

Slovenská kancelária poisťovateľov

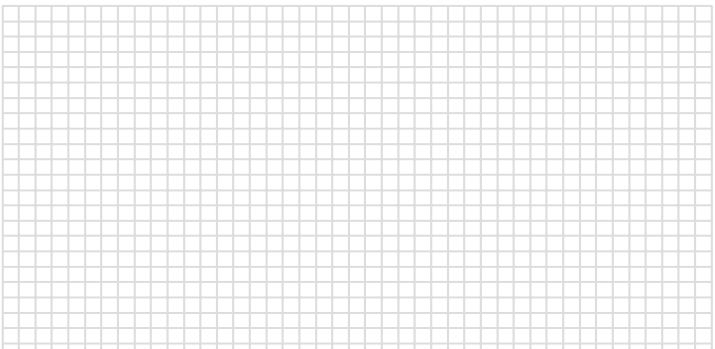
Trnavská cesta 82, 82658 Bratislava, Tel.: +421-2-4445 5452-4, Fax.: +421-2-4444 1632

Report of the claimant

1. THE DAMAGED PARTY	Code of the Insurer where was the accident announced: <input type="text"/>
Name and Surname / Company: <input type="text"/>	
Address: <input type="text"/>	Post code: <input type="text"/>
Country: <input type="text"/>	Birth date / Identification number of company: <input type="text"/>
Bank account No.: <input type="text"/>	Tel./Fax: <input type="text"/>
Driver of a vehicle in the time of accident	
Name and Surname: <input type="text"/>	
Address: <input type="text"/>	Post code: <input type="text"/>
Country: <input type="text"/>	Birth date: <input type="text"/>

2. THE GUILTY PARTY	
Driver of a vehicle in the time of accident	
Name and Surname: <input type="text"/>	Tel./Fax: <input type="text"/>
Address: <input type="text"/>	Post code: <input type="text"/>
Country: <input type="text"/>	Birth date: <input type="text"/>
Holder (owner) of a vehicle	
Name and Surname / Company: <input type="text"/>	Tel./Fax: <input type="text"/>
Address: <input type="text"/>	Post code: <input type="text"/>
Country: <input type="text"/>	Birth date: <input type="text"/>
*MTPL insurance company: <input type="text"/>	
Insurance Policy No.: <input type="text"/>	
Number of Green Card: <input type="text"/>	valid from: <input type="text"/> till: <input type="text"/>
Number of Frontier Insurance Policy: <input type="text"/>	valid from: <input type="text"/> till: <input type="text"/>

3. ACCIDENT DESCRIPTION
Date of accident: <input type="text"/> at <input type="text"/> : <input type="text"/> o'clock
Place (Country, Town, Street, Road): <input type="text"/>
<input type="text"/>
Has the accident been investigated by the Police body? Yes <input type="checkbox"/> No <input type="checkbox"/>
Investigated by the Police in: <input type="text"/>
<input type="text"/>
Has a photo-documentation of this accident been made out? Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/>

4. COURSE OF THE ACCIDENT	Draft of collision and location of vehicles after the accident:
Description: <input type="text"/>	

5. FELLOW - TRAVELLERS IN DAMAGED VEHICLE (name and surname, address, tel., fax)

6. ANOTHER WITNESSES OF THE ACCIDENT (name and surname, address, tel., fax)

7. VEHICLE OF THE DAMAGED PARTY

Registration No.: VIN Code / Chasis or Engine No.:

Category and make of vehicle: Colour:

Is vehicle insured with the Motor Hull Casco Insurance? Yes No

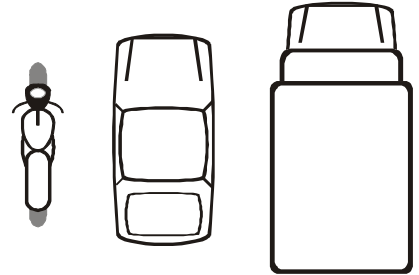
Insurance company:

Will you claim damages from your Motor Hull Casco Insurance? Yes No

Is the vehicle used also for commercial purposes? Yes No

Are you the Value Added Tax payer? Yes No

Please, describe the damage of the vehicle with a schematic draw:

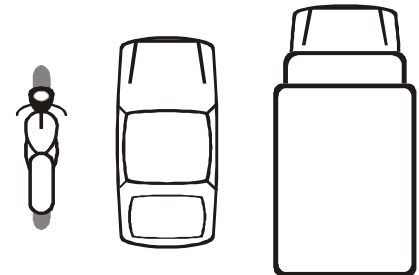


8. VEHICLE OF THE GUILTY PARTY

Registration No.: International Registration Plate of the country:

Category and make of vehicle: Colour:

Please, describe the damage of the vehicle with a schematic draw:



9. ANOTHER DAMAGE TO PROPERTY (luggage, fencing, pillar of public lighting system, etc.)

10. INJURED PERSONS (name and surname, address, measure of injury)

Attached with seat belt

..... Yes No

..... Yes No

..... Yes No

I declare that all above data provided by me, regarding the accident and my claim for damages are just and my consideration is definite and legally binding.

In

Date . .

Signature (stamp) of the claimant