yes, please specify: ……

4. <u>Family income situation</u>

Working status of the deceased as at the date of the accident				Working status of the spouse/partner as at the date of the accident		
	Tick as appropr.	Since			Tick as appropr.	Since
Worker (blue-collar)	□			Worker (blue-collar)	□	
Employee (white-collar)	□			Employee (white-collar)	□	
Civil servant/military officer - statutory - contracted	 □ □			Civil servant/military officer - statutory - contracted	 □ □	
Self-employed	□			Self-employed	□	
Student/Child	□			Student/Child	□	
Retired	□			Retired	□	
Early retired	□			Early retired	□	
Jobseeker	□			Jobseeker	□	
In receipt of benefit from mutual health insurance provider	□			In receipt of benefit from mutual health insurance provider	□	
In receipt of benefit from CPAS/OCMW	□			In receipt of benefit from CPAS/OCMW	□	
Unemployed	□			Unemployed	□	
Other	□			Other	□	

[Logo insurance company]

If the deceased was in paid employment				If the spouse/partner is in paid employment			
Name and address of the employer: …… …… ……				Name and address of the employer: …… …… ……			
Contract	Full-time:	Part-time:		Contract	Full-time:	Part-time:	
No. of hours/ week				No. of hours/ week			
Wage/salary	Gross	Taxable	Net	Wage/salary	Gross	Taxable	Net
Per hour				Per hour			
Per month				Per month			
Per year				Per year			
Other benefits (bonuses, 13th month, meal vouchers, …): ……				Other benefits (bonuses, 13th month, meal vouchers, …): ……			

If the deceased was self-employed				If the spouse/partner is self-employed			
as □ main occupation □ secondary occupation				as □ main occupation □ secondary occupation			
	Tick as appropr.	Taxable income	Fixed costs		Tick as appropr.	Taxable income	Fixed costs
Company director	□			Company director	□		
One-person company	□			One-person company	□		
Independent worker (natural person)	□			Independent worker (natural person)	□		

Please enclose tax assessment notice for the past three years.

BCE/KBO no.: ……..

- If the deceased was a student:

Name of school/college: ……

Type and duration of course:……

Year of course at the time of the accident: ……

[Logo insurance company]

5. Circumstances of the accident

Did the accident occur

□ at work or on the way to work?

□ at school/college or on the way to school/college?

□ in private life?

- If the accident occurred at work or on the way to work:
  name and address of the occupational accident insurer of the deceased's employer:
  ……
  ……
  ……

- If the accident occurred at school/college or on the way to school/college:
  address of school/college and name and address of school's/college's insurer:
  ……
  ……

- Were there any witnesses to the accident? □ Yes □ No

If yes, please specify their identity (first name, name and address):

……

……

……..

- Was a bicycle or an electric bicycle involved in the accident? □ Yes □ No

If yes, please specify brand and type of bicycle: ……..……..……..

If yes, was it a bicycle that can autonomously (without pedal-assistance) exceed a speed of 25 km/h? □ Yes □ No

- Was a personal light electric vehicle involved in the accident (segway, hoverboard, monowheel,…) ? □ Yes □ No

If yes, please specify brand and type: ……

If yes, was it a vehicle that can autonomously exceed a speed of 25 km/h? □ Yes □ No

1. Material consequences of the accident

Description of damage to items other than a vehicle. Please enclose all supporting documents (receipts, invoices) and retain any damaged items.

Item	Description of damage	Date of purchase	Amount paid for item (estimation)

2. Bodily injury caused by the accident

Nature of the injuries: ……
……
……
……

Was the deceased admitted to hospital following the accident? □ Yes □ No
Name of the hospital:
……
……
……

In case of a hospital admission:
Date of admission ……/……/…… Date of discharge: ……/……/……

Please enclose the document 'Medical certificate to be completed by a doctor'.

6. Involvement of associations or insurers

What cover/insurances did the deceased hold? Please specify in the table below.

	Identity of the association/insurer	Reference
Occupational accident insurer		
Motor liability insurer		
Medical expenses insurer		
Hospitalisation insurer		
Personal accident insurer		
Income protection insurer		
Material damage insurer		
Travel insurer		
Mutual health insurance provider (mutualité/ziekenfonds)		
Public Social Assistance Centre CPAS/OCMW		
Other		

Mutual health insurance provider (attach a sticker):

Did the deceased hold personal/family civil liability cover? □ Yes □ No

Did the deceased hold legal expenses cover? □ Yes □ No

7. Comments

……

……

……

This is not an exhaustive questionnaire. Please provide any other useful or necessary information concerning the accident to which your relative fell victim.

The personal data collected by means of this document are processed by the recipient insurers of this document, who are the data controllers, for the following purposes: to manage the claims in question, in particular to ascertain and assess the bodily injury sustained by the undersigned or the person he or she represents; to detect and prevent fraud; for statistical purposes.

For these purposes only, these data may, if necessary, be passed on to other insurance companies involved in bodily injury compensation of the undersigned or the person he or she represents, to their representatives in Belgium, their correspondents abroad, their reinsurers, their claims

settlement offices, an expert, a lawyer, a technical consultant, the insurance intermediary of the undersigned or of the person he or she represents and, more generally, to any person or entity seeking recourse or against whom recourse is sought in relation to the aforementioned damage.

The legal basis for the processing of the data is created by the insurance contracts (legal expenses insurance, third party liability or any other contract), as well as by the obligation on the part of the data controller insurer, arising from the third party liability contract, to compensate, where applicable, the victims of bodily injury further to the claim(s) in question. Where this questionnaire is not completed correctly, the insurer will be unable to process this claim. Moreover, the processing is based on the insurer's legitimate interest in preventing insurance fraud and compiling statistics.

The data processed are retained by the responsible insurer for the duration required to process the claim, which will vary with the circumstances. This duration will be extended by the limitation period so that the insurer can deal with any appeals made after the closure of the insurance claim.

The people involved may view these data and, if necessary, have them corrected by sending a dated and signed request, accompanied by a photocopy of the front and back of their identity card, to the recipient insurer of this document. The said persons may also, using the same procedure, and within the limits set down in the General Data Protection Regulation, object to the processing of data or request that any such processing be limited. They may also request the deletion or transfer of their personal data.

Further information, including the contact details of the data protection officer, may be obtained from the same insurer.

A complaint may be submitted, where applicable, to the Belgian Data Protection Authority.

Within the context of the compensation process, the insurer is obliged to comply with the 'rules of conduct for claim settlement: relations with the victims of serious accidents', which can be found on the website www.assuralia.be. Any complaint relating to the proper application of these rules of conduct by the insurance company must be submitted by the victim to the complaints department of the company concerned, in accordance with the code of conduct for complaints management in insurance companies (available at www.assuralia.be). If the victim is not satisfied with the response received from this department, he or she may submit the complaint to the Insurance Ombudsman via the website www.ombudsman.as. www.ombudsman.as.

☐ By ticking this box, the undersigned consents to the processing of data concerning his/her health or the health of the person he/she represents where necessary for managing the claim in question. The undersigned consents to the processing of data related to his/her health or the health of the person he/she represents being undertaken outside the responsibility of a healthcare professional. The undersigned consents to a potential medical examination.

This consent may be withdrawn at any time. Where consent is withdrawn, the insurer will be unable to process this claim.

The said health-related data are processed with the utmost discretion and exclusively by authorised persons.

DATE SIGNATURE OF THE VICTIM'S REPRESENTATIVE