

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

School E-mail

School Phone

Certificate Number *Available from the school (this must be quoted)*

Address (line 1)

Address (line 2)

County

Eircode

2. Name of Injured Pupil or Staff Member

Name *(Injured Person)*

Class Name/Year

Date of Birth

Contact Phone

Email

Address (line 1)

Address (line 2)

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. These benefits cease on the Insured Person's 21st Birthday with the exception of: (i) Employees (ii) Post Leaving Certificate Students (iii) Insured Persons over 21 years of age, where a 1 year time limit from Date of Accident applies.

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(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
<input type="text"/>	<input type="text"/>

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

