

Notification of traffic accident

It is important that all questions are answered and as accurately as possible.

I. Basic information

The insured _____ Id. no. _____

Address _____ Postcode _____ City/Town _____

Telephone / Mobile phone _____ Email _____

Name of injured if other than the insured _____ Id. no. _____

II. Information about the accident

Date of accident _____ Time _____ Location of accident _____

Type of accident? During working hours On direct route to/from work During leisure time Vehicle registration no. _____

Was the injured under the influence of alcohol/medicinal products Yes No Were the police contacted? Yes No

When was medical assistance sought after the accident? Day/month/year _____

Name of doctor/health centre _____

Who is the general practitioner? _____

Names of others providing treatment (if appropriate) _____

What injuries resulted from the accident? _____

Was the injured unable to work due to the accident? Yes No If yes, how long? From date _____ to date _____

Has the injured been assessed for disability? Yes No

If yes, specify who performed the assessment and specify the disability in % _____

Did the injured suffer illness/injury before the accident? Yes No

If yes, specify the illness/injury and the treating physician _____

III. Other information

Payments are to be deposited into bank account no. _____ — _____ — _____

IV. Own statement and signature

I, the undersigned, hereby certify that my responses to the above questions are, to the best of my knowledge, correct and truthful, and that no attempt is made to conceal anything that may be of importance in the company's determination of liability to pay compensation and the amount of the compensation.

_____ **Date**

_____ **Signature**

V. Informed consent for the processing of sensitive personal information

Name of the injured party _____ Id. no. _____

I, the undersigned, hereby grant Vördur tryggingar hf. unequivocal permission to collect information from physicians, hospitals, healthcare centres and other medical institutions/treatment entities about my current health. This permission, moreover, applies to the collection of information about previous illnesses and/or accidents as deemed necessary for processing this case.

Furthermore, I authorise the company to collect information from Tryggingastofnun (the Social Insurance Administration), pension funds, unions, tax authorities, Vinnueftirlit ríkisins (Administration of Occupational Safety and Health) and other insurance companies as deemed necessary for processing this case and determining the amount of compensation.

I am aware that Vördur tryggingar hf. will use this information for the sole purpose of processing my case within the company, and that access to this information within the company is solely in the hands of those parties who are responsible for processing personal damages.

This declaration includes my consent for processing personal information in accordance with Act No. 77/2000. This consent may be revoked at any time by submitting written notification thereto to the company.

Place/Date

Signature of the injured party

To be completed by a Vördur employee

Tjónsdagsetning _____ Tjónsnúmer _____

Dagsetning móttöku _____

Undirskrift starfsmanns Varðar _____