1B Braemar Avenue, Kingston 10, Jamaica W.I. • **Phone** (876) 656-8000 • **Telefax** (876) 656-8001
Email info@ironrockjamaica.com • **Web** www.ironrockjamaica.com

By completing this form, you consent to the use of your data as outlined below:

Data Retention: We will keep the data you provide for 7 years as required by law. After that, it will be kept indefinitely for statistical and research purposes. Your privacy will be protected through anonymization or pseudonymization of the data.

Data Usage: During the retention period, your data may be used to fulfil legal obligations, respond to authorized inquiries, conduct internal analysis, direct marketing, and generate anonymized statistics.

Data Security: We implement measures to ensure the security and confidentiality of your data, including secure storage, restricted access, encryption, and monitoring.

Data Sharing: We may share your data with authorized third parties for legal compliance or research purposes, ensuring they comply with Jamaica's data protection requirements.

Your Rights: You have rights to access, rectify, erase, restrict processing, and data portability. For concerns or inquiries, please contact us.
For our full privacy statement please visit our website at https://www.ironrockjamaica.com/customer-care/privacy-and-security/

I consent to the data privacy terms above: ____________________

PERSONAL ACCIDENT CLAIM FORM

INSURED DETAILS

Surname ________ First Name ______________ Middle Name(s) ______________ Policy Number _________

TRN No. _________ ID Type ______________________ ID# _______________ Expiry Date ________________

Home Address (Street Number & Name)____

Town / Postal Zone______________________ Parish/Country ________________________

Location of Accident ____________________________ Time of Accident ______ Date of Accident ________

ACCIDENT DETAILS

How did the accident happen, and what were you doing at the time?	
What injuries have you sustained?	
Has the same body part been injured previously? If yes please provide details.	
How long have you been totally or partially disabled from engaging in or attending to your usual business as a result of the injuries?	Totally: From __________ To ______________ Partially: From __________ To ______________
How long have you been confined to: 1. Bed? 2. House?	1. Bed: From __________ To ______________ 2. House: From __________ To ______________
Name and address of Doctor who is attending you. Are they your usual Doctor?	Name: Address: ☐ Yes ☐ No
Have you required medical or surgical treatment during the past five years? If so, please give particulars.	
Provide the names and addresses of any witness of the accident.	
Are you claiming under any other insurance? If so please give particulars.	

*This form should be completed and returned within seven days of receipt. It is necessary that the questions on page 3 be answered by a registered medical practitioner.

I declare that the statements and particulars on this form are true and that all particulars affecting the assessment of the claim have been disclosed.

Date ______________________ Insured Signature ____

IronRock INSURANCE

MEDICAL CERTIFICATE

Name of Patient	
What injuries has the Patient sustained?	
When were you first consulted?	
Has the same body part been injured previously? If yes please provide details.	
How long has the Patient been totally or partially disabled from engaging in or attending to your their business as a result of the injuries?	Totally: From ___________ To ______________ Partially: From ___________ To ______________
How long do you consider such disablement will continue?	Totally: From ___________ To ______________ Partially: From ___________ To ______________
Does the Patient have any disease or any health conditions? To what extent may recovery be affected thereby?	

Name ______________________________ Qualifications ______________________________

Signature ______________________________ Address ______________________________

Date ______________________________