Mapfre Malta p.l.c.
Middle Sea House, Floriana FRN 1442 Malta

T: (+356) 2124 6262
info@Mapfre.mt
Registration Number: C5553

Personal Accident Claim Form

IMPORTANT NOTES

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

ALL RELEVANT QUESTIONS MUST BE FULLY ANSWERED

Claim no.:	Policy no.:
Intermediary / Agent:	

1. INSURED DETAILS

Title:	
Name and surname of policy holder:	
Address:	
ID. Card no.:	Passport no.:
Tel. / Mob. No.:	
E-mail address:	
VAT Reg. No.:	Business / Occupation:

2. CLAIM DETAILS

Date and Time of Incident:
Address at which incident occurred:
Description of incident:
Nature of injury / illness:
Name and address of doctor who attended:
Has a similar injury / illness been sustained before? YES ☐ | NO ☐ If so when?

Name and address of usual doctor:
During what period was the person totally disabled from attending to any part of his/her occupation/profession?
From:
To:

If total disablement continues, the medical certificate report included in this claim form must be completed by the injured person's doctor.

3.PAYMENT DETAILS - ***Let us know your bank account details for processing of payment***

Use the bank details below for this and future claims Yes ☐ No ☐
Account Holder Name:
IBAN Number:
Bank Name:
Bank Branch:
BIC/SWIFT Code

PERSONAL DATA PROCESSING

If you would like to know more about how Mapfre Malta p.l.c. processes your personal data, please refer to the following link: www.mapfre.com.mt/privacy-policy/.

DECLARATION

I/we hereby declare that, after checking all details, the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I/we understand that in the event of an incomplete and/or non-disclosure of material information, Mapfre Malta p.l.c reserves the right to repudiate the claim. Furthermore, I/we declare that I/we have not withheld any information relevant to the claim and assume full responsibility for the statements being made.

If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We confirm that 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.

I/we give explicit and unequivocal consent to Mapfre Malta p.l.c. to seek any information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my/our health in order for the validity of the claims to be established. I/we hereby authorise any doctor, surgeon, hospital, clinic, laboratory or persons that have records to provide full medical information concerning myself/ourselves and my/our dependants.

Signature of claimant:	Date:

Medical Certificate

(To be completed by the injured person's treating doctor only in the event that total disablement continues)

To your knowledge, how was the injury caused?
Please describe fully the nature of injuries sustained (indicating whether left or right in the case of an eye or limb)
Are the symptoms which the Insured Person suffers due solely to the injury? YES ☐ | NO ☐
When were you first consulted regarding the injury?
Are you still in attendance? YES ☐ | NO ☐
Are you the usual medical attendant of the injured person? YES ☐ | NO ☐
If so, how long have you known him/her?
Is he/she suffering from any illness or physical defect in addition to the injury? YES ☐ | NO ☐
If so, to what extent will his recovery be delayed?
Please indicate whether, on your advice, the injured person is, or has been:
a. Confined to bed

From:	To:
b. Confined to home	
From:	To:
c. Able to leave home but unable to work	
From:	To:

If the injured person is unable to attend to any part of his occupation please state:
Date disablement commenced:
Probable duration:
If he/she is able to attend to any part of his/her occupation please state:
Date disablement commenced
Probable duration:
The nature of the duties he/she is able to carry out:
On what date did you certify the injured person as recovered and able to resume his/her occupation?
Additional Remarks:

Name of Medical:	Date:
Address:	
Practitioner Signature:	