

PA - Medical Expenses Form



Important note: This form should be completed by an administrator and not the injured person. If the accident was caused by a piece of equipment, please retain for inspection should the need arise.

Please make sure that the information you give is as clear and complete as possible.
Please complete in BLOCK CAPITALS or on-line save and print.

1. Policyholder Details

Name:

Telephone No:

Policy No:

2. Accident Details

Location:

Date:

Time:

3. Injured Person Details

Name:

Address:

Age:

Nature of Injury:

Did injured person require medical treatment: Yes No

Are injuries ongoing: Yes No

If 'Yes', please give further details:

If 'Yes', state the name and address of the doctor/hospital:

Please confirm their Health Insurance provider:

Policy Scheme/Plan:

Do you have other Personal Accident Policies with any other Insurer? Yes No

If yes, please provide full company name:

4. Accident Details

This should include the nature of the activity in which the injured person was engaged when the accident occurred.

Name and phone number of the person to whom the accident was first reported:

Date:

By whom:

Has any claim been made against the policyholder : Yes No Date:

If 'Yes', please give details:

5. Declaration

IPB Insurance is classified as a Data Controller under Irish Data Protection Legislation. The information you provide to us as part of your claim application will be processed by us to confirm your identity, process your application and to record and cross reference particulars of your claim in insurance industry databases for fraud prevention purposes. This may involve exchanging information with Insurance Link, the anti-fraud claims database run by the Irish Insurance Federation. In certain cases we may also share your information with other insurance providers and private investigators.

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief

Signature of Administrator:

Date:

Please return completed form to:

The Claims Department

IPB Insurance

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Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: claims@ipb.ie Web: www.ipb.ie

Reg. No. 7532 Republic of Ireland.

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