Personal Accident Claim Form

(PA 11 2019)

Important note: Please make sure that the information you give is as clear and complete as possible.
You must enclose estimates/valuations/original receipts with this claim form.
Please complete in BLOCK CAPITALS or on-line save and print.

Claim No:

1. Policyholder and Claimant Details

Policyholder Name: Policy No:

Claimant Name & Address:

Claimant Telephone No: Home: Mobile:

Email:

Date of Birth:

Occupation:

At time of accident, were you employed elsewhere? Yes ☐ No ☐

If 'Yes', please provide full company name and occupation:

2. General Details

Name and Address of attending Doctor:

Note: Please ensure that the Medical Certificate overleaf is completed by this Doctor.

Is he/she your usual medical attendant? Yes ☐ No ☐

If 'No', please provide the name and address: of your usual Doctor:

Please confirm your 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:

How long have you been:
(a) wholly unable to attend to any portion of your profession or occupation? Date: from to
(b) able to attend only partly to your profession or occupation? Date: from to

3. Accident Details

Location:

Date: Time:

Please describe exactly what happened:

What injuries have you sustained?

3. Accident Details (continued)

Have you previously suffered from similar injuries? Yes ☐ No ☐

If 'Yes', please give details:

Name(s) and Address(es) of any witness(es):

4. Medical Certificate (to be completed by attending Doctor)

This is to certify that Mr/Mrs/Miss/Ms:

is suffering from:

and will be unfit to resume work until:

Disablement from attending to usual business or occupation commenced on:

Total disablement occurs when the Insured is wholly prevented from attending to his/her business or occupation whereas partial disablement shall mean disablement from a substantial part of the Insured person's usual occupation.

If a date of return to work can be given, please complete the following:

Temporary total disablement: from to

Temporary partial disablement: from to

Is surgical intervention necessary or likely to be so? Yes ☐ No ☐

Is claimant confined to bed or house? Yes ☐ No ☐

On the basis of your existing knowledge and without undertaking any further examinations, is it your opinion that the disablement indicated above is solely attributable to the specified injury sustained? If not, please state below any contributing factors and the extent to which disablement is or has been thereby affected:

Signature:

Qualification:

Official Stamp

Date:

Notes for Policyholders: Any fee for the medical certificate is payable by the claimant. Further medical certificates are required at regular intervals during periods of disablement. Interim payments of benefits are normally made on request subject to satisfactory medical evidence. The claimant may be required to submit to medical examination on behalf of and at the expense of IPB Insurance in connection with any claim.

5. Data Protection Notice

IPB Insurance (IPB) is committed to protecting your personal information. IPB Insurance is a data controller and is required to comply with the Data Protection Acts 1988 – 2018 and the General Data Protection Regulation. The information that you provide ('data') will be used for the administration of your policy and/or any claims made on the policy. Data is at all times treated as confidential and the appropriate measures are taken to ensure it is secure. A copy of our Data Protection Notice can be found on our website www.ipb.ie. The notice explains why we collect and use your data, who we share your data with, your data protection rights, how long we retain your data for, where your data is located and what to do if you have any data protection complaints. If you would like to receive a copy of the Data Protection Notice you can email dpo@ipb.ie or write to IPB Insurance, 1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820.

6. Declaration

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:

Date:

Please return completed form to:

The Claims Department
IPB Insurance, 1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820, Ireland.
Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: claims@ipb.ie Web: www.ipb.ie