Personal Accident Claim Form

Policy No:		Claim No:	
Intermediary:			

Name of Insured:		I.D Card/ Co. Reg No.:	
Address:			
Tel/Mobile No:		E-mail:	
Injured Person:		I.D Card/ Co. Reg No.:	
Postal Address:			
Trade or Occupation:			
State the nature of the accident, how it occurred, and what the Insured Person was doing at that time:			

When did it occur?

Date:		Time:	
Place of Accident:			
Name and Addresses of any Witnesses:			

State as fully as possible, the injuries sustained:	
Have injuries previously been sustained to the same part or parts?	

Give dates of inability to carry out usual duties:

Totally disabled		To:	
Partially disabled		To:	
Date first received medical attention:			
Name of Medical Attendant			
Address			
Tel/Mobile No:		E-mail:	
Give details of any physical defect or infirmities			
Previous injuries with dates and period of incapacity			

Will any claim be made upon any other Company in respect of this accident? ☐ Yes ☐ No

If yes, please give names of all Companies	

Declaration by the Insured

I, the undersigned, hereby declare that I am the person entitled to the benefit of the above Policy and I solemnly affirm that the answers I have given are true.

Signature of Insured	Name in Blocks	Date

To be completed and signed by the Insured Person's Medical Attendant

Name of Patient:		Age:		Trade or Occupation:	

Are you the patient's usual doctor? ☐Yes ☐No

If yes how long have you known the patient	
Cause of incapacity:	
Date first seen by you in connection with this incapacity:	

Disablement	From	To	Prognosis (Please indicate probable duration of disablement)
Confined to house			
Unable to give attention to any occupation			
Able to give some attention to his occupation			

If patient has now fully recovered, date of recovery:	
Dates and details of injuries from which he has previously suffered:	

I hereby certify having personally examined the above mentioned patient and that in my opinion the disability arises solely as a result of the accident described above and that there are no other circumstances tending to produce either total or partial disability.

Name & Qualifications:	
Address	

Signature _____ Date _____

Any fee for this report is to be paid by the Insured.

Note:
Correspondence and claims. All communications and claims received by you concerning the incident are to be forwarded immediately to Atlas without acknowledgement to the sender.

I/We declare that to the best of my/our knowledge and belief the statements made on this form are true and complete. If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We have read those answers and that they are correct and that such person completing this form on my/our dictation or instruction for this purpose will be regarded as my/our agent.

Data and Privacy Protection

Atlas Insurance PCC Limited and/or any other subsidiaries of Atlas Holdings Limited or any of its daughter companies (hereinafter 'Atlas') are the data controllers, as defined by relevant data protection laws and regulations, of personal data held about the Insured or relating to the Insured and/or to any other person/s whom the Insured insures with Atlas (hereinafter 'Others').

In completing all the forms related to the Insured's policies or claims, the Insured confirms to have understood and accepted the terms in Atlas's Data Protection and Privacy Statement. The Insured hereby warrants that the Insured has informed Others why Atlas asked for this information and what Atlas will use it for and have obtained the necessary explicit verbal consent.

Atlas collects and processes information about the Insured and Others for purposes which include, carrying out its contractual obligations including handling and settling of claims, and preventing or detecting crime (including fraud). Atlas may monitor calls to and from customers for training, quality and regulatory purposes.

Atlas may collect and disclose the Insured and Others' information from/to other entities in order to conduct Atlas' business including

- managing claims, which may require obtaining data including medical information from healthcare providers (including any public or private hospital or clinic) and/or employers (for company schemes) and which the Insured and Others hereby authorise;
- administering policies with insurance brokers or other intermediaries appointed by the policyholder;
- helping Atlas prevent or detect crime by sharing the Insured and Others' information with regulatory and public bodies in Malta or, if applicable, overseas, including the Police, as well as with other insurance companies (directly or via shared databases such as the Malta Insurance Fraud Platform), or other agencies or appointed experts to undertake credit reference or fraud searches or investigations; and/or
- Atlas's third party suppliers or service providers to whom Atlas outsource certain business operations.

Atlas will retain data for the period necessary to fulfil the above-mentioned purposes unless a longer retention period is required or permitted by law.

The Insured has the right to access their personal data and ask Atlas to update or correct the information held or delete such personal data from Atlas's records if it is no longer needed for the purposes indicated above. The Insured may exercise these and other rights held in Atlas's Data Protection and Privacy Statement, by contacting Atlas's Data Protection Officer at The Data Protection Officer, Atlas Insurance PCC Limited, 419 Ta' Xbiex Seafront, Ta' Xbiex XBX 1021 Malta or email dpo@atlas.com.mt Please note, however, that certain personal information may be exempt from such access, correction or erasure requests pursuant to applicable data protection laws or other laws and regulations.

If the Insured and Others consider that the processing of personal data by Atlas is not in compliance with data protection laws and regulations, the Insured and Others may lodge a complaint with Atlas and/or the Office of the Information and Data Protection Commissioner by following this link https://idpc.org.mt/en/Pages/contact/complaints.aspx

If the Insured wishes to view the full Atlas's Data Protection and Privacy Statement, for a better understanding of how Atlas uses this data please visit https://www.atlas.com.mt/legal/data-protection/.

I confirm my understanding and acceptance of the above.

Signature of Insured: _____ **Date:** _____

Name (in BLOCK Letters): _____

(If a Limited Company give status of signatory): _____