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

Policy No.:

OUTPATIENT TREATMENT CLAIM FORM

PART A

TO BE COMPLETED BY THE INSURED

Name of Insured: ……..

Name of Patient: ……..

Date of Birth: ……../……../…….. **Identity Card No.:** …… **Telephone No.:** ……...……

Address: …….

ILLNESS (DIAGNOSIS) - If the illness is due to injury from accident, state where and how it happened. If not, give the exact diagnosis.

……

The date that symptoms of illness first appeared: ……

Are you entitled to any compensation from another Fund or Insurance Company? If yes, give details. □ Yes □ No

……..……..……..……

INFORMATION

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

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

When CNP CYPRIALIFE LTD 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 CNP CYPRIALIFE LTD'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 CNP CYPRIALIFE LTD.

At the stage of making a claim for compensation, I will provide CNP CYPRIALIFE LTD 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.

INSURED´S BANK DETAILS FOR DIRECT CREDIT PAYMENT

BANK: ……

IBAN No.: ……..
***Confirmation from the Banking Institution to be attached**

Signature: …….. **Date**: ……../……./…….

Note – The claim must be submitted to the Company´s Head Office within 30 days of the accident / illness and be accompanied with all original receipts.

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PART B

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of insured: ……..……………..……….……………………………………………………….……………………………...

Name of Patient: …..……….……………………………………………………………………………...……………………….…

1. The above patient consulted me on ………………………………….. and found him/her suffering from ………………………………………………………………………………………..……………………………….………..,
   and I have advised the following treatment.

2. Did the patient suffer or was hospitalized before for a similar incident (accident or illness)? If yes, please provide details/date. ……………………..………………………………………………………………………………………………………..………..

3. Was the patient examined by another doctor? Give name and date. …………………………………………………………

PRESCRIPTION FOR MEDICINES – TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1……………………………………………………………………… 4……………………………………………………………..…

2……………………………………………………………………… 5……………………………………………………………..…

3……………………………………………………………………… 6……………………………………………………………..…

LABORATORY TESTS – TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1………..………………… 3……………..……………… 5……………….……..……… 7…………..…………..……

2………………………… 4………………………….. 6………………………….. 8……………………..……….

X-RAYS / MRI – TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1……………………………………...……………………………………………………………………………………………...

2……………………………………………..…………………………………………………………………………………….…

3………...

INFORMATION

In the context of examining the claim of the Insured person mentioned above, CNP CYPRIALIFE LTD (the "Company") intends to collect and process the personal data that concern you which are included in this form.

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.

Physician´s Name: ………

Physician´s Speciality: ………….………………………………………..……..……… **Telephone No.:** ………………………

Physician´s Signature: …………………….………………………………………..… **Date**: ………./………./……….

Note – The claim must be submitted to the Company´s Head Office within 30 days of the accident / illness and be accompanied with all original receipts.