

Branch/Broker/TII:

Policy No:

Return this form together with respective documents (medical certificates) to: - Gasamamo Insurance, Msida Road, Gżira GZR 1405 Malta. For any queries please call 2134 5123 ext 5.

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

## INSURED'S DETAILS

Name of Insured:

Address:

Tel No / Mob No:

ID No.:

Occupation:

Business Address:

Email:

Present Age:

Height:

Weight:

## SECTION 1

Date, Time & Place of Accident:

Please state exactly how the accident occurred and what the injured person was doing at the time.

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Name & Address of any witnesses to the accident:

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Name, address and contact details of the doctor attending you:

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## SECTION 2

What injuries were sustained by the injured person? (If to eye or limb, please state whether right or left.)

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Have you been able to attend to any part of your business or occupation as a result of this accident?

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If yes, please state the period during which the you have been totally disabled from attending your business.

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Are you still totally unable to attend work?

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To what extent have you been able to attend work?

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Have you previously claimed or received compensation under an Accident and/or Sickness policy?

Yes

No

If yes, please give details.

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### SECTION 3

Are you claiming under any other insurance?

Yes

No

If yes, please give details.

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**PRIVATE & 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, please 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, to whom 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 & Qualifications

Date:

Address:

Email:

Tel No / Mob No:

**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.

## 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 payment.

### Account holder details

Name:

ID No:

Address:

Town:

Mob No:

Email:

### 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: