Pet Insurance Claim Form

For Boarding Fees and Daily Minding

Please send this form to Atlas Insurance PCC Limited – Ta' Xbiex Seafront, Ta' Xbiex, Malta. Do not forget to attach original accounts (invoices or receipts) where applicable. PLEASE FILL IN ALL DETAILS and use BLOCK capitals throughout.

Policy No.

Making a claim

Please follow these instructions carefully to ensure that your claim will be processed efficiently and without any need for further clarification.

1. Your doctor must complete section 5 of this claim form.
2. Claims should be submitted as soon as possible and not later than 2 months from the date expenses were incurred and must include
   a. the invoices and/or receipts from the boarding establishment or written confirmation from the person looking after your pet indicating the relevant dates.
   b. the discharge certificate from the hospital that confirms the dates of your admission and subsequent discharge from the hospital.
3. We recommend that you photocopy the completed form and any enclosures for your records.
4. We are unable to accept original receipts where alterations have been made unless such alteration is signed by the person issuing the receipt.

1. About You - to be completed by Policyholder(s)

Policyholders' Full Name

ID. Card No.

Postal Address

Telephone No.

Mobile No.

Email Address

2. About Your Pet - to be completed by Policyholder(s)

Your Pet's Name

Male ☐ Female ☐ Dog ☐ Cat ☐

Breed

3. Boarding Kennel/Home Carer

Name of Boarding Kennel / Home Carer

Address of Boarding Kennel / Home Carer

Telephone No.

Boarding fees per day: €

Date of boarding/Homecare: from to

4. Policyholder Declaration - to be completed by Policyholder(s)

Atlas Insurance PCC Limited (hereinafter "Atlas") is the controller of personal data held about You or relating to You and/or to any other person/s on whose behalf you are making this claim (hereinafter "Others"), and this in terms of the Data Protection Act (hereinafter the "Act"). By making a claim with Atlas, You and Others accept the terms of this Statement. You hereby warrant that you have presented this statement to 'Others' and have obtained their necessary explicit verbal consent to:

a. the processing of any information by Atlas and/or by any other subsidiary companies of Atlas or Atlas Holdings Limited (hereinafter the "Group") which constitutes personal data in terms of the Act, insofar as such processing relates (but not limited) to handling and settling of claims, detecting and prevention of fraud and the keeping of statistics;
b. the disclosure by the Group, of personal data held by them to other insurers or to persons acting on their behalf and/or instructions, including (but not limited to) the Malta Insurance Association, Insurance intermediaries, the Malta Association of Credit Management (MACM), the Malta Insurance Fraud Platform and other appointed experts, together with the Commissioner of Police and any public or private hospital or clinic, other healthcare providers of any kind or any person, body or authority authorised by law to receive personal data;
c. the abovementioned third parties, and other third parties legally entitled to communicate such data, disclosing relevant personal data to the Group and processing such data as described in paragraph (a) above;
d. the Group keeping You and Others informed of their products and services by any means. You understand and have explained to Others that You or Others may inform Atlas in writing if You or Others do not wish to receive this information;
e. the recording of telephone calls for training, security and quality control purposes.

You also confirm that You understand (and have explained to Others) that You have the right to submit a written and signed request for access to or rectification of data held by the Group and that You and Others are aware that the full details of our Data Protection Policy, updated from time to time, may be found on http://www.atlas.com.mt/Legal/Data_Protection.aspx.

Signature of Policyholder _____ Date | | | | | | | | |

5. About the Illness or Injury - to be completed by Policyholder(s)s General Practitioner or Hospital Physician/Surgeon

Policyholders' Name

Name of G.P./ Physician/Surgeon

Name of Admitting Hospital

Date of Hospitalisation: from | | | | | | | | | to | | | | | | | | |

Medical Condition requiring hospital treatment

Date of first visit to any doctor for this condition | | | | | | | | |

Name of the illness or injury, or state the clinical signs if you have not yet made a diagnosis

☐ I confirm that to the best of my knowledge the statements are true and complete in every respect.

Signature of G.P/Hospital Physician/Surgeon (please delete as applicable) _____

Telephone No. _____ Date | | | | | | | | |

Stamp _____