2A CHRYSOSTOMOU INSURANCE AGENCY LTD
GRAWE Cyprus
Arch. Makariou III Ave. 3, 2572 Pera Chorio Nisou, Nicosia
Tel.: +357 22441189, Fax: +357 22441198, e-mail: info@2achrysostomou.com.cy

Personal Accident Claim Form for Students

Claim No.: ..... Policy No.: .....

1. School: ..... Class: .....

2. Student's Full Name: .....

Identity Card or Birth Certificate No.: ..... Date of Birth: .....

STATEMENT OF PRINCIPAL/TEACHER
- I declare that the above accident occurred during school hours ……
- I acknowledge the accident which occurred outside of school hours ……

Signature and Stamp:
.....
ACCIDENT DETAILS:

A) DOCTOR'S STATEMENT
Doctor's Full Name: ..... Phone:
.....
Child's Full Name: ..... Date of Birth:
.....

(a) Describe the nature of the accident in detail:
.....

(b) Were there any visible signs of injury that confirm the described accident? (If yes, please describe)
.....

(c) Diagnosis: .....
2. (a) Date of first examination: .....
(b) Was surgery performed? (If yes, please describe) .....
(c) Was the patient previously examined by another doctor? (If yes, state by whom and when)
.....
3. Describe the patient's current condition: .....
4. Did the patient suffer from or was hospitalized for a similar condition in the past?
.....
5. Is there a possibility of disability? .....
6. Will physiotherapy be required? If yes, how many sessions?
.....
7. Will diagnostic tests be needed? .....
8. List the prescribed medication: .....

I certify that my responses are true and complete.

Doctor's Signature and Stamp: ..... Date: .....

PARENT OR GUARDIAN DECLARATION:

1. Parent or Guardian Full Name:
.....Phone: .....

2. Home Address: ..... Email: .....

3. (a) Total submitted expenses € .....
(b) Number of submitted receipts: .....

4. Date of the accident: ..... Time: ..... a.m./p.m.

5. Was the accident at school? (YES or NO) .....

6. Provide a brief description of the accident:
.....

7. Provide the names and addresses of two witnesses:
a. .....
b. .....

8. What physical injuries were sustained due to the accident?
.....

9. If the child was hospitalized, please answer the following:

a. Name and address of the hospital or clinic: .....
b. Admission date: ..... Time: ..... a.m./p.m.
c. Discharge date: ..... Time: ..... a.m./p.m.

PARENT OR GUARDIAN STATEMENT:

I hereby declare that I am the parent or guardian of the patient. I wish to submit a claim and declare that all the details provided are true and accurate to the best of my knowledge. I consent and authorize my doctor to discuss the accident and treatment details with Grawe Insurance Company (Cyprus) Ltd.
I declare that I will have no other claims from the incident and will consider myself fully satisfied with the payment of this claim through bank transfer or check in my name.

Date: ..... Parent or Guardian's Signature: .....

Attached are original medical expense receipts …..
Medical expense receipts will follow …..
Attached are radiological exam reports……

CONSENT DECLARATION FOR THE PROCESSING OF PERSONAL DATA AND SPECIAL CATEGORY DATA

I declare that I have been informed verbally and via the website of Grawe Insurance Company (Cyprus) Ltd about:
- the processing of personal and special category data by the company and its representatives.
- my rights as the subject of the data, as well as my child's rights.

I acknowledge that the processing of my and my child's data is necessary for the execution of the insurance contract I am requesting, and that any withdrawal of consent in the future will result in the immediate cancellation of the insurance contract.
I provide my explicit consent to the company and its representatives for the processing of my and my child's data.

Parent/Guardian Name: ..... ID No.: .....

I AGREE - I DO NOT AGREE

Signature: .....