ETHNIKI
GENERAL INSURANCE (CYPRUS) LTD

MEDICAL CLAIM FORM

Please check and confirm that the claim form is fully completed.

Policy Owner

Policy Number

CLAIMANT'S DECLARATION

Insured

Telephone

Patient Name

Date of Birth

ID / Passport No:

Details for Sickness / Accident

Sickness / Accident

Date of accident

Symptoms

Date of appearance of symptoms

Have you ever been treated in the past YES ☐ NO ☐ WHEN ☐

Clinic / Hospital

Treating doctor's name

I hereby authorize Ethniki General Insurance (Cyprus) Ltd to transfer/pay the amount of this claim by direct payment (Direct Credit) into my bank account which I use to pay the premium of the above policy by Direct Debit. ☐

I hereby authorize Ethniki General Insurance (Cyprus) Ltd to transfer/pay the amount of this claim by direct payment (Direct Credit) into the bank account the details of which are included in the attached relevant document (IBAN). ☐

PHYSICIAN'S STATEMENT

I have examined the above patient and prescribed the above lab tests, x-rays, medication from the treatment of the diagnosed conditions.

First diagnosis

Final diagnosis

Diagnostic Tests (attach results)

Medication treatment

Suggested treatment Surgical ☐ Conservative ☐ Other ☐
Please give details

Date of first appearance of symptoms relating to the illness. Please give details.

Previous Doctor's name and date of examination regarding this incident

When was the first time he/she fist visited you?

Have you ever suffered from the same cause in the past; If YES, when?

In case of bodily injuries resulting from an accident, state where and when the accident occurred

In case of hospitalization what was the patient's clinical condition during admission

Medical history of current and previous medical condition / Factors that necessitated the admission

This is the first time the patient receives treatment for this illness/accident? YES ☐ NO ☐
If No, when was the first incident and how it was dealt?

Suffer or suffered in the past from illness, any other sickness or syndrome? YES ☐ NO ☐
Please give details

Admission Date

Exit Date

Estimated duration of hospitalization

Estimated cost of treatment

Physician's Name

Specialty

Telephone

Hospital - Clinic Name

Physician's Signature

Examination Date

Patient's declaration and consent

I declare that I am the patient, parent or guardian of the patient (if the patient is under 18 years of age) please cross out what is not applicable. I wish to claim benefit and declare that all the particulars I have given are to the best of my knowledge, true and correct.

I consent and authorize my doctor to discuss my illness and the details of my treatment with Ethniki General Insurance (Cyprus) Ltd.

I agree that one copy of this consent document will have the validity of an original.

Signature	Date

STATEMENT OF CONSENT

STATEMENT OF CONSENT REGARDING THE PROCESSING OF PERSONAL DATA AND THE PROCESSING OF SPECIAL CATEGORIES OF PERSONAL DATA

I hereby declare that:

1. I have been informed verbally and via the corporate website of Ethniki General Insurance (Cyprus) Ltd. ("The Company") regarding:
   - the processing of personal data and special categories of personal data conducted by the Company.
   - My rights as the data subject.

2. I acknowledge that processing my personal data (including special categories) is mandatory for the execution of the insurance contract that I have requested and that any potential future revocation of my consent shall result in cancellation of the insurance contract with immediate effect.

3. I expressly provide my consent to the Company to process my personal data including special categories of personal data where applicable, as well as to request and receive on my behalf any information regarding the physical or mental state of my health from any doctor, clinic, medical or diagnostic center that at any time with attended or in which I have conducted diagnostic tests.

THE POLICY OWNER	**THE INSURED / DEPENDANTS**
I CONSENT ☐ **I DO NOT CONSENT** ☐	**I CONSENT** ☐ **I DO NOT CONSENT** ☐
Name, Surname and ID No.:	Name, Surname and ID No.:
Signature:	Signature:
THE INSURED / DEPENDANTS	**THE INSURED / DEPENDANTS**
I CONSENT ☐ **I DO NOT CONSENT** ☐	**I CONSENT** ☐ **I DO NOT CONSENT** ☐
Name, Surname and ID No.:	Name, Surname and ID No.:
Signature:	Signature:

STATEMENT OF CONSENT REGARDING THE PROCESSING OF PERSONAL DATA FOR COMMERCIAL/MARKETING/STATISTICAL PUPROSES

I have been expressly informed that, on condition of my explicit consent below, the Company shall collect, store and process my personal data so as to conduct targeted marketing or promotional activities, or for the purpose of assessing the quality of provided services.

In order to achieve the aforementioned objectives my personal data may be communicated to research or marketing companies collaborating with the Company.

I have been informed regarding my right to object to the processing of my personal data for commercial/marketing/statistical purposes at any time by sending a relevant request to the Company.

THE POLICYHOLDER	**THE INSURED / DEPENDANTS**
I CONSENT ☐ **I DO NOT CONSENT** ☐	**I CONSENT** ☐ **I DO NOT CONSENT** ☐
Name, Surname and ID No.:	Name, Surname and ID No.:
Signature:	Signature:
THE INSURED / DEPENDANTS	**THE INSURED / DEPENDANTS**
I CONSENT ☐ **I DO NOT CONSENT** ☐	**I CONSENT** ☐ **I DO NOT CONSENT** ☐
Name, Surname and ID No.:	Name, Surname and ID No.:
Signature:	Signature:

Date ……………………………………………………………………… Place of signing ………………………………………………………..…………………………..