

Claim No.													Any	appl	icable	e exte	nsions:				
Policy No.													Spi	rint Co	over						
Intermediary													Far	nily C	over						
						ic	ycl		Cla	sin	n E	or	m								
						IC	.yCı	16 (LIC	2111		OI I									
General Section	n																				
Policy Holder Nan	ne																				
Name of Claimant	t/s																				
Address																					
I.D. Card No.										E	mail	Addr	ess								
Telephone No.											Мо	obile	No.								
Occupation/Name Employer	e of																		Age		
Do you have any o	other	insura	nce po	licy/p	olicie	es in f	force	with	Atla	as Ins	surar	nce Po	CC Lir	nited	?				Yes		No
Is there any other	insur	rance iı	n force,	whicl	h also	o cov	ers th	nis los	ss/e	xper	nse?								Yes	$\overline{}$	No
If yes, state which	polic	:y/insu	rance c	ompa	any																
Have you ever bef	fore c	:laimec	d under	a bic	ycle į	polic	y?												Yes		No
If yes, give details	5																		_		
Bicycle Cover																					
Date of occurrenc	ce								Tir	me						Place					
Date and time advauthorities/securi				ort												Time					
Circumstances of Details of items cl			age:																		
No. of articles			Desc	riptio	n			Wh	nen	bou	ght	Wh	ere bo	ought	t	Cost p	oaid	aft	er de	duct	imed ion for

Hospitalisation							
Nature of injury							
Date of occurrence							
Name and address of your family doctor							
Has the person ever suffered	from the same injury or any other medical condition?			Υ	'es	No	
If yes, give details including d	late of last occurrence		<u>_</u>	<u>_</u>			
No. of days as an in-patient							
Do you have a private health	insurance policy?			Υ	'es	No	
If yes, give details							
Broken Bones							
Nature of injury							
Date of occurrence							
Name and address of your family doctor							
Has the person ever suffered	from the same injury or any other medical condition?			Υ	'es	No	
If yes, give details including d	late of last occurrence		<u></u>	<u></u>			
No. of days as an in-patient							
Do you have a Private Health	Insurance Policy?			Υ	'es	No	
If yes, give details							
Dental Treatment							
Reason for admittance							
Date of occurrence							
Has the person ever suffered			Υ	'es	No		
If yes, give details including d	late of last occurrence						
Do you have a Private Health	Insurance Policy?			Y	'es	No	
If yes, give details	,						

Personal Accident	
Date of occurrence	Time of Accident:
Place of accident	
State circumstances	
Public Liability	
Date of loss	Time
Place of incident	
State circumstances of incident	
Details of third parties	involved (including third party legal representatives if applicable)
Name/s	
Address	
Email	Tel No. Fax
Details of any damaged	d third party property
Insured's Direct Cre Please complete your ba	dit Details ank details if you wish us to transfer claim settlement into your bank account.
Bank Account details	
Name of Bank	
Country	
IBAN No.	

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Signature of Policyholder	Date				