Commercial General Insurance Ltd
Head Office
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Claim Form
Medical Insurance for Foreign Workers

This form must be completed by the Contracting Employer. Answer all of the following questions as fully as possible. Where there is insufficient space, use a separate sheet of paper.

Claim No. _____
(for use by the Company only)

(Please provide all original receipts, invoices, medical reports and other relevant certificates with this form)

Personal Information

Policy Number

Name/ Employer Name

ID Number/ Company Registration Number Telephone

Address

Personal Information of Foreign Worker

Name of Foreign Worker Gender: Male Female

Date of Birth Passport Number Country of Issue

Occupation or Work Telephone

General Information

Declare the Insurance Cover Scheme that is valid according to your insurance policy:
Figure 1 – In Patient Hospital Care ☐
Figure 2 – In Patient Hospital & Out Patient Hospital Care ☐

Is there any participation in a Trade Union or other Fund? YES ☐ / NO ☐ If YES, state your compensation.

Indicate whether the patient was previously suffering from the same condition.
State the date when the first symptoms occurred.

Medical Practitioner's Declaration (To be completed by the Medical Practitioner)

Patient's Name

Illness Accident Examination Date

Symptoms

When were the first symptoms recorded;

Cause of Illness / Accident

Diagnosis

Give details of the treatment and medication you have suggested to the patient (eg blood tests, laboratory tests, specialised examinations, etc.)

When, in your view, do you expect the patient to fully recover?

I declare that I am the patient's medical practitioner and the particulars giver are to the best of my knowledge true and correct.

Name of Doctor Doctors speciality

Doctors Signature _____ Date

Accident Details (Only to be filled in case of an accident)

Date of Accident

Time

Location

Accident Description

Describe the nature and extent of the injuries and attach the relevant certificates.

State the name and address of any person who witnessed the accident:

Name

Address

Telephone

Name

Address

Telephone

Declaration

We declare the foregoing particulars to be true in every respect, and we hereby assign to Commercial General Insurance Ltd (CGI), in accordance with the terms of the Policy, the handling of all claims and litigation arising out of this accident and to which the Policy applies. We further authorise CGI to initiate all necessary legal measures and/or settle any claim which is deemed reasonable without any further notice to us. We further undertake to give all such information and assistance as CGI may require.

We agree to provide CGI with data and information that may be used as necessary proof for the examination of our claim by CGI and/or any third party that CGI cooperates with. The personal data collected by CGI is completely relevant and necessary for the purpose of assessing our claim under the terms of our insurance policy, subject to the provisions of the General Data Protection Regulation (GDPR) and any related legislation. Furthermore, we acknowledge CGI's right to share our personal data with any third parties to the extent required for the performance of a contract, due to legal obligations and legitimate interest, considering that CGI has taken all appropriate measures to ensure that such third parties follow the guidelines of the GDPR regarding the safe processing of personal data.

We understand that in the event where we require further information as to the way CGI processes personal data, we may contact CGI's Data Protection Officer at 101 Arch. Makarios III Avenue, 1071, Nicosia or through email at DPO@cgi.com.cy or refer to CGI's Privacy Notice which is available at http://www.cgi.com.cy.

We further authorise any authorities such as the Police and/or other institutions or insurance companies to provide full information on the facts of this claim to CGI when such a request is made by CGI for the purpose of assessing our claim.

Signature of Employer **Date**

Signature of Insured Person/Foreign Worker **Date**