



Instructions for filling the easy first notice of loss for private accident


Start page

Accident report

LÄHITAPIOLA

FI | SV | EN

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Welcome to reporting a new accident insurance claim. Please ensure principles of claim reporting from insurance holder. Would you like to report a workers' compensation insurance claim or it's additional group free time insurance claim? Or would you like to report a private accident insurance claim or remote work insurance claim?

Workers compensation or it's additional free time insurance

Private accident or remote work insurance

- Once you have opened your employers link please choose **”Private accident or remote work insurance”**
- In order to complete this first notice of loss you need to have personal information of the injured person and some basic information of the accident

1. In what role you are filling the form?

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Accidental damage

Information of the incident

All fields are mandatory, unless otherwise stated.

This claim concerns an injury I have suffered

This claim concerns an injury someone else has suffered

[Next](#) [Cancel](#)

- Are you filling the first notice of loss of your own accident or on behalf of another person?

2. Personal and contact information of injured person

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Accidental damage


Information of the injured party


First name

Last name

Personal identity code

No Finnish personal identity code


Phone number 

E-mail address (optional information) 

Street address

Post code

Area

Language 

- Input personal and contact information for injured person
- If injured person does not have Finnish social security number please provide date of birth, nationality and gender
- Address information is optional

3. Contact information for person filling the form


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Accidental damage


Declarer information

Name

Phone number

E-mail address (optional information)

[Next](#) [Cancel](#)

- Please enter your name and contact information if you are filling the form on behalf of another person


4. When did the accident occur?

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Accidental damage

Date of the incident

Date



Time

[Next](#) [Cancel](#)

- Please select time and date when did the accident occur

5. Policy number


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Accidental damage

Policy information

Business ID

Select the policy under which you wish to claim compensation.

 353-

 353-

[Next](#) [Cancel](#)

- Please select correct policy number from the list
- If the policy number is no in the list, please enter your policy number to the policy number -field

6. How and where did the accident occur?

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Accidental damage

Description of the damage

Please tell how the incident occurred

0/300

Did the damage happened

In Finland

Abroad

City

Select▼

Next

Cancel

- Please tell how did the accident happen in short
- Tell also did the accident happen in Finland or abroad

7. What kind of injury did the accident cause?

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Accidental damage

Information on the injured body part

Injured body part

Select ∨

Has this body part been injured or shown any symptoms before?

Yes

No or not known

[Next](#) [Cancel](#)

- Select which body part was injured and has the injured body part shown any symptoms before the accident

8. Need of medical attention or disability for work

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Accidental damage

Information on medical treatment

Has the accident required any medical treatment?

Yes

No or not known

Has the accident caused any disability for work?

Yes

No or not known

[Next](#) [Cancel](#)

- Please tell if injury has required any medical treatment or has injured person been on a leave due to accident

9. Additional information of the accident

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Accidental damage

Additional information

Was the injured party under the influence of alcohol or some other intoxicant when the accident occurred?

Yes

No or not known

Did the accident lead to any police investigation?

Yes

No or not known

Has any compensation for this incident been claimed under some other insurance policy?

Yes

No or not known

[Next](#) [Cancel](#)

- Please give additional information if the injured person was under influence of alcohol or narcotic substance when the accident happened
- If there has been an accident related police investigation please write the name of the police station
- Please provide specific name of the insurance company if injured has received claim settlement from another insurance company

10. Summary

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Accidental damage

Summary

Check the information you report once more and send the claim. To update the information you have already given, go to the previous view.

Information on the injured person

First name	Test
Last name	Subject
Phone number	0404040400
Language	English

Information on the incident

Policy number	353-1234567-1
Date when the incident occurred	01.05.2022 at 11.22
Country where the incident occurred	In Finland
City where the incident occurred	Akaa
This accident required medical treatment	No
This accident resulted in disability for work	No
Description of the incident	I fell and broke my left leg.
Injured body part	Ankle, Left
The same body part has been treated in the past	No

Additional information

The injured party was under the influence of alcohol or some other intoxicant when the accident occurred	No
There has been a accident related police investigation	No
There has been another insurance claim settlement related to accident	No

Authorization

I authorize the use of automatic claim handling. [Read more about automatic claim handling.](#)

I declare the information provided by me to be correct and complete.

I allow that LocalTapiola group can acquire necessary medical documentation of insured person from both private and public medical institutions for claim handling. I also allow that LocalTapiola group can request additional claim information from other insurance companies, pension insurance companies and social insurance institution of Finland including personal health information of the insured person.

I allow that LocalTapiola can give claim specific data to public or private medical institutions, to other insurance companies, to pension insurance companies or to social insurance institution of Finland in order to request necessary claim information including personal medical information of the insured person.

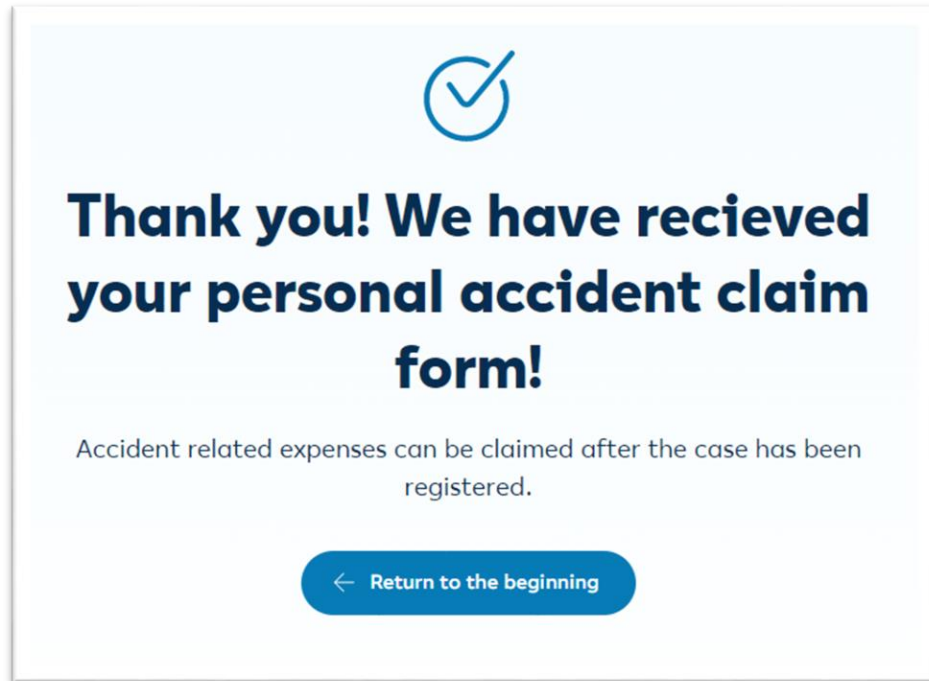
I understand the contents of this authorization and thus give authorization to LocalTapiola to request necessary information for claim handling purposes including medical information of the insured person.

Print the summary (PDF)

[Submit](#) [Delete](#)

- Please check that filled information is correct
- Please give necessary authorization for processing the form
- If you want to change something you can navigate to previous page by using back-button
- You can print out the summary in PDF-form
- Finally press send and the form will be sent to LocalTapiola for processing

11. Form has been successfully sent



- Finally you will receive a confirmation message when the first notice of loss has been successfully sent
- You can now close your browser