Olé

ACCIDENTAL DISABILITY CLAIM FORM

INSURED INFORMATION

Name of Insured: Policy number:______________________

______________________ ______________________ ______________________ ______________________

First name | Middle name | Surname | Second surname

Identification No.:______________________ Date of Birth: dd / mm / yy

Address of the Insured: ____

______________________ ______________________ ______________________ ______________________

City | state | Country | Postal Code

Occupation:______________________

ACCIDENT INFORMATION

When did the accident occur? ____

Where did the accident occur? ____

How did the accident happen? ____

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____

What were you doing at that time? ____

____

____

What was the cause of the accident? ____

____

____

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What injury(s) did you have in this accident? ______________________

What was the initial treatment (first aid) you received after the accident occurred, who performed it and where? ______________________

Were you taken to the hospital by, or received care from, emergency medical services such as paramedics, Red Cross, municipal emergency medical services, police, firefighters, etc.?

Name and contact of all doctors consulted and hospitals where you were treated:

NAME OF DOCTOR OR HOSPITAL	PHONE OR EMAIL	DATE(S) OF SERVICE (mm/dd/yy)

Was any surgery or operation performed as a result of the injury? ______________________

If you were hospitalized, indicate the name of the hospital: ______________________

From: dd / mm / yy Until: dd / mm / yy

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Are any surgeries, hospitalizations, medical tests or medical treatment pending?

Names and telephone numbers of witnesses to the accident.

NAME	TELEPHONE

Did you notify local authorities? **YES** ◯ **NO** ◯

Was there any publication of the accident in the local press? **YES** ◯ **NO** ◯

CERTIFICATION AND AUTHORIZATION

I certify that the above statements are complete and true to the best of my knowledge and belief. I authorize the doctors and hospitals where I was treated to grant Olé Insurance Group Corp. I.I. the medical reports, records and medical history they request (which may include previous illnesses of the Insured), so that they can carry out the claim evaluation.

Name of Insure: ______________________ Birthdate: dd / mm / yy

Signature of the Insured: ______________________ Date: dd / mm / yy

In the event that the Insured is unable to sign, the certification and authorization for access to medical reports, files and medical history in terms of the previous paragraph is granted by:

Full name: ______________________ Family relationship: ______________

Signature: ______________________ Date: dd / mm / yy

Notice: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be charged with insurance fraud and subject to civil and criminal penalties.

BANKING INFORMATION OF THE INSURED

Name of Account Holder: ______________________

Name of the bank: ______________________

Bank address: ______________________

Bank Telephone No.: ______________________

SWIFT/ABA: ______________ Account number: ______________________

Account Type (Savings/Checking): ______________________

Please include the following documents:

1. Copy of the insured's government issued ID
2. Report from each doctor who was involved in your care
3. Copy of the medical record of the hospitalization
4. Police and/or ambulance or paramedic report, if applicable
5. Medical bills related to the incident
6. Copy of publications about the accident in the local press, on the internet or social networks