

CHARTIS EUROPE LIMITED

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PERSONAL ACCIDENT CLAIM FORM



Please complete this form fully.
In the event of the Claimant being unable to sign the form,
it should be completed and signed by a responsible
person on his/her behalf.
Return to Chartis immediately.

1. INSURED

Name _____

Address _____

Policy Number _____

Day Time Phone No. _____

Date Last Premium Paid _____

2. CLAIMANT

Name _____

Address _____

Date of Birth _____ Occupation _____

3. PARTICULARS OF ACCIDENT

Date and time of accident / / Time _____:_____ AM PM

Place accident occurred _____

How did accident occur and what were you doing at the time?
(GIVE EXACT DETAILS)

4. WITNESSES

Names, occupations and addresses of witnesses of the accident

Was the accident attended/investigated by the Gardai? YES NO
Name and station of investigating Garda

5. INJURIES SUSTAINED

State fully the nature and extent of injuries

Have you ever suffered similar injuries? YES NO

Details _____

6. MEDICAL DETAILS

Were you taken to hospital YES NO

Which hospital _____

As an in patient _____ or an out patient _____

from / / to / /

Give name and address of medical practitioner who attended you on your meeting with the accident

Is the doctor your usual medical practitioner YES NO

How long have you been totally or partially disabled from engaging in or attending to your usual business as result of the injuries

Totally: from / / to / /

Partially: from / / to / /

7. OTHER INSURER

Are you claiming or entitled to claim compensation for the accident from any other source? YES NO

If so give particulars _____

Do you have a personal accident policy with any other company or society? YES NO

Company _____

I hereby declare the foregoing particulars to be true in every respect.

Signature _____ Date _____

MEDICAL AUTHORISATION

On production of this Authorisation, or a photocopy thereof, I authorise you to furnish Chartis Europe Limited with full reports on the condition of

_____ including the history of the complaint(s) which caused the above named to be admitted to hospital on

Signature of claimant _____

Dated _____

NOTE If the claimant is a child this authorisation should be signed by a parent

Chartis Europe Limited is classified as a 'Data Controller'.

MEDICAL CERTIFICATE

To be completed by the attending Doctor, and supplied at the expense of the policyholder

1.

Name of claimant _____

2.

When did the claimant first consult you in connection with this accident? _____

Please state fully the nature of the injuries sustained _____

Are the symptoms being suffered due to the accident alone? _____

3.

How long has the claimant been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?

Totally: From _____ To _____ Partially: From _____ To _____

Is the claimant suffering from any disease in addition to the present injuries, or has he/she any physical effect?

If so, state the nature of same, and to what extent the recovery may be affected

4.

General Remarks _____

Chartis Europe Limited is classified as a "Data Controller" under Irish Data Protection Legislation. By providing your Personal Information to Chartis or Personal Information regarding other individuals you represent that you have the authority to do so and consent to the collection and processing (including the disclosure and international transfer) of this Personal Information as stated in the Privacy Policy which is available at www.chartisinsurance.com/ie, by e-mailing postmaster.ie@chartisinsurance.com or by writing to the Data Protection Officer at Chartis Europe Limited, Ireland Branch, Chartis House, Merrion Road, Dublin 4.

I certify that to the best of my belief the above met with the accident referred to, and that the foregoing statements are correct.

Signature _____ Qualification _____

Address _____ Date / /