WATERSKI & WAKEBOARD VLAANDEREN

AG - POLICY 99669462

Van Dessel Insurance Brokers

ACCIDENT DECLARATION

Send this declaration to
federations@ag.be or by post to
AG INSURANCE, Berchemstadionstraat 70 – 2600 Antwerp

THE ACCIDENT DECLARATION SHOULD BE COMPLETED WITHIN A REASONABLY ACCEPTABLE TIMEFRAME.

A. Details victim

Name / First name .....

Date of birth .....

Address .....

.....

E-mail .....

Phone .....

Bank account number BE .....

Professional status ☐ self-employed ☐ other

Please mark what is applicable		
Covered by hospitalization policy	☐ no ☐ by employer ☐ underwritten personally	
WSV-member	☐ yes ➔ club:	☐ no
As **non-member** with a 1-day license	☐ yes ➔ club:	☐ no

B. Details accident

Location .....

Date and time .....

Practiced discipline .....

Activity ☐ competition ☐ recreational

Describe the accident

.....

.....

"In the interests of a well ordered administration concerning the accident report, and for this purpose only, I, the victim of the documented accident, consent with the processing of medical data related to me personally." ***(article 7 of the law from 12/08/92 upon protecting the personal private life)***	I, undersigned:_____ Acting on behalf of :_____ Confirm that the accident occurred during activities organized by WSV
Date: ..... Signature **victim**	Date: ..... Signature **head of the club**

WATERSKI & WAKEBOARD VLAANDEREN

AG - POLICY 99669462

Van Dessel Insurance Brokers

ACCIDENT DECLARATION

Send this declaration to
federations@ag.be or by post to
AG INSURANCE, Berchemstadionstraat 70 – 2600 Antwerp

C. Medical certificate (to be completed by the attending physician)

Name / First name patient .....

Address .....

.....

Date accident .....

Date first medical exam .....

Established **injuries**: .....

.....

.....

Applied **medical treatment**: .....

.....

The intervention of a specialist is	☐ required ☐ not required
Radiography is	☐ required ☐ not required
Treatment in hospital is	☐ required ☐ not required
There is a pre-existent condition	☐ yes* ☐ no

*please clarify: .....

.....

Expected duration of **incapacity to work**

☐	Complete:		From	.....	Until .....
☐	Partial:	..... %	From	.....	Until .....
		..... %	From	.....	Until .....
		..... %	From	.....	Until .....

The accident can cause a **permanent incapacity to work** ☐ Yes ☐ no

Date: .....

Stamp and signature by physician