Notification of Claim – Temporary Total Incapacity to work due to Accident or Illness
Personal Accidents - Death or Permanent Disability

OCIDENTAL grupo ageas

Policy ☐☐☐☐☐☐☐

Branch ☐☐☐☐ _____

Current Account Number ☐☐☐☐☐☐☐☐☐☐☐

Case identification number (Company) ☐☐☐☐☐☐☐

ILS / Loan Number ☐☐☐☐☐☐

Millennium bcp

☐ PTS - SALARY PROTECTION PLAN INSURANCE
☐ PTE - EXPENSES PROTECTION PLAN INSURANCE
☐ PTI - INCOME PROTECTION PLAN INSURANCE
☐ PL3 - PERSONAL LOAN PROTECTION PLAN INSURANCE
☐ MLP - MORTGAGE LOAN PROTECTION PLAN INSURANCE
☐ OTHER PROTECTION PLAN INSURANCE_____

It is important to know that:

Your insurance policy includes the terms and conditions that must be met for your coverage to be valid.

Upon signing your insurance policy, you were provided with a document providing details regarding those conditions. Please read those guidance documents to validate the specific conditions of your coverage

Following the reception of this notification duly completed and accompanied by the necessary documents, we will register your case and allocate a reference number to it. This number will be mentioned in our correspondence, please use it (case number) in all future communications with the Insurance Company.

Subsequently, we will analyse your case according to the terms and conditions of your insurance policy. This analysis will take 10 business days, after which you will receive a letter informing you of our decision.

If you do not send all of the necessary documents (see page 4 and/or 6), another letter will be sent requesting the missing documents. This additional request for information will increase the time needed to resolve your case.

Please note that: The case will be analysed by our Medical Department, such that the Company reserves the right to request further information, if necessary.

If you have any doubts regarding the claim or completion of the form, please contact us by phone on 21 004 24 90 - Personalized customer service available all business days from 8:30 a.m. to 7:00 p.m. Cost of a call to the national fixed network

*** Compulsory fields**

Identification of the Insured Person *	
Name:	
Address:	
City/Town:	Postal Code:
Date of Birth:	I.D. / C.C.:
Taxpayer No.:	Social Security Beneficiary No.:
Profession practised:	

Elements of the Financing Contract (to be completed if it applies to the situation) *	
Start Date / /	Duration:
Monthly Instalment:	In full:
Amount financed:	In full:

Questionnaire *		
Have you ever reported an incident relative to this or any other contract?	Yes?	No?
If yes, please provide details:		

Self-employed Persons *	
Nature of Activity	
Address	Postal Code:
City/Town	
Telephone:	Taxpayer No.:
You must attach a copy of your last personal income tax declaration (model 3)*	

Information of the Employer *	
Start date of employment: / /	
Date of incapacity to work: / /	Date of return to work (if applicable) / /
Position that the claimant holds:	
Has the claimant suffered from this illness while at your service? Yes No	
If yes, please provide details:	

Representative of the Employer *		
Name:		
Position:	Telephone:	Fax:

_____ _____/_____/_____

Signature Date

Mandatory Stamp

Statement – To be completed by the claimant (compulsory signature) *

I expressly authorise, in a free and informed manner, and deem it to be in my interest since refusal to give consent prevents the payment of the sums insured due, Ageas Portugal - Companhia de Seguros, S.A. to collect, store and process personal data related to my health in the course of the insurance contract and after my death or in the case of incapacity that prevents me from consenting to the execution of this insurance contract, namely but not limited to copies of histological examinations, date and location of the diagnosis, information on medical consultations, established therapies, start date of treatments, and authorise my attending doctor and other doctors from the hospitals or other health units where I have been treated or followed, as well as other official entities, without prejudice to their duties of professional secrecy, to provide Agea Portugal - Companhia de Seguros, S.A any information requested during the analysis relative to my insurance policy or when paying any benefit under the terms of this contract, which include information or reports on my health status or relative to my medical history or to any hospitalization, recommendation, diagnosis, treatment, illness or disease, as is strictly necessary to establish the origin, causes and evolution of the illness or accident which resulted in my death, absolute and definitive disability or temporary total incapacity to work, in accordance with the applicable law.

_____ _____

(place and date) (Signature)

Complete if you intend to activate the guarantee
Temporary Total Incapacity to Work due to Accident or Illness

Information of the Attending Doctor

The matters set out below are essential for the resolution of this case, are confidential and of reserved use, only being able to be provided with the consent of the Insured Person. Please complete the following fields in legible handwriting.

Name of the Insured Person

In case of accident, describe the clinical situation:

Date of Accident: / /

In case of disease diagnosis, I need:

Date of first diagnosis: / /

Please indicate:

Manifestations

Dates on which they occurred / /

Evolution

Was the patient referred to a specialist doctor? Yes ☐ No ☐

If yes, please provide details:

Is he/she your attending doctor? Yes ☐ No ☐ Since when? / /

Clinical history of the last 5 years

Date	Diagnosis	Duration

Are the conditions referred to above related to self-inflicted damage, delivery, pregnancy or abortion, consumption of alcohol or drugs without medical prescription, war, civil commotion, nervous disorders or inexplicable symptoms? Yes ☐ No ☐

If yes, please provide details:

When will the patient be able to return to work? / /

Comments the doctor deems convenient to make:

Name of the Doctor (in capital letters):

No. of professional license:

Health Centre of:

Telephone:

Vignette

(Place and date)

(Signature)

Documents to be attached to this notification (mandatory)

Regarding the guarantees of Temporary total incapacity to work

Photocopy of the reports of the auxiliary diagnostic tests
Photocopy of the Report of the Hospital Discharge Note

- Documents to attach to the Claim Notification, if any.

Photocopy of the Sick Leave Certificate and its renewal

- Document to send to Ocidental whenever you complete more than 30 (thirty) days of incapacity.

Photocopy of the invoices/receipts of the expenses domiciled at an account with reference to the period of incapacity

- Document to send to Ocidental every month for reimbursement (in the case of the Salary Protection Plan and the Expenses Protection Plan).

Photocopy of the personal income tax declaration

- Document to send in the case of the Specific Temporary Insurance or Monthly Income Protection.

Complete if you intend to activate the guarantee Death or Permanent Disability

Description of the Incident

Date of the Incident:	Time:	Place of the Incident:
Damage occurred/incurred:		
Brief description of the Incident:		
Identification of Witnesses (as applicable):		
Police notification No.:		Date: / /

Identification of the Third Party (where applicable).	
Name:	
Address:	
City/Town:	Postal Code:
Contact telephones:	

Documents to be attached to this Notification (mandatory)

Regarding the Death or Permanent Disability guarantee

INDEMNITY DUE TO DEATH

- Death Certificate;
- Certificate of Inheritance, whenever there are no named beneficiaries. Whenever minors are involved, Certificate of full copy of birth registration;
- Autopsy report with the result of the blood toxicological analysis and Record of Occurrence, if the death derives from a road accident;
- Statement of the Transport Company that the vehicle was undertaking public transport (whenever the incident was due to a public vehicle).

INDEMNITY DUE TO PERMANENT DISABILITY

- Medical report with the injuries suffered and degree of devaluation of the Permanent Disability attributed based on the Personal Accident devaluation table which is part of the General/Special Conditions of the Personal Accident Branch;
- Record of the Occurrence, whenever the claim is due to a road accident.

The present document is a translation of the Portuguese version. In case of discrepancy between the versions, the Portuguese version shall prevail. Does not exempt consultation of the legally required pre-contractual and contractual information.