ARACHAS
Pupil Cover

Pupil/Staff Personal Accident Report Form

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 Chubb European Group SE and that all claims are subject to Policy terms and conditions.

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

1. School

School Name
Address *(line1)*
School E-mail
Address *(line2)*
School Phone
County
Eircode
Certificate Number *Available from the school (this must be quoted)*

2. Name of Injured Pupil or Staff Member

Name *(Injured Person)*
Address *(line1)*
Class Name/Year
Date of Birth
Address *(line2)*
Contact Phone
Email
County
Eircode
Both Parents/Guardians names
1.
2.
If you do not wish to receive claim communication by email please tick this box: ☐

3. Accident Circumstances and Related Particular

To be completed by the School Principal/Parent or Staff Member as appropriate

Date of accident
Time of accident

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)

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

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Name and Address of Doctor/Dentist attending injured person:

Is the injured pupil or staff member the beneficiary of Private Healthcare Insurance (*e.g. VHI, Laya Healthcare, Irish Life Health, etc.*) or Medical Card cover? **Yes** **No**

Please identify the insurer:

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:

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) €

Are you entitled to recover any amount from Private Healthcare Insurance, Medical Card or other insurance?

Yes **No** If 'NO' why not?

Please state the amount you are seeking to recover from Chubb European Group SE, the underwriters of this policy:

€

Have the injuries described prevented attendance at school? **Yes** **No**

If 'YES' between what dates? From To

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

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 to confirm injured person is insured on the Schools Pupil Personal Accident Policy)

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 *(or Insured Person, if an adult)* Date

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

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

IBAN Code BIC Account holder's name

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 €	