FONDS DE GARANTIE DES VICTIMES
www.fondsdegarantie.fr

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

Act of terrorism
CLAIM FOR COMPENSATION FORM

(to be return completed by the victim)

Please complete, date and sign the document and attach a copy of the initial medical certificate. If is this the case, also attach a copy of the medical certificate of consolidation, a copy of the passport and a bank statement.

Identity

- Last name and first name : ..... ▪ Date of birth : .....
- Birth name : ..... ▪ Place of birth : .....
- Marital status : ..... ▪ Nationality : .....
- Address : .....

.....

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- ☏ Home phone ..... Cell phone : .....
- E-mail : .....

Information on the act of terrorim

- Date of the event : .....
- Place (municipality, département) :

.....

- Clarifications you would like to make : .....

.....

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If you have filed a complaint

- Please attach a copy of the receipt of the complaint and a copy of your statement if you have been given one to you

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Description of the damage

Occupation : (in case of unemployment, please attach the daily allowance and unemployment benefit slips)

YOU ARE → ***Employee*** ***Not employed***

Are you experiencing lost wages ?

◯ yes

- Amount of net lost wages (attach the salary slip for the month prior to the event and an employer's certificate of lost wages net) :

  .....

- Amount of daily benefits received (attach payment slips from your social security organization) :

  .....

◯ no, my salary is maintained (employer, mutual insurance company)

◯ to be determined later

- Amount of lost income (attach the tax notice for the year of the for the year of the event and the two previous years)

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- Amount of any daily allowances received (attach payment slips from your social security organization) :

  .....

Social sécurity

- Name and address of the social security organization to which you are affiliated :

  .....

  .....

- Registration number: .....

- The attack took place during your : ◯ work
  ◯ commuting to and from work
  ◯ private life

Additional guarantees

- Name and address of the social complementary organization (mutual insurance company, insurer, etc.) :

  .....

  .....

- Affiliation number : .....

Can your loss be assessed now ?

☐ yes

- ◯ Because my condition is consolidated (i.e.That is medically established that my health is stabilized ans that it should not evolve further)
- ◯ Because my claim is limited to loss of income and medical expensess (attach supporting documents)

☐ no, because there are still problems

DONE AT : ON :

SIGNATURE :