International Healthcare

Notification of Accident Form

MAI Medical Administrators International
Expatriates serving expatriates

For claims above € 500, US$ 675 or CHF 750
This form, duly completed and signed, should be returned to:

Medical Administrators International
21A One Capital Place
18 Luard road, Wanchai
Hong Kong
Tel: +852 3516 8181

For claims below € 500, US$ 675 or CHF 750
You can also send this form by:
1- Scan and email to: hospi@medical-administrators.com
2- Fax: +852 2529 9200

* Original invoices must be kept for a minimum period of 12 months. During this period, the Insurer reserves the right to ask for the original invoices at any time.

A. Details of Insured (Victim)

Family Name (also maiden name) : _____

First name : _____

Address : _____

_____

Date of birth : _____

Subscriber's family name — First name : _____

Employed by (organisation) : _____

MAI pers. ref. no. (if available) : _____

Duty station : _____

B. Inquiries on the accident

Place of accident : _____

Date : _____

Hour : _____

Detailed circumstances : _____

_____

_____

_____

Please enclose the statement established by the emergency services (ambulance)

Witness(es) - Name(s), address(es) and phone number(s) : _____

_____

_____

_____

☐ In case of a road accident : enclose the statement of accident (e.g. police report)
Please state: ☐ Driver ☐ Passenger ☐ Pedestrian
If driver : Provide a copy of driver's license

☐ Should you be victim of a sport related accident, please indicate: ☐ Professional ☐ Competition ☐ Leisure

☐ Did it occur during performance of duties ? ☐ Yes ☐ No
If YES, please attach evidence provided to employer

☐ Have you been taking medication prior to the accident? ☐ Yes ☐ No
If YES, please provide further details

NAVIGATOR
Insurance Brokers Ltd.

Tel (852) 2530 2530
Fax (852) 2530 2535
crew@navigator-insurance.com
www.navigator-insurance.com

Unit 8E Golden Sun Centre
59-67 Bonham Strand West
Sheung Wan, Hong Kong

C. If caused by illness

Date symptoms first noticed : _____

Symptoms : _____

_____

_____

_____

_____

D. Inquiries on the injuries / disability and the medical treatment

Injuries : _____

_____

_____

_____

First medical treatment by :

☐ General practitioner ☐ Specialist ☐ Hospital physician

Date : _____

Hospital stay is / was : ☐ Required

Name and address of the hospital : _____

_____

Duration of stay : _____

☐ Not required

Incapacity to work from / / to / / .

E. Inquiries on the responsible third party / other insurance coverage

☐ Victim's responsibility

☐ Third party responsible

Name, address and phone number of third party : _____

_____

_____

Insurance company : _____

Policy number : _____

Declaration: I hereby certify that the above information is true and correct to the best of my knowledge.

I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force. This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract. I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.

Signature _____

Place and date _____

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