MetLife®

☐ First Notice
☐ Partial Payment
☐ Full Settlement

CLAIMANT STATEMENT DUE TO ACCIDENT

1. CLAIMANTS PERSONAL INFORMATION

POLICY NUMBER: …… IDENTITY CARD.: ……
SOCIAL INSURANCE NUMBER : …… DATE OF BIRTH : ……

2. CLAIMANTS DETAILS

FULL NAME : ……
OCCUPATION (Exact duties)) : ……
EMPLOYERS NAME……
BUSINESS ADDRESS : ……
E- Mail …… TEL.: ……
RESIDENCE ADDRESS : ……
…… TEL.: ……

3. ACCIDENT DETAILS

DATE OF ACCIDENT: …… …… PLACE AND TIME OF ACCIDENT . ……
……
HOW DID ACCIDENT HAPPEN GIVE DETAILS……
……
NAME OF A PERSON WHO WAS PRESENT AT THE TIME OF THE ACCIDENT;
1. …… 2. ……
WHERE AND WHO GAVE YOU THE FIRST AID;: ……
HAS THE POLICY BEEN INVOLVED? YESI ☐ NO ☐
IF IT WAS A ROAD TRAFFIC ACCIDENT GIVE DETAILS OF THE CARS, PERSONS AND INSURANCE COMPANIES INVOLVED:
……
……

4. DETAILS OF INJURIES SUSTAINED

DESCRIPTION OF THE INJURY : ……
NAME OF THE DOCTOR …… …… DATE OF FIRST VISIT : ……
PERIOD OF DISABILITY DUE TO THE ACCIDENT FROM : …… TO : ……
HOSPITILIZATION PERIOD IF ANY: FROM : …… TO : ……
PRESENT CONDITION OF HEALTH : ……
WHAT TREATMENT HAS BEEN FOLLOWED : ……
……
ARE YOU ABLE TO PERFORM YOUR DUTIES PARTIALLY ; YESI ☐ NO ☐
IF YES SINCE WHEN; ……
HAVE YOU RETURNED BACK TO WORK? If yes ☐ WHEN DATE : …… NO ☐
PLEASE STATE WHERE CAN A COMPANYS REPRESENTATIVE CAN VISIT YOU; ……
……

CL4A

Βλέπε πίσω .../2

5. OTHER INFORMATION

MONTHLY SALARY AT THE DATE OF THE ACCIDENT : .....

Are you entitled compensation from another fund or insurance company YES ☐ NO ☐

If yes give details : .....

DO YOU HAVE ANY OTHER PERSONAL ACCIDENT OR HEALTH INSURANCE POLICY YESI ☐ NO ☐

If yes give details (type of policy, name of insurance company) .....

ARE YOU RECEIVING OR HAVE YOU APPLYIED FOR REIMBURSEMENT FROM SOCIAL INSURANCE : YES☐ NOI ☐

If yes give details .....

6. TO BE COMPLETED IFYOU ARE SELF EMPLOYED

ARE YOU SUPERVISING YOUR WORK YES ☐ NO ☐

ΑΝ ΟΧΙ, ΤΟΤΕ ΠΟΙΟΣ ΕΠΙΒΛΕΠΕΙ; .....

NOTES

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DECLARATION/AUTHORIZATION

I hereby declare that all information on this form is true, accurate and complete. At the stage of claims compensation I consent to provide MetLife the results of my medical and diagnostic examinations and therapies for evaluation by the contracted doctors of the Company, according to the provisions of the Processing of Personal Data (Protection of Individuals) Law 138(I) 2001, as amended each time, the data only which is completely related and indispensable for the purpose of examining my claim in case the Company deems that this is absolutely necessary to decide whether it will compensate me according to the terms of my Insurance Policy or/and determine the amount of compensation. Furthermore I authorize my doctor, the hospital or the clinic to provide any information to MetLife related to this declaration.

Insured signature : ..... **Date:** .....