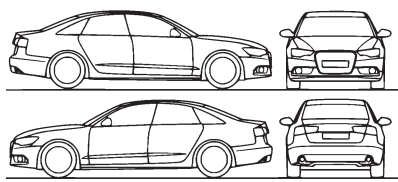


Claim file number: \_\_\_\_\_

## CLAIM NOTIFICATION FORM FOR MOTOR CLAIM

<b>This statement maybe made only personally by the operator / owner / driver.</b>					
If the notifier is not the operator / owner / driver, please specify your title:	<input type="checkbox"/> related <input type="checkbox"/> employee <input type="checkbox"/> authorized/mandated <input type="checkbox"/> other:				
Phone number: _____	E-mail address: _____				
Accident time:    _____ day    _____ month    _____ year    _____ hour    _____ minute					
Location of accident    - inside settlement (Country, City / Settlement, District, Street, House reg. number): - outside settlement (road no., km):					
Max. speed limit at accident location: _____ km/h	Were the police involved? <input type="checkbox"/> yes <input type="checkbox"/> no				
Police Department: _____					
Licence number of reported vehicle: _____	First owner? (please specify) _____				
Validity of registration certificate: _____ day    _____ month    _____ year	Validity of registration certificate in Hungary: _____ day    _____ month    _____ year				
Liability insurer name: _____					
Valid MOD insurance? <input type="checkbox"/> yes <input type="checkbox"/> no	MOD insurer name: _____				
Owner name: _____					
Mother's maiden name: _____					
Address: (Country, City / Settlement, District, Street, House reg. number) _____					
Phone number: _____	E-mail address: <sup>1</sup> _____				
Payment data (bank account number _____ - _____ - _____ or postal address): _____					
Driver name: _____					
Address: (Country, City / Settlement, District, Street, House reg. number) _____					
Phone number: _____	E-mail address: <sup>1</sup> _____				
Date of birth: _____ day    _____ month    _____ year	Validity of motor vehicle inspection: _____ day    _____ month    _____ year				
Category of driver's license: _____	Date of motor vehicle inspection: _____ day    _____ month    _____ year				
Expiry date of driver's license: _____ day    _____ month    _____ year	Restriction code, if any: _____				
Please draw the scope of current damage  	Has the vehicle been damaged earlier? <input type="checkbox"/> yes <input type="checkbox"/> no  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">                             Location/date of previous damage?                              (Pls. also indicate already repaired damage (if any))                         </td> <td style="width: 50%;">                             Loss was settled by (pls. provide insurer name):                         </td> </tr> <tr> <td style="height: 100px;"></td> <td></td> </tr> </table>	Location/date of previous damage? (Pls. also indicate already repaired damage (if any))	Loss was settled by (pls. provide insurer name):		
Location/date of previous damage? (Pls. also indicate already repaired damage (if any))	Loss was settled by (pls. provide insurer name):				
Description of loss (other items to be disclosed):  <div style="border: 1px solid black; height: 100px; width: 100%;"></div>					

<sup>1</sup> By entering my e-mail address, I agree that Allianz Hungária Co. Ltd. will send the notifications and information via e-mail (via open mail system) during the claims settlement. Detailed information and rules on data processing are available at <http://www.allianz.hu/hu/adatvedelem.html/>.

Site map sketch: Please show street (name, house no., milestone, nearby cities), the position of the vehicle after the accident, tyre tracks and traffic signs (lamp, road sign), and specify license numbers:

Any further parties involved in the accident? <input type="checkbox"/> yes <input type="checkbox"/> no		Did the vehicles collide? <input type="checkbox"/> yes <input type="checkbox"/> no	
License number:	type:	colour:	
License number:	type:	colour:	

Was there personal injury? <input type="checkbox"/> yes <input type="checkbox"/> no	Total casualties: _____ persons
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**Persons injured in the accident:**

Name:	<input type="checkbox"/> driver <input type="checkbox"/> passenger <input type="checkbox"/> pedestrian	<input type="checkbox"/> slight <input type="checkbox"/> serious <input type="checkbox"/> fatal
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Address: (Country, City / Settlement, District, Street, House reg. number)

Name:	<input type="checkbox"/> driver <input type="checkbox"/> passenger <input type="checkbox"/> pedestrian	<input type="checkbox"/> slight <input type="checkbox"/> serious <input type="checkbox"/> fatal
-------	---	---

Address: (Country, City / Settlement, District, Street, House reg. number)

**Owners of other items damaged in the accident:**

Name:	Damaged item:
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Address: (Country, City / Settlement, District, Street, House reg. number)

Name:	Damaged item:
-------	---------------

Address: (Country, City / Settlement, District, Street, House reg. number)

**Witnesses:**

Name:	Passenger: <input type="checkbox"/> yes <input type="checkbox"/> no
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Address: (Country, City / Settlement, District, Street, House reg. number)

Name:	Passenger: <input type="checkbox"/> yes <input type="checkbox"/> no
-------	---

Address: (Country, City / Settlement, District, Street, House reg. number)

**Declaration**

I am making my present declarations in the knowledge of such information. I hereby declare that I am familiar with and acknowledge the information concerning the handling of personal data on the number of AHE-52400 form that has been given to me.

Who is liable for the accident (loss) in your opinion?	<input type="checkbox"/> me / driver of my own vehicle <input type="checkbox"/> the other party <input type="checkbox"/> both
--	---

Please settle the damage to my own vehicle on the basis of my MOD insurance.	<input type="checkbox"/> yes <input type="checkbox"/> no
--	--

I was under the influence of drugs, alcohol or medication that has a negative impact on driving.	<input type="checkbox"/> yes <input type="checkbox"/> no
--	--

I was driving through a red traffic.	<input type="checkbox"/> yes <input type="checkbox"/> no
--------------------------------------	--

My speed was \_\_\_\_\_ km/h at the time of the accident.

By signing the present declaration, I the undersigned operator/owner/driver confirm my explicit and voluntary consent that Allianz Hungária Insurance Co. Ltd. may		
a) handle my personal and special details for the purpose of evaluating and carrying out insurance settlement (including electronic data handling);	<input type="checkbox"/> yes* <input type="checkbox"/> no**	
b) make a photocopy of my permits and licenses which are necessary for claim evaluation and settlement;	<input type="checkbox"/> yes* <input type="checkbox"/> no**	
c) use my personal data related to the accident in order to gain access to police and public prosecutor's case files and to receive copies of such files;	<input type="checkbox"/> yes* <input type="checkbox"/> no**	
d) obtain eventual historical loss files related to my insured property from co-insurers in order to assess and evaluate my present claim (by post or by e-mail), furthermore in order to protect the risk community; I hereby grant exemption to the co-insurers from the secrecy obligation. Further information about data protection can be found on <a href="http://www.allianz.hu/hu/adatvedelem.html/">http://www.allianz.hu/hu/adatvedelem.html/</a> .	<input type="checkbox"/> yes <input type="checkbox"/> no	
e) render data related to the present loss (except my personal data) accessible to other involved co-insurers upon a written request from them for the purpose of settling eventual future losses of the vehicle, provided such information is needed for the determination of legal basis and/or the settlement amount; the request may be forwarded by post or by e-mail.	<input type="checkbox"/> yes* <input type="checkbox"/> no**	
By signing the present declaration, I the undersigned operator/owner/driver confirm my explicit and voluntary consent that Allianz Hungária Insurance Co. Ltd's forwarding this information regarding the present loss to the insurance company settling the loss under motor third party liability tor to MABISZ ESZE.		
I hereby declare that I am entitled to reclaim VAT in connection with the present vehicle on the basis of the applicable rules of law in force:	<input type="checkbox"/> yes <input type="checkbox"/> no	Rate <sup>2</sup> : _____%

\* Please fill out the yes\*  bracket if you agree

\*\* Please fill out the appropriate no\*\*  bracket if you do not consent to any of the given cases of data handling or data transfer

<sup>2</sup> If the damaged party entitled to deduct VAT from repair cost, please provide the VAT refund rate.

Dated: \_\_\_\_\_, \_\_\_\_\_ day \_\_\_\_\_ month \_\_\_\_\_ year

\_\_\_\_\_  
handwritten signature of operator/owner  
(official signature)

\_\_\_\_\_  
handwritten signature of driver

Received:

Recipient's name:

Please be informed that the filing of your claim does not mean the recognition of the claim due to the fact that claim evaluation and assessment is subject to further inspection of the case.