

Please return completed form to:

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Sender:

Unfallkasse Nordrhein-Westfalen
Regionaldirektion Rheinland or Westfalen-Lippe
PO Box
Postcode

Commuting Accident Questionnaire (Insured persons)

Note:

In the case of accidents involving children in day care facilities, pupils or students, the terms referring to employees are to be understood to apply mutatis mutandis (e.g. workplace = day care facility, school, university or location of school or university event).

Questions	Answers
1 Time and place of accident	
1.1 When did the accident occur?	Date: _____ Time: _____
1.2 Your working hours on the day of the accident?	Start: _____ (time) End: _____ (time)
1.3 Did the accident occur during a work break?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer Question 1 on the supplemental sheet.
1.4 Where did the accident occur (exact location and street/road name and details)?	
1.5 At what place (road, pavement, inside or outside your house etc.)?	
2 Starting point and destination of commute route	
2.1 Where were you coming from when the accident happened (e.g. place of work or home; please include exact address)?	
2.2 Where were you planning to go (exact address)?	
2.3 What time did you set out on the route on which the accident occurred?	If the accident occurred on the way to your workplace: Left your home at _____ (time) Start of working day on the day of the accident _____ (time) If the accident occurred on the way from your workplace: Left your workplace at _____ (time) Actual end of working day on the day of the accident _____ (time)

Questions		Answers		
2.4	Which route do you usually take from your home to your workplace and vice versa? (Please specify exact location and street/road name and details.)			
2.5	How do you usually travel (e.g. on foot, car, bus, train)?			
2.6	How long is your usual route?	kilometres		
2.7	How much time does this route take?	hour(s)	minute(s)	
2.8	Is this the direct route between your home and workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, why did you not take the direct route?		
2.9	Which route were you taking when the accident occurred (exact location and street/road name and details)?			
2.10	If you did not take your usual route:			
2.10.1	Why did you take a different route?			
2.10.2	How did you travel (on foot or by what means of transport)?			
2.10.3	How much longer/more time-consuming is this route than your usual route?	kilometres/	hour(s)	minute(s)
2.11	Did you run or plan to run any errands or make any visits or any other stops along the way (e.g. shopping, doctor's appointment, stop at a restaurant, administrative errands)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer Question 2 on the supplemental sheet.		

Please enclose a copy of a website printout (route planner) or map of the route to the completed questionnaire. In particular, please indicate the starting point (**S**), destination (**D**) and location of the accident (**L**) and, if applicable, your home (**H**) and place of work (**W**) – if these locations differ.

Please mark the direct route between your home and workplace with a dashed line (- - -) and mark the route taken on the day of the accident with a solid line (-----).

- This will facilitate our insurance-related investigation pursuant to insurance law. -

3 Circumstances of accident and injuries

3.1	How did the accident happen?			
3.2	Who was with you (name, address)?			
3.3	Were there any eyewitnesses to the accident (name, address)?			

Questions	Answers
3.4 Who was the first person to approach the accident scene (name, address)?	
3.5 Who performed first aid (name, address)?	
3.6 Which doctor/hospital did you go to after the accident (name, address)? When (date, time)?	
3.7 What discomfort/medical problems/consequences of the accident did you notice?	
3.8 Did you (continue to) work after the accident? If yes, until when (date and time)?	<input type="checkbox"/> No <input type="checkbox"/> Yes, until (date) (time)
3.9 Have you returned to work? If yes, when?	<input type="checkbox"/> No <input type="checkbox"/> Yes, on at (time)
3.10 Which doctors (please provide exact addresses) did you visit in connection with the above accident?	
3.11 Are you currently still undergoing medical treatment due to the consequences of the above accident? If yes, under which doctor's care?	
3.12 a) What health insurance companies have you been insured with over the past 10 years (please provide names, exact addresses and policy numbers)? b) What is the first name, surname and date of birth of the primary insured person?	
3.13 Have any findings been determined or issued by the police or others (e.g. by the public prosecutor's office, insurance company)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom (name, address, file/reference number)?
4 Persons involved in the accident	
4.1 Was another vehicle involved in the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer Question 3 on the supplemental sheet.
4.2 Is the accident attributed to winter road conditions, damaged roads, building defects etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer Question 4 on the supplemental sheet.
4.3 Was another person or an animal involved in the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer Question 5 on the supplemental sheet.

Place, date _____

Signature _____

Tel. no. for enquiries _____

**Supplemental Sheet
for Commuting Accident Questionnaire (Insured persons)**

Please answer only those questions that are relevant! –

Questions	Answers
1 If the accident occurred during a work break	
1.1 How long was your work break?	From (time) to (time)
1.2 Why did you leave the workplace (for what purpose)?	
1.3 Where did you want to go during your work break?	
1.4 How far is that location from your workplace?	kilometres/ hour(s) minute(s)
2 If you ran errands, made visits etc. along the way	
2.1 What errands/visits and where (exact name and address)?	
2.2 For what reason?	
2.3 How long were you there or would you have been there?	From (time) to (time)
2.4 Did the accident happen before, during or after the errand, visit etc.?	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After
2.5 Did you consume any alcohol or alcoholic beverages prior to the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, what kind and how much?

Questions	Answers	
3 If other vehicles were involved in the accident		
	(1st) vehicle	(2nd) vehicle
3.1 Type of vehicle(s)		
3.2 Registration number/nationality		
3.3 Have any lawyers been brought in?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide name and address.	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide name and address.
4 If the accident was attributed to winter road conditions, damaged roads, building defects etc.		
4.1 What, specifically?		
4.2 In your opinion, who is responsible for maintaining safety (e.g. duty to grit the pavement/road) at the scene of the accident (name, address)?		
5 If another person or an animal was involved in the accident		
5.1 How? What were the circumstances?		
5.2 What is the name and address of the person or owner of the animal?		
5.3 What insurance company is the other party insured with (name and address of the insurance company, insurance policy number)?		