Attachment 3

State Office for Taxes and Finance
Payroll Office - Work-related
Accidents
Stauffenbergallee 2
01099 Dresden, Germany

Investigation of a work-related accident according to § 50 Saxon Civil Servant Pensions Act (SächsBeamtVG)

Information

Any accidents involving civil servants that occur during or as a result of their duties and which result in physical injury must be reported immediately to their superiors, regardless of their severity. The accident report must be submitted within twelve months of the accident occurring (§ 50 SächsBeamtVG). The claim to accident benefits in accordance with § 32 para. 2 sentence 2 BeamtVG must be asserted by the legal guardians within two years of the child being born. Supervisors must investigate the accident as soon as they become aware of it (§ 50 para.3 sentence 1 SächsBeamtVG). For this purpose, the injured person must complete this accident report form. The injured person must complete sections A to C. If said person is absent from work (e.g. due to serious illness), their supervisor is required to fill out the form on their behalf (without the need to submit the attending physician's report).

After the attending physician completes the written report, the injured person must submit the completed form in a sealed envelope marked State Office for Taxes and Finance, Work-related Accidents (German: *Landesamt für Steuern und Finanzen, Dienstunfallfürsorge*) to their superiors.

The supervisors must complete section D of the accident report form and forward it to the State Office for Taxes and Finance, Work-related Accidents alongside the sealed envelope.

If the accident also caused damage to property and you are applying for compensation, please complete attachment 3 (Application for compensation for damage to property as part of a work-related accident) and submit it to the State Office for Taxes and Finance, Department for Work-related Accidents, alongside a statement from the superior. A preclusive period of twelve months also applies (§ 50 SächsBeamtVG).

If civil servants are injured or killed in an accident, their statutory claims for damages against the party responsible for the accident are transferred to the Free State of Saxony to the extent that the latter is obliged to pay benefits (§ 90 SächsBG). However, this does not apply to claims for damages for which the employer does not provide benefits, such as legal fees, court costs and compensation for any suffering endured. This means that civil servants can assert such claims themselves against the injuring party or its insurance company.

The data is stored to the extent necessary for processing and is not accessible to third parties.

A Accident report by the injured person (§ 50 para. 1 sentence 1 SächsBeamtVG)
- To be completed by the

applicant - I Personal details

1. Personal information

Last name, first name	Birth name or former name	Date of birth

Personnel number	(or date of appointment as a civil servant) and salary group	Telephone (work) (optional): Private

Home address (street and house no., zip code, city)	If applicable, address of accommodation at or near the place of employment (street and house no., zip code, city),

Name/address of the employing office	if applicable, name and address of the external work location/employing office on the day of the accident

2. Working time

What working hours were scheduled on the day of the accident? (in case of flexitime: indicate earliest start time possible and latest end time permitted as well as core working hours)

Weekly working time					Hours:
Minimum working time	from	...	until	...	Hours:
Fixed working hours	from	...	until	...	
Core working hours	from	...	until	...	
Working time frame	from	...	until	...	
Actual working time	from	...	until	...	

3. Health insurance and other care procedures

What kind of health insurance do you have?

☐ Statutory public Health insurance ☐ private health insurance

☐ For police officers: Entitlement to free medical care Name and

address of the statutory or private health insurance:

Insurance number:

In the case of statutory health insurance: Have you claimed benefits using your health insurance card?

☐ no ☐ yes

Has a disability been official determined?

☐ no ☐ yes, address of the responsible authority and reference number:

If you have any certificates or similar evidence, please enclose a copy.

Was or is an examination procedure pending due to a previous, similar work-related injury (e.g. with the body responsible for the special provisions for activities as a police officer in the GDR, or with a professional association, accident insurance fund, etc.)?

☐ no ☐yes, address of the responsible authority and reference number:

If you have any certificates or similar, please enclose a copy.

4. Bank details for transferring the amount to be refunded

Account holder	
IBAN or account number	
BIC or bank code	
Bank	

II Details of the accident

Date, time and exact location of the accident (address or precise description of the accident site)
Detailed description of the accident. Describe the type of work-related activity at the time of the accident, the causes of the accident and a description of what actually happened (detailed description and external factors) in as much detail as possible (attach a sketch or supplementary sheet if necessary).
Was a medical professional consulted following the accident? □ No ☐ yes, please complete and submit the "Written report of the attending physician")
The first medical treatment following the accident took place on:
Name and full address of the physician who provided the initial treatment: and the medical professional(s) providing further treatment:
Are/were you unable to work as a result of the accident? □ no ☐ yes, from until
Was the accident recorded by the police? Have investigations been carried out by the public prosecutor's office? □ no □ yes, please indicate the investigating authority(s) and the reference number:

Were there any witnesses to the accident?

☐ No ☐ yes, please indicate their name, address and telephone number (witness statement on a separate sheet if necessary)

Is there evidence of any third-party negligence?
Please note: If an accident has been caused by a third party, a corresponding form must also be completed. Please contact your personnel administration office concerning this.

☐ No ☐ yes: a) Details of the liable party (address, license plate number, insurance provider and insurance number, if applicable):

b) Declaration of consent:
I agree that my personal details provided in this application and the fact that I am claiming the reimbursement of expenses in connection with an accident caused by a third party will be forwarded to the responsible legal department of the State Office for Taxes and Finance for the purpose of examining and asserting any legal claims against third parties.

Place, date Signature of the applicant/injured person

III. Causes of the accident

When examining the causal link between the accident and the physical injury/consequences of the accident, any existing factors that influenced the accident or the injury must be taken into account. As part of the burden of proof incumbent on you and your duty to cooperate under civil service law, you are requested to answer the following questions in full.

Had the part of the body injured during the accident sustained an injury or been afflicted in the past?

☐ No ☐ yes, when and what kind of injury (please specify the ailment and duration of medical treatment as well as name and address of the attending doctors) - use separate sheet if necessary.

Had you taken any substances that could have affected your ability to drive (e.g. medication, alcohol, other drugs) in the 24 hours leading up to the accident?

☐ No ☐ yes, specify type, quantity and time

Was the accident caused by a) an internal bodily process (e.g. sudden circulatory weakness, nausea, alcohol) or b) a pre-existing injury or disability (caused by a work-related or an accident occurring outside of work)? ☐ No ☐ yes, please provide details of the illness, previous harm, etc. (type, cause) as well as the name and address of any attending physicians - use a separate sheet if necessary.

If you answered "yes" to any of the questions in section A III, please submit the relevant examination documents (e.g. medical reports, X-rays) from hospitals, rehabilitation facilities, insurance companies and attending physicians immediately. This also applies to the investigation documents relating to the reported accident.

B For accidents occurring when commuting or during business trips, also to be completed by the applicant

☐ Commuting to and from the office ☐ Route between accommodation and private residence ☐ En route to the implementation of a medical procedure in accordance with § 33 BeamtVG ☐ Any other journey _____ → Continue with letter a)	☐ Business trip at work location or place of residence ☐ Continuing education trip *Please submit a copy of the official approval in each case.* → Continue with letter b)

	a)	b)
Departure (time and exact location)	at o'clock from:	at o'clock from:
Destination (exact location)	to:	to:
Distance traveled (attach sketch if necessary):		
Was this the...	...most convenient route based on traffic, which you usually take? ☐ No ☐ Yes	...shortest route based on traffic or mandated route? ☐ No ☐ Yes
In the case of a detour or alternate route: Did the accident take place on the...	...most convenient route based on traffic, which you usually take? ☐ No ☐ Yes	...shortest route based on traffic or requested route? ☐ No ☐ Yes
If not, why was a different route chosen?	(e.g. car pool, taking a child to school, etc.)	(e.g. detour)
Duration of the detour:		

Interruption of the usual route (e.g. due to shopping, doctor's appointment, visit to a restaurant)	☐ No ☐ yes, reason:	☐ No ☐ yes, reason:
Duration of the interruption:		
Which means of transportation was mandated for the business trip?	(n/a)	

Information on data protection pursuant to Art. 13 and 14 General Data Protection Regulation
Your data will be processed by the State Office for Taxes and Finances in order to determine, arrange and reimburse following a work-related accident in accordance with the applicable provisions on data protection. Further information can be found on the following website: http://www.lsf.sachsen.de/Datenschutz.html (Department for Work-related Accidents). You can contact the Data Protection Officer of the State Office for Taxes and Finances at: Landesamt für Steuern und Finanzen, Behördliche/r Datenschutzbeauftragte/r, Stauffenbergallee 2, 01099 Dresden, Email: Datenschutz@lsf.smf.sachsen.de

I confirm that the information provided in sections A and B is complete and correct and that I have read the data protection information.

Place, date	Signature of the applicant/injured party

C. - to be signed by the applicant -

Declaration of release from medical confidentiality

Last name, first name	Date of birth:	Date of the accident:
Address - please indicate again		

The State Office for Taxes and Finance shall obtain the information/documentation required for processing the accident in question directly from the medical practitioners/institutions involved and thus expedite the work-related accident procedure, in particular the causality assessment and the determination of the consequences of the injury. If necessary, the State Office for Taxes and Finance will commission an reviewer and make the medical documents available for review.

I hereby release all medical practitioners, including the police medical service, hospitals, social insurance institutions, public health authorities, health reviewers, psychotherapists, psychiatrists and psychologists from their duty of medical confidentiality vis-à-vis the State Office for Taxes and Finance, which is responsible for making the decision under work-related accident law, and any medical experts to be consulted.

I agree that the State Office for Taxes and Finance and the reviewers commissioned by the State Office for Taxes and Finance may be provided with the information required for the determination as well as the medical examination documents (medical papers, records, medical history, examination results, X-rays, MRI/CT /OP scans,
evaluations (in particular to also determine ability to work), documents to clarify previous injuries or the reduction in an ability to work, to ascertain the facts and to properly process the work-related accident.

The aforementioned consent can be refused or restricted (e.g. to individual medical professionals, facilities, documents) and revoked with effect for the future. Any resulting difficulties in providing evidence when determining the conditions on which the claim is based may be to the detriment of the civil servant.

If necessary, the aforementioned medical documents will be made available to the office processing the matter (State Office for Taxes and Finance, Legal Department) for the purpose of assessing the claims for compensation transferred to the Free State of Saxony, insofar as the liability of a third party comes into consideration for the damaged caused.

Place, date	Signature of the applicant/injured person

D Results of the investigation by the supervisor (§ 50 para. 3 sentence 1 SächsBeamtVG)

Name and role of the supervisor and address of the authority

When did the supervisor first become aware of the accident?

On _____

☐ by verbal notification
☐ by written notification
☐ in any other way (short description)

The information in sections A (personal details, type of employment) and B is confirmed:

☐ No ☐ Yes

Justification:

What customary and obligatory duties was the civil servant performing at the time of the accident?

According to the supervisor, should the accident be considered a work-related accident?

☐ No ☐ Yes

Justification:

Did the injured person cause the accident intentionally or negligently?

☐ No ☐ Yes

Justification:

What damage did the accident cause?

Claims for reimbursement from the Free State - can a third party be held liable for the accident?
Please note: If an accidents has been caused by a third party, a corresponding form must also be completed.

☐ No ☐ Yes

Name, address of the third party:

Additional information:

The results of the investigation were made known to the officer/judge or dependents of the person who suffered the accident.

Place, date

Signature of the supervisor with the stamp of the authority and
the name and role of the supervisor in block capitals