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

Policy Number:

MEDICAL CERTIFICATE OF ACCIDENT/ILLNESS

We request that you ask your doctor to complete the certificate below (on your own expenses) and submit it with the claim form.

Full Name of Insured …….. Identity Card No. ……

Address ……

Occupation ……

1. Examination date of:

First time …… Last time …….. Total examinations ……

2. Was the patient examined by another doctor? Name the doctor and when.

……

3. a) Give detailed report of the accident/illness as the patient described it:

……

……

b) In your opinion, is the accident/illness caused due to the above incident? ……

……

4. Were there body marks to reveal the existence of the accident? If yes, please describe.

……

……

Diagnosis: ……

Treatment: ……

Was a surgery taken place? If yes, please give details.

……

Describe the development of the condition: ……

Prognosis: ……

5. Has the patient suffered or hospitalized in the past due to similar occurrence (accident or illness)?

……

6. As far as you know, has the insured suffered from physical injury or illness prior to the accident? Has this contributed to the cause of the accident or to the extension of the disability?

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7. When was the patient hospitalized?

a) in hospital From …… To ……..

b) at home From …… To …….

8. During his/her sick leave the patient according to his/her occupation was:

□ Totally disabled for work From …… To ……..

□ Partly disabled for work From …… To …….

9. When did he/she undertake or when can he/she undertake in your opinion even part time job?

……

10. Is there a chance of total or permanent partial disability? If yes, what percentage of disability do you expect?

……

11. Have you carried out radiographic examinations or any other screening examinations?

□ Yes □ No (Please submit the above)

12. Provide any additional information to assess the accident:

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INFORMATION

In the context of examining your Claim, CNP CYPRIALIFE LTD (the «Company») intends to collect and process the personal data that concern you which are included in this certificate.

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.

DECLARATION

I declare responsibly and with full knowledge of the consequences of the Law of Perjury that the above answers are true, complete and precise.

Full Name …….. Specialisation……

Signature …….. Telephone No. ……

Doctor's Stamp: …… Date……../……../…….