

**OFFICE DES NATIONS UNIES À
GENÈVE**

ASSURANCE MUTUELLE
CONTRE LA MALADIE ET LES ACCIDENTS
DU PERSONNEL DES NATIONS UNIES



**UNITED NATIONS OFFICE AT
GENEVA**

UNITED NATIONS
STAFF MUTUAL INSURANCE SOCIETY
AGAINST SICKNESS AND ACCIDENT

DECLARATION OF ACCIDENT FORM
(Kindly fill the form with all the requested details)

SERVICE INCURRED *THIRD-PARTY LIABILITY OTHER

Name: _____ **Ins. No.:** _____ **Tel. no.:** _____

Date of incident/accident: ___/___/___ Place of incident/accident: _____

Time of incident/accident: ___hrs___min. *Witnesses (if any): _____

*Name of 3rd Party: _____ Tel. no: _____

*Name of the insurance of the 3rd party: _____

*Has a Police Report been established: Yes No By whom ? _____

Are you entitled to reimbursement from any other insurance ? : Yes No

If yes, name of the insurance _____

Circumstances of the incident/accident (*Please note, if the description is not sufficiently detailed, the medical claim could be returned to the member*):

I certify that the above information is correct.

Name: _____

Signature: _____

Place & Date: _____