

Pupil Personal Accident Report Form

Dear Policyholder,

We acknowledge receipt of your recent Notification. Please complete this form fully in accordance with the explanatory notes overleaf. All claims are subject to Policy terms and conditions.

1. School

Name:	<input type="text"/>	Policy Number:	<input type="text"/>
Address:	<input type="text"/>	Is the injured pupil covered for school activities only <input type="checkbox"/>	
		or 24 hour cover? <input type="checkbox"/>	
		Telephone Number:	<input type="text"/>
		E-mail Address:	<input type="text"/>

2. Names of Injured Pupil and Parent

Pupil's Name:	<input type="text"/>	Class Name/Year:	<input type="text"/>
Address:	<input type="text"/>	Telephone Number:	<input type="text"/>
Parent's Name:	<input type="text"/>		

3. Accident Circumstances and Related Particulars (to be completed by the School Principal / Parent as appropriate)

Date and time of accident:

Please describe fully the location, circumstances and nature of the accident:

Please describe fully the nature and extent of the injuries suffered:

Does the injured pupil suffer from a pre-existing physical defect, infirmity or medical condition? YES NO

If 'YES' give details:

Name and Address of Doctor/Dentist attending injured pupil:

Is the injured pupil the beneficiary of Private Healthcare Insurance (e.g. VHI, Quinn Healthcare, etc) or Medical Card cover? YES NO

Please state the amount recovered to date, if any, from the above source: € (please tick as appropriate)

Have the injuries described prevented attendance at school? YES NO

If 'YES' between what dates: From: € To: €

Data Protection Act – Statements and Consents

Allianz p.l.c. is a member of the Allianz Group, and shall be the data controller in respect of all personal information provided on this form. References to We and Us in these statements and consents shall be construed accordingly. Allianz p.l.c. is regulated by the Financial Regulator.

By providing Us with the pupil's information and by the parent/guardian signature, the parent/guardian consents to all of the information being used, processed, disclosed and retained for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention). We will not retain any personal information for longer than is necessary for the purposes for which it is obtained.

We may share with our agents and service providers, members of the Allianz Group, other insurers and their agents, and with any intermediary acting for you, and with recognised trade, governing, and regulatory bodies (of which We are a member or by which We are governed), information We hold about the pupil and the pupil's claim history.

We may need to collect sensitive data relating to the pupil (such as medical or health record or condition, etc.) in order to administer claims which arise. By the parent/guardian signature, the parent/guardian signifies consent to such information being disclosed by Us, our agents and other insurers for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention).x

4. Declaration

I/We declare that the foregoing statements are true to the best of my/our knowledge and belief.

Signature of School Principal:

Date:

Signature of Parent/Guardian:

Date:

5. Notes

1. This Form must be completed, signed and dated by both Parent and School Principal. It should be returned to the Company as soon as possible after the accident has occurred.
2. Please attach copy invoices in support of the amount claimed.
3. **The Medical Certificate below need only be completed by a registered medical/dental practitioner, at the sole expense of the claimant, if the claim exceeds €250 in value.**
4. It is important to quote the Policy Number on ALL correspondence.

6. Medical Certificate

Name of Patient:

Age:

Date of your first attendance on Patient:

Are you still in attendance on Patient?:

Full details of injuries suffered:

Are they consistent with the description of the accident as stated overleaf?:

Is the disability wholly due to the accident?:

Please state date of return to school:

Has the Patient been confined to bed or house on your instructions?:

YES

NO

If 'YES' between what dates: From:

To:

If disability is continuing, please state the probable further duration of such total disablement from this date:

If the Patient has recovered please state date of recovery:

General remarks:

Signature:

Date:

Address:

Qualification:

Please return the completed forms and invoices(s), if any, to:

Allianz p.l.c.,
Allianz House,
Elmpark,
Merrion Road,
Dublin 4.

Telephone: (01) 613 3000 Fax: (01) 613 4444

Email: info@allianz.ie Website: www.allianz.ie

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