HEAD OFFICE
15 Esperidon Str., 2001 Strovolos
P.O.Box. 24579, 1301 Nicosia
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PERSONAL ACCIDENT CLAIM FORM

Claim Number (to be completed by the Company)		Policy Number	

NOTE: This form must be completed and returned without delay.

1. Full Name;	
2. Residential Address:	Tel.:
3. Current work / occupation: (if more than one please declare all)	
4. Employment address	Tel.:
5. Date of Birth:	Identity Card Number:
6. Date of accident:	Time of accident:
7. Place of accident:	
8. Give details of the kind and the circumstances of the accident:	
9. State the nature and the extent of the injuries:	
10. Names and addresses of any witnesses of the accident:	
1 1 . Name and address of attending physician :	
12. Please state where and when can a physician or a Company employee visit you, if necessary:	
13.State the period during which as a sole and direct result of the accident you were totally disabled (unable to work):	From To
14. Do you continue to be partially disabled? If not, as from which date were you able to perform your occupational duties?	From To

*I hereby declare that all the above information is full and true and I authorize all physicians, hospitals or other institutions that I have used to furnish A***tlantic Ins. Co. Public Ltd** *any information and copies of their records in respect to the above accident.*

Date	Signature of the Claimant