



PERSONAL ACCIDENT CLAIM FORM

Argus Insurance Company (Europe) Limited

P.O. Box 45, Regal House
Queensway
Gibraltar

Tel: +350 200 79520
Fax: +350 200 70942

enquiries@argus.gi
www.argus.gi

Please complete in full the relevant sections and submit it to: NewClaimsNotification@argus.gi or Argus Insurance Company (Europe) Limited, P.O. Box 45, Regal House, Queensway, Gibraltar.
If any sections are not applicable please add N/A.

INSURED

Full Name:

Policy No.:

Address:

Postcode:

Business or Occupation:

(incl. part-time occupation)

Phone No. Home:

Mobile No.

E-mail:

Work:

INSURED PERSON'S DETAILS

Full Name:

Address:

Postcode:

Date of Birth:

Occupation:

Duties carried out:

Annual salary or gross basic: £

Date first absent from work:

Please provide a doctor's report

Name and address of the doctor who signed the medical certificate:



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Name and address of your usual doctor, if different from above:

Four horizontal lines for text input.

ACCIDENT CLAIM

Date of accident: Time (am/pm):

Place:

How did the accident occur?

Four horizontal lines for text input.

What are your injuries?

Four horizontal lines for text input.

Have you ever had a similar accident before? Yes No

If 'Yes', give details:

Four horizontal lines for text input.

Are you claiming under or being paid any benefit by any other insurance or sources in respect of this disablement? Yes No

If 'Yes', state name and address of insurer, policy number and benefits:

Four horizontal lines for text input.



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CONSENT TO OBTAIN A MEDICAL REPORT

I wish to see the report before it is sent to Argus

Yes

No

Delete as applicable

Doctor's name:

Doctor's address:

Insured Person's Signature:

Date:

Give names and addresses:

COMPLAINTS PROCEDURE

Our aim is at all times to provide a first class standard of service. However, there may be occasions when you feel that this objective has not been achieved. Should you have any query or complaint regarding this insurance please write to Argus Insurance Company (Europe) Limited, PO Box 45, Regal House, 3 Queensway, Gibraltar. If you are dissatisfied with the response you receive you should write to the Department of Consumer Affairs, 10 Governor's Lane, Gibraltar.

GDPR - INFORMATION USES

Information you supply may be used for the purposes of insurance administration by the insurer, its associated companies and agents, by reinsurers and your intermediary. It may be disclosed to regulatory bodies for the purposes of monitoring and/or enforcing the insurer's compliance with any regulatory rules/codes. Your information may also be used for offering renewal, research and statistical purposes and crime prevention. It may be transferred to any country, including countries outside the European Economic Area for any of these purposes and for systems administration. In assessing any claims made, the insurer or its agents may undertake checks against publicly available information (such as electoral roll, county court judgments, bankruptcy orders or repossessions). Information may also be shared with other insurers either directly or via those acting for the insurer (such as loss adjusters or investigators). With limited exceptions, you have the right to access and if necessary rectify information held about you.



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VERY IMPORTANT - FRAUDULENT AND EXAGGERATED CLAIMS

Deliberately exaggerated claims could invalidate your policy cover. Insurance fraud is a crime and liable to prosecution. The above answers to our questions will be the basis of consideration of your claim. You must ensure that all information is true, correct and complete to the best of your knowledge and belief, and that all material facts have been disclosed. A material fact is one that is likely to influence us in the assessment or acceptance of this claim, or application of cover under the terms and conditions of your policy. If you are in any doubt as to whether a fact is material, you must disclose it. Failure to do this may mean that your policy becomes invalid and a claim payment will not be made.

I / We declare that the foregoing particulars to be correct to the best of my/our knowledge and belief. I /We understand that you may seek information from other insurers to check the answers I/we have provided. This report is made in the bona fide belief that litigation may ensue and to enable solicitors and/or agents to conduct such litigation and advise in relation thereto.

DECLARATION

I / We confirm the facts stated on this form to be true and accurate to the best of my / our knowledge.

I / We give authority to the insurers or their representative to contact my / our Medical practitioners for any additional information required in connection with this claim.

I confirm the information submitted on this form is correct to the best of my knowledge and belief.

Insured Person's Signature:

Date:

Insured's Signature:

Date:

Position: