



FONDS DE
GARANTIE
DES VICTIMES

www.fondsdegarantie.fr

Fonds de Garantie des Victimes - 64bis avenue Aubert, 94682 Vincennes cedex

COMPENSATION CLAIM FORM

(to be returned completed by the victim)

Identity

- Last name and first name :
- Birth name :
- Marital status :
- Address :
- Date of birth :
- Place of birth :
- Nationality :
-  Home phone
- E-mail address :
- Work phone :

Accident information

- Date of the accident :
- Place (municipality, département) :
- Exact nature of the véhicule that caused the accident :
- Circumstances of the accident :

To be completed if the at-fault party is known

- Last name :
- Address :
- 
- Given names :

To be completed if you know the insurer of the at-fault party

- Insurance company name :
- Contract number :

If the police/gendarmerie authorities have carried out an investigation

- Address of the competent police station :
- Ticket number :
- Address of the police squad :
- Ticket number :

INSTRUCTIONS FOR COMPLETING THE DOCUMENT

If your injuries do not require further treatment, simply fill out the section ①

If there is a lingering physical injury, please complete the section ② and attach the initial medical certificate and, if applicable, the medical recovery certificate or consolidation certificate

① My injuries do not require further treatment

- ☐ I have no claim
- ☐ The claim is limited to loss of income and medical expenses (attach supporting documents)

② There is a lingering personal injury

YOU ARE :

An employee

Are you losing income ?

- ☐ Yes
 - I can assess it now
(attach a statement from your employer showing the net salary loss and daily allowance payment slips from your welfare agency)
 - I cannot yet assess it
(attach the pay slip for the month prior to the accident)
- ☐ No, my salary is being paid (employer, mutual insurance company)

Self-employed

- Amount of income lost
(attach the latest two tax notices) :
- Amount of any daily allowances received
(attach payment slips from your welfare agency) :

In case of unemployment, attach the daily allowance and ASSEDIC slips.

Social safety net

- Name and address of the welfare agency with which you are affiliated :
- Registration number :
- If it was an accident :
 - ☐ in the workplace
 - ☐ on the commute to work
 - ☐ in your private life

Supplementary mutual insurance company

- Name and address of the supplementary organisation with which you are affiliated :
- Member number :

Additional comments