EUROPEAN UNION

ACCIDENT AND OCCUPATIONAL DISEASE INSURANCE

ACCIDENT REPORT*

IMPORTANT (*please read very carefully*):

1. The accident report, **duly completed and signed**, should be submitted not later than 10 working days following the date on which the accident occurred, to the address given in point 7. The report **must** be accompanied by a **medical certificate** completed by a doctor.
2. Any subsequent medical documents concerning your accident (e.g. reports on X-rays or MRIs, hospitalisation reports, etc.) must be given to the doctor during your consultation or sent to the address referred to in point 7 **(please do not send scans or X-rays,** however it is essential that you retain them).
3. Supporting documents for absences must be sent **within 5 days** to the Medical Service or your sick-leave administration department.
4. The medical expenses related to your accident can be submitted to **your Settlements Office / JSIS online** (for the Court of Justice, the Unit for Rights under the Staff Regulations, office TA03/0032), in accordance with the current rules, using a separate claim form on which the **date of the accident** must be indicated. Your doctor must mention the date of the accident on all bills and medical documents (medical prescriptions, requests for specialist examinations, medical reports).
   Supplementary reimbursement under Article 73(3) of the Staff Regulations will follow reimbursement from the Joint Sickness Insurance Scheme **once the accident has been recognised**.

1. INSTITUTION ☐ Council ☐ Parliament ☐ Commission ☐ Court Of Justice ☐ Ombudsman ☐ EEAS ☐ Court Of Auditors ☐ Committee Of The Regions ☐ EESC ☐ Other: ……

2. ACCIDENT VICTIM ☐ OFFICIAL ☐ TEMPORARY STAFF MEMBER ☐ CONTRACT STAFF MEMBER ☐ OTHER BENEFICIARY, specify (pensioner, spouse, child): ……..... Other beneficiaries are **not covered by Article 73** of the Staff Regulations and are not entitled to supplementary reimbursements, but their accident reports enable the institution to recover the medical expenditure incurred under Article 72 from the liable third party's insurance.

2.1. Surname:…… First name: ……..…….. Maiden name: ……...

2.2. Date of birth: …… Sex: ☐ M ☐ F

2.3. Private address: …… Private phone: ……..... ……..……

2.4. Member's personnel number: …… Present grading (Grade/Step): ……..…… Place of employment: …… Office address: …… Office phone: ……

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3. ACCIDENT

3.1. Date: ……..Time: ……

3.2. Exact place: ……

3.3. Detailed description of the accident:
……
……
……
……
……

3.4. : Did the accident happen: ☐ at work ☐ on the way to or from work ☐ in your private life

3.5. Were the police involved (official report)? ☐ YES ☐ NO

If so, which police force (give full address)? ……

If an official report was drawn up, please attach a copy or indicate the number of the report:……..

3.6. Did the accident lead to incapacity for work? ☐ YES ☐ NO

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* The accident data will be processed in accordance with Regulation (EU) 2018/1725 (https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32018R1725)

4. LIABLE THIRD PARTIES (ARTICLE 85a OF THE STAFF REGULATIONS)

Where a third party is responsible for your accident, it is VITAL that you complete the next part of the report VERY CAREFULLY so that the institution can recover the expenditure it incurred following the accident from the third party's insurance.

4.1. Was an accident statement drawn up? ☐ YES ☐ NO
If so, attach a copy

4.2. Third party concerned (surname, first name) ……

(full address) ……

……

4.3. Policy holder (surname, first name)……

(full address)……

……

4.4. Their insurance company (name) ……

(full address) ……

……

4.5. Number of their insurance policy……

……

If any settlement is reached with the third party or their insurance company, I undertake to first inform my institution and to enter the following before my signature: 'subject to compliance with Article 8 of the Common rules on insurance against accident and occupational disease and Article 85a of the Staff Regulations of Officials of the European Union'.

Signature: ……

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5. COMMENTS (e.g. justification in case of late submission of the accident report, Article 15(2))

……
……
……

6. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Done at …… (date) …… ……

(signature)

7. WHERE TO SEND MY REPORT (and the medical documents concerning my accident)

FOR THE COUNCIL	**FOR THE PARLIAMENT**	**FOR THE COMMISSION, EEAS, COURT OF AUDITORS, EESC, CoR OMBUDSMAN and AGENCIES,**	**FOR THE COURT OF JUSTICE**
Council of the European Union Accident Insurance Department Office: 00 40 GM 44 Rue de la Loi 175 B - 1048 Brussels	European Parliament Pensions and Social Insurance Unit Accidents Section Office: GEO 03B038 L – 2929 Luxembourg	European Commission Health and Accident Insurance Unit Accidents Department B – 1049 Brussels	Court of Justice of the EU Staff Regulations, Social and Medical Affairs, Working Conditions Unit. L – 2925 Luxembourg D. Karzel (TA03/0032) or A. Michel (TA03/0012) or H. Guerra (TA03/0019)
Fax: +32 2 281 64 92 Tel: +32 2 281 66 99	Fax: +352 43 49 69 Tel: +352 4300 22528	Tel**:** +32 2 29 97777	Fax: +352 43 03 27 10
Email: Accident.insurance@consilium.europa.eu	**Email:** SecteurAccidents@europarl.europa.eu	**Send the accident report to PMO :** My IntraComm > Staff> Health > Specific-events > Accident > Contact us	**Email:**accidents@curia.europa.eu
+ send a copy to the sick leave administration/ 0070.LM.31		**+ Send a copy to the unit in charge of coordinating sick leave**	

MEDICAL CERTIFICATE - INITIAL ACCIDENT REPORT

To be completed and signed <u>by a doctor</u> or replaced by an equivalent report

CONSULTATION
Dr: …….
Address ……
……
Tel. ……..……..

ACCIDENT VICTIM
Surname: ……
First name: ……..
Personnel No: ……
Date of birth: …..……

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1. Date of accident: ……
Date of initial treatment: ……
Is there a direct link between the accident and the injuries? ☐ YES ☐ NO ☐ PARTIALLY

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2. Description of injuries (indicating left/right side where appropriate):……
……
……
……..……..
……
a. Treatment prescribed? ……
…..……
……

b. Have further examinations (X-rays, scans, MRIs, etc.) been carried out? YES ☐ NO ☐
If yes, please provide the accident victim with a copy of the reports

c. Was the accident victim admitted to hospital? ☐ YES ☐ NO

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3. Temporary incapacity resulting from the accident:

Total: from (date) …….. probable duration: ……..……

Partial: from (date) …….. probable duration: ……..

Expected to return to work on: ……..……

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4. Likely result of the accident:

Recovery ☐ Consolidation of injuries ☐ Probable date ……..……

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5. Pre-existing diseases or disabilities which have aggravated the injuries resulting from the accident:

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6. Comments:

……..……
……..
……..

Done at …….. **(date)**……

(signature and stamp of doctor)