Pupil/Staff Personal Accident Report Form

Brennan Insurances

Please complete this form fully and return it to Brennan Insurances as soon as possible.
Please note that the issue of this form is not an admission of liability on the part of Brennan Insurances or Allianz plc and that all claims are subject to Policy terms and conditions.

Important: Please only attach original invoices/bills as we cannot pay your claim if you submit photocopy invoices/bills. Please retain copies for your own records.

OFFICE USE ONLY
Our Ref:
Cover: 24 hr. ☐ S.R.A. ☐

1. School

Name:

Address:

E-mail Address:

Telephone Number:

Certificate Number: (this must be quoted)

2. Name of Injured Pupil or Staff Member

Name:

Address:

Class Name/Year: Date of Birth: / /

If the Injured person is under 18 years of age, please complete the following:

Parents' Telephone Number: Home Mobile

Both Parents/Guardian names should also be clearly stated:

3. Accident Circumstances and Related Particulars (to be completed by the School Principal/Parent or Staff Member as appropriate)

a) Date and time of accident: / / am/pm

b) Please describe fully the location, circumstances and nature of the accident:

c) Please describe fully the nature and extent of the injuries suffered by the injured person:

d) Does the injured pupil or staff member suffer from a pre-existing physical defect, infirmity or medical condition?: Yes ☐ No ☐
If 'YES' give details:

e) Name and Address of Doctor/Dentist attending injured person:

f) Is the injured pupil or staff member the beneficiary of Private Healthcare Insurance (e.g. VHI, Laya Healthcare, Aviva Health, etc.) or Medical Card cover? Yes ☐ No ☐
Please identify the insurer:

g) Is the injured pupil or staff member the beneficiary of any other Insurance (e.g. via a Sports Club or Youth Club etc.) Yes ☐ No ☐
Please identify the insurer:

h) Have you put them on notice of this claim? Yes ☐ No ☐
If 'YES' please state the amount recovered to date, if any, from the above source(s): €

i) Are you entitled to recover any amount from Private Healthcare Insurance, Medical Card or other insurance? Yes ☐ No ☐
If 'No', why not?

j) Please state the amount you are seeking to recover from Allianz plc, the underwriters of this policy: € _____

k) Have the injuries described prevented attendance at school?: Yes ☐ No ☐

If 'YES' between what dates: From: __ __ / __ __ / __ __ __ __ To: __ __ / __ __ / __ __ __ __

l) Is the treatment complete? Yes ☐ No ☐

If 'No', please outline the nature of the treatment proposed and the anticipated completion date?

_____

4. Dental Injuries

If you are making a claim for ongoing dental injuries please state the nature of the treatment which will be required:

_____

_____

Data Protection Acts - collection and use of personal information

The information you provide to Us when you report an accident/make a claim will be collected and used by Us to process your claim. Allianz p.l.c. is the data controller in respect of all such information, and references to We and Us in this statement shall be construed accordingly.

USES. Information you supply may be used for the purposes of insurance administration (including processing, claims handling, reinsurance and fraud prevention) by Us, our agents, our reinsurers, and any intermediary acting for you. In assessing any claims made, We may undertake checks against publicly available information such as electoral roll, court judgments, bankruptcy or repossessions.

DISCLOSURE. We may share with our agents and service providers, members of the Allianz Group, other insurers and their agents, and with any intermediary acting for you, and with recognised trade, governing, and regulatory bodies (of which We are a member or by which We are governed), information We hold about you and your claims history. This includes Insurance Link, the Irish Insurance Federation's anti-fraud claims matching database. We may in certain circumstances use private investigators to investigate a claim.

SENSITIVE DATA. We may need to collect sensitive data relating to you (such as medical or health record or condition, convictions etc.) in order to administer your claim. By your signature you signify your consent to such information being used, processed and disclosed by Us, our agents and other insurers for the purposes of insurance administration (including processing, claims handling, reinsurance and fraud prevention). RETENTION. Under the Consumer Protection Code we are obliged to retain your records for 6 years from the date your claim is settled. In certain circumstances we will retain your information for longer periods if this is required under specific insurance legislation.

CONSENT. By providing Us with your information and by your signature you consent to all of your information being used, processed, disclosed and retained for the purposes of insurance administration (including processing, claims handling, reinsurance and fraud prevention). Please note that when processing your claim, Brennan Insurances may deem it appropriate to obtain medical expert advice. By your signature you also signify your consent to Brennan Insurances sharing your information with independent medical professionals to obtain this medical expert advice and to the medical report compiled by the independent medical professionals being shared with Allianz plc.

CALL RECORDING. Calls may be recorded or monitored for regulatory, training and quality purposes.

5. Declaration/Discharge (School Principal/Staff Member must also sign if the accident happened in school)

I/WE HEREBY CERTIFY that to the best of my/our knowledge and belief the statements and particulars contained herein are fully made and that I/we have withheld no material fact concerning the accident or the injured party.

Signature of Parent/Guardian: _____ Date __ __ / __ __ / __ __ __ __

Signature of School Principal/Staff Member: _____ Date __ __ / __ __ / __ __ __ __

6. Payee Declaration(To be completed by Parent/Guardian in the event that the payee is not the Parent/Guardian)

I/WE HEREBY CONFIRM that payment should be issued to: _____

Please state relationship of Payee to the Insured person: _____

Signature of Parent/Guardian: _____ Date __ __ / __ __ / __ __ __ __

7. Notes

1. This Form must be completed, signed and dated by Parent/Guardian/School Principal/Staff Member. It should be returned to Brennan Insurances, Construction House, Canal Road, Dublin 6 as soon as possible after the accident has occurred.
2. Please attach original invoices in support of the amount claimed.
3. The Medical Certificate below should only be completed by a registered medical/dental practitioner if the claim may exceed €1,000 in value.
4. It is important to quote the Certificate Number on ALL correspondence

8. Medical Certificate

To be completed at the sole expense of the claimant.

Name of Patient: _____

Age: ___ Date of your first attendance on Patient: __ / __ / ____

Are you still in attendance on Patient?: Yes ☐ No ☐

Full details of injuries suffered:

_____

_____

Are they consistent with the description of the accident as stated overleaf?: Yes ☐ No ☐

Is the disability wholly due to the accident?: Yes ☐ No ☐

Please state date of return to school:

Has the patient been confined to bed or house on your instruction?: Yes ☐ No ☐

If 'YES' between what dates: From: __ / __ / ____ To: __ / __ / ____

If disability is continuing, please state the probable further duration of such total disablement from this date:

If the patient has recovered please state date of recovery: __ / __ / ____

Signature of Medical Practitioner: _____ Date __ / __ / ____

Address: _____

_____

Qualification: _____

Please complete the following sheet in all cases:

Date of invoice	Invoice provider	Amount of invoice	Amount of invoice
		Total Amount being claimed: €	

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Website: www.pupilcover.ie