

**Part A - To be completed by the Insured:**

Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_  
 ID No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Declare**

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_  
 Name of the Hospital/Clinic where you were treated: *(attach relevant certificates)*: \_\_\_\_\_  
 \_\_\_\_\_ Tel. No.: \_\_\_\_\_  
 Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_  
 Name of the doctor who treated you:  
 1: \_\_\_\_\_ Tel. No.: \_\_\_\_\_  
 2: \_\_\_\_\_ Tel. No.: \_\_\_\_\_

**Please answer the following questions:**

Did you remain confined at home?  
 Yes  No If Yes, from: \_\_\_\_\_ to: \_\_\_\_\_  
 Did you monitor or supervise your work in any way during your temporary disability?  
 Yes  No If Yes, from: \_\_\_\_\_ to: \_\_\_\_\_  
 -When do you expect to return to your normal duties? \_\_\_\_\_  
 Are you entitled to compensation from another fund or insurance company, and what is the amount?  
 Yes  No \_\_\_\_\_

I hereby declare responsibly and with full knowledge of the consequences of the Law regarding false statements that the above answers are correct and true, and I authorize my doctor, the Hospital, or the Clinic to provide any information in connection with this declaration.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

For internal use:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Part B - Medical Section**

Patient's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

1. Date of Examination of the Patient:

First Time: \_\_\_\_\_ Last Time: \_\_\_\_\_ Total Examinations: \_\_\_\_\_

Was the patient examined by another doctor? (If yes, by whom and when) Yes  No

2. a) Were there any signs of trauma on the body indicating the occurrence of the accident? Yes  No

If yes, describe: \_\_\_\_\_

b) Other Clinical Findings: \_\_\_\_\_

c) Diagnosis (in detail): \_\_\_\_\_

d) Treatment provided: \_\_\_\_\_

e) Was any part of the body immobilized? If yes, until: \_\_\_\_\_

3. Has the patient previously suffered from or been hospitalized for a similar incident? Yes  No

4. The patient was confined to bed in the hospital/clinic from: \_\_\_\_\_ to: \_\_\_\_\_

5. You have provided the patient with a sick leave from: \_\_\_\_\_ to: \_\_\_\_\_

6. During the period of sick leave, the patient:

a) Could supervise their work or work partially from: \_\_\_\_\_ to: \_\_\_\_\_

b) Was completely unable to perform any work or supervise work from: \_\_\_\_\_ to: \_\_\_\_\_

7. Has the patient fully recovered? (If not, please provide explanations): Yes  No

8. Please provide any additional information for the assessment of the accident:

Name of Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Tel No: \_\_\_\_\_

**Company Doctor's Assessment and Comments:** \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**We aim to provide you with prompt and efficient service.**

To facilitate the process, in the event of an accident, please send us the completed statement below within 6 days from the date of the incident, accompanied by **the medical leave certificate**, indicating **the duration and reason for the leave**.

**Insured's Details:**

Name: _____	Policy Number: _____
Date of Birth: _____	ID Number: _____ Social Insurance No.: _____
Home Address: _____	Tel. No.: _____
Name of Employer/School: _____	
Work/School Address: _____	Tel. No.: _____
Profession ( <i>Please describe your duties in Detail</i> ): _____	
Salary: _____	

**Accident Details**

Date: _____	Time: _____	Place: _____
Brief Description: _____ _____		
Names and address of two persons who were present:		
a. _____	Tel. No.: _____	
b. _____	Tel. No.: _____	
What Physical injuries did you sustain from the accident? _____ _____		

Please tick (✓) the appropriate box and provide details where the answer is Yes.

Were you hospitalized?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name and address of the Hospital or Clinic: _____	
Date of Admission: _____	Date of Discharge: _____
Have you started, even partially, to work or to supervise your work?	
If yes, since when; _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had similar accidents in the past?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you entitled to compensation from another fund of insurance company?	
And what is amount? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby declare responsibly and with full knowledge of the consequences of the Law regarding false statements, that the above answers are correct and true, and I authorize my doctor, the Hospital, or the Clinic to provide any information in connection with this declaration.

Date: _____	Signature of the Policyholder/Parent of Guardian: _____
Full Name of the Insured/Parent of Guardian: _____	