Return this form together with respective documents (medical certificates) to:-
GasanMamo Insurance, Msida Road, Gzira GZR 1405 Malta

For any queries please call 21 345 123 ***ext*** *5*

GasanMamo INSURANCE
We're always there

Group Personal Accident Claim Form

This form should be completed and returned without delay.
The **Medical Certificate Overleaf** is to be furnished at the expense of the Insured.

Branch/Broker/TII _____ **Claim Number** _____

Name of Insured_____ **ID Card No.** _____

Address _____

Telephone No. _____ **E-mail Address** _____

Company Reg No. _____

Business Address _____

Name of Injured Person_____

Address _____

Telephone No. Home _____ **Mobile** _____ **I.D. Card No.** _____

Occupation _____**E-mail address** _____

No. of years at present employment _____ **Gross weekly salary** _____

Present age _____ **Height** _____ **Weight** _____

Policy no. _____ **Period of Insurance** _____ **Sum Insured** _____

1. Date, Time & Place of Accident	
2. State exactly how the accident occurred and what the injured person was doing at the time	

Signature _____

3. What injuries were sustained by the injured person? (if eye or limb please state if left or right)	
4. Names & addresses of any Witnesses to the accident	
5. Name, address and contact details of the Doctor attending the injured person	
6. (a) Has the injured person been able to attend to any part of his/her business or occupation as a result of this accident? b) If yes, state the period during which the injured person has been totally disabled from attending his/her business c) Is the injured person still totally unable to attend work? d) To what extent has the injured person been able to attend work?	a. b. c. d.
7. Has the injured person previously claimed or received compensation under an Accident and/or Sickness policy?	**YES** ☐ **NO** ☐ If **Yes** provide details
8. Is the injured person claiming under any other insurance?	**YES** ☐ **NO** ☐ If **Yes** provide details

Signature _____

PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATE TO BE COMPLETED BY INJURED PERSON'S DOCTOR

I Certify that Mr/Mrs/Ms _____

was injured on _____

His/Her injuries are _____

Is the claimant suffering from any other conditions which might affect his/her recovery? If yes, state what they are.

_____

Are you the claimant's usual medical attendant? How long have you been so?

_____

What treatment, medication or therapy has been prescribed?

_____

Do you envisage the need to refer the claimant to a specialist? If yes, who and when?

_____

Are you aware of anything in the claimant's previous history which may delay his/her recovery?
If yes, please give details

_____

He/She is solely and directly totally/partially disabled as a result of the injuries and will be so disabled until;

_____

Signature and Qualifications _____ Date _____

Address _____

E-mail address _____

Telephone numbers _____

Total Disablement *occurs when the insured is wholly prevented from attending to his business or occupation.*

Partial Disablement *when prevented from attending a substantial portion thereof.*

SECTION 4: Direct Credit Details

Kindly complete your bank details below if you would like to receive payment of your claim directly into your bank account. We can only make SEPA payments.

Account Holder Details:

Name_____ ID/Passport No:_____

Address: _____Company Reg. No.:_____

Town:_____Country:_____

Email Address:_____Mobile:_____

Bank Account Details:

Name of Bank:_____Country:_____

IBAN No:_____

DATA PROTECTION NOTICE:

To the extent that the information supplied by you, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, you consent to the processing of such data for purposes of administering your proposal for insurance, your Policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. We may be required to collect further information from our sub-agents, other insurance companies, insurance intermediaries or insurance associations.

In addition, we may pass some or all of the information to other insurance companies, or insurance associations for underwriting and claims handling purposes and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. This also helps us to check the information provided. When we deal with your request for insurance, we may search this information. When you tell us about an incident which may or may not give rise to a claim, we will pass information relating to it to the Malta Insurance Association.

We and other companies within our group would like, on occasion, to keep you informed of our products and services, by mail, fax, e-mail or other electronic means. Please inform us in writing if you do not wish to receive this information or if you wish to receive such information solely from GasanMamo Insurance Ltd. Moreover, we hereby ask you whether you wish to receive direct marketing information from us by e-mail to your e-mail address provided above.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd, Msida Road, Gzira GZR 1405.

Declaration: -
I/We declare that the statements made are true to the best of my/our knowledge and belief and fully agree with the above and hereby consent to the above treatment of my personal data.

_____	_____	_____
Date	*Full name in block letters*	*Signature of Policyholder*