CNP CYPRIALIFE

Registr.No. .46532 – Private
17, Acropoleos Str., 2006 Strovolos
Tel. 22 11 12 13

Policy Number:

ACCIDENT / ILLNESS CLAIM FORM

The claim form must be completed by the Insured and submitted to the Company's Head Offices within 10 days of the accident / illness / hospitalisation, otherwise the claim will not be accepted. All questions must be fully answered and not applicable points can be deleted.

INSURED´S INFORMATION

1. Full Name: ……
2. Date of Birth: ……/……/…… Identity Card No.: ………………………… Social Ins. No.: ……………………………
3. Home Address: ………………………………………………………………………………… Telephone No.: ……………………
4. Office Address: ………………………………………………………………………………… Telephone No.: ……………………
5. Name of Employer: ………
6. Employed as: ……
7. Profession (exact duties): …………………………………………………………………………………………………

ACCIDENT / ILLNESS INFORMATION

1. Date of accident / illness: ……/……/…… Place: ………………………… Time am/pm ……………………
2. Provide a detailed description of the accident / illness:

   ……
   ……
   ……

   Are there any marks on the body that would support the occurrence of the described accident / illness? If yes, please describe. ……………………………………………………………………………………………………
3. Is there a police report referring to the above incident? □ Yes □ No

HOSPITAL´S / CLINIC´S / DOCTOR´S INFORMATION

(Please attach original receipts)

1. Did you visit a hospital or clinic? □ Yes □ No When? ……/……/……
2. Were you admitted into the hospital or clinic? □ Yes □ No

   Duration of stay: From: ……/……/…… To: ……/……/……
3. Name, address and phone number of hospital / clinic: ……………………………………………………………………

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4. Name, address and phone number of attending physician: ………………………………………………………………

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5. Were you referred to another physician? Please provide name, address, phone number and reason.

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6. Did you remain at home? □ Yes □ No From: ……/……/…… To: ……/……/……

7. Did you attend or supervise your work in any way during your temporary disability?

□ Yes □ No From: ……./…../……. To: ……./……./……...

8. When do you expect to resume work? ……………………..…………………………………………………………………...

9. Are you entitled compensation from another fund or insurance company? □ Yes □ No

Provide details: ………………………………………………….…………………..…………….…………………….....……

10. What was your gross monthly salary before the accident? € ………………

11. During the past 2 years have you been absent from work due to any health reasons? If yes, give reasons and dates of absence.
…..……….…………………………………………………………………………....…...……………………………………

12. a) Were there any changes in your duties at work due to health reasons? □ Yes □ No

b) Provide details: ………………………………………………………..………………………….……………………….…

c) When did this change occur? Give exact date: ……/……./…….

INFORMATION

In the context of examining your Claim, CNP CYPRIALIFE LTD (the «Company») intends to collect and process your personal data, as well as the data of individuals mentioned in your Claim.

The Company requests data which are necessary and relevant to the purpose of examining your Claim. Certain data that concern you will be forwarded to the Company's associates for the purpose of evaluating your Claim (such as doctors for instance).

When the company collects and processes personal data, it ensures that this is carried out in a legitimate manner and that all necessary measures are taken in order to ensure their safety. For more information, please refer to the Company's Privacy Policy that is available on our website.

DECLARATION

I solemnly declare that all information included in this form is true, accurate and complete. I also declare that I have informed the individuals whose details are contained in this Claim regarding the provision of their personal data by me to the Company.

At the stage of making a claim for compensation, I will provide the Company with the results of my medical and diagnostic examinations and treatments as necessary in order for the Company to examine my Claim. The examination of my Claim includes, inter alia, the decision on whether I will receive compensation under the terms of my Insurance Policy and/or the determination of the amount of the compensation.

Please deposit the amount of compensation to the account which is maintained with the Bank ……………………………………………….. IBAN No*…………………………….………………………………………………..

*Confirmation from the Banking Institution to be attached.

Insured´s Full Name ……………………………….……………………….………………….………

Signature …………………………………. Date ……./……./……..

To be completed by the Insurance Intermediary

A. If the insured person is self-employed

- Is he/she continues with his/her professional activities? □ Yes □ No
- Does the insured person supervise his/her professional activities? □ Completely □ Partially □ Not at all

B. Personal evaluation by the Insurance Intermediary

- Could the insured person work: □ Completely □ Partially □ Not at all
- Could the insured person supervise his profession? □ Yes □ No

Insurance Intermediary´s Name ……………………….…………………………………………

Signature ……………………..…..….. Code ……..………….. District …………….……… Date ……../……../…….