PLEASE COMPLETE ALL QUESTIONS TO AVOID CLAIM FORM BEING RETURNED

Pupil/Staff Personal Accident Report Form

ARACHAS
The Irish for Insurance

Brennan Education

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

Important: Please only attach original itemised 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

School Name:
School Address:
School E-mail Address:
School Telephone Number:
Certificate Number: Available from the school (this must be quoted)

2. Name of Injured Pupil or Staff Member

Name (Injured Person):
Address:

Class Name/Year: Date of Birth: / /
If the Injured person is under 18 years of age, please complete the following:
Contact Telephone Number: Home Mobile
Contact Email Address:
If you do not wish to receive claim communication by email please tick this box: ☐
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:

(Note: If a sporting injury, please confirm whether representing the school, a club or neither)
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 LAMP Insurance Company, 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 – How we use your information

The Company processes data in line with the provisions of Data Protection legislation. Information supplied is kept secure, is used only for legitimate purposes and retained for no longer than is necessary and to comply with regulatory rules. . We may also need to collect sensitive personal data to fulfil insurer's requirements in providing insurance quotations. By providing us with your information and proceeding with a contract of insurance, you consent to all of your information being used, processed, disclosed, transferred and retained for the purposes of insurance administration, including underwriting, processing, claims handling, collection of debt and fraud prevention. In the event that we partner with third party suppliers we accept no responsibility for the security or content of any third party websites or third party social media activity. We may share information about you with regulatory and public bodies including An Garda Síochána and with third party outsourced suppliers providing regulated and unregulated services to the firm. We may also use your details for training purposes for in-house training and for customer research and statistical analysis.

YOUR CONSENT. By providing your information, you consent to the use of your information as outlined below. This includes specific/explicit consent for sensitive information such as medical or conviction details.

Please note that when processing your claim, Arachas may deem it appropriate to obtain medical expert advice. By your signature youalso signify your consent to Arachas 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 LAMP Insurance Company.

REPRESENTATION. If you provide information about someone else, such as an additional insured, you must have obtained this person's consent and have made them aware of the terms of this insurance.

When you request a quotation from us, you may receive a telephone call or text message and/or email in relation to that quote. There may also be requirements to contact you for the purposes of discussing renewal terms of an existing policy with us or any other query directly related to an existing policy with us. We may also use the information to notify you by telephone, post, mobile phone, e-mail and/or SMS message about new or existing products or special offers. You have the option to decline to receive further marketing information from us by writing to us or by following any additional opt out instructions that may be received in communications.

You may have entitlements under legislation to inspect all personal information held on file by the Company and to have inaccuracies in that information corrected. Requests for specific information should be sent to the Data Protection Officer at Arachas Corporate Brokers Ltd, The Courtyard, Carmanhall Road, Sandyford Business Estate, Dublin 18. There is no fee for such requests.

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

5. Declaration/Discharge

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 (or Insured Person, if an adult): _____ Date __/__/____
Signature of School Principal/Staff Member: _____ Date __/__/____
(Parent/Guardian/Insured Person (over 18 years) /must always sign. School Principal/Staff Member must also sign if the accident happened in school/school related activity)

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 __/__/____
Before submitting form, please refer to question 7 on the attached page.

PAYMENT DETAILS (payment will be sent to this account unless otherwise requested)

IBAN Code:

BIC Code:

Account holder's name:

Bank branch address:

7. Notes

1. This form should be completed, signed and dated by Parent/Guardian and School Principal or Staff member (If applicable). It should be returned to Arachas, The Courtyard, Carmanhall Road, Sandyford Business Estate, Dublin 18 as soon as possible after the accident has occurred.
2. Please attach original itemised invoices / receipts 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
5. If you require the original receipt(s) to be returned please tick the box below, whilst a copy will be retained on file all original receipt(s) received will be destroyed once payment has been made. ☐

8. Medical Certificate (Only to be completed if the claim may exceed €1,000 in value)

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:

9. Invoices / Receipts

Please complete the following sheet in all cases:

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