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

FONDS DE GARANTIE DES VICTIMES

www.fondsdegarantie.fr

COMPENSATION CLAIM FORM

(to be returned completed by the victim)

Identity

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

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 :
- Given names :
- Address :
- ☎

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 requiere further treatment, simply fill out the section ❶
If there is a lingering physical injury, please complete the section ❷ and attach the initial medical certificate and, if applicable, the medical recovery certificate or consolidation certificate

❶ *My injuries do not require further treatment*

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

❷ *There is a lingering personal injury*

YOU ARE :

An employee

Are you losign income ?

- [ ] Yes
  - I can assess it now (attach a statement from hour employer showing the net salary loss and daily alllowance 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

In accordance with the French Data Protection Act (Loi Informatique et Libertés) of 6 January 1978, amended in 2004, you have the right to access and rectify information concerning you, which you can exercise by contacting the Guarantee Fund for Victims – Data Protection Correspondent – 64 bis avenue Aubert – 94682 Vincennes Cedex - France

DONE AT : ON :

SIGNATURE :