



1. PERSONAL INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Fathers' Name: \_\_\_\_\_

Address: \_\_\_\_\_

e-mail: \_\_\_\_\_

Telephone	Landline:	Mobile:	Fax:
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Please indicate the way you wish to receive the relevant information from the Mutual Insurance Cooperative by filling in the fields accordingly and marking your choices with an **x**:

<input type="checkbox"/> I wish to receive the information at the following address:		<input type="checkbox"/> I do not wish to receive information
<input type="checkbox"/> I wish to receive the information at the email address:		<input type="checkbox"/> I do not wish to receive information
<input type="checkbox"/> I wish to receive the information at the Cooperative's registered offices and the Cooperative shall inform me via the following email address:		<input type="checkbox"/> I do not wish to receive information

In case that you wish to authorize a third party to handle the procedure, please fill in the following fields:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Fathers' Name: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_

Telephone:	Landline:	Mobile:	Fax:
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2. YOU ARE (Please mark with an <b>x</b> )	3. THE COMPLAINT REFERS TO (Please mark with an <b>x</b> )
Policyholder <input type="checkbox"/>	Sale <input type="checkbox"/>
Indemnity beneficiary <input type="checkbox"/>	Indemnity <input type="checkbox"/>
Claimant <input type="checkbox"/>	Terms of Insurance Policies <input type="checkbox"/>
Other <input type="checkbox"/> [Please specify]	Commissions and expenses, premiums <input type="checkbox"/>
	Insurance policy management <input type="checkbox"/>
	Other <input type="checkbox"/> [Please specify]

4. PLEASE DESCRIBE YOUR COMPLAINT

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(If you need more space, please attach a separate sheet with the description of your complaint.)



5. PLEASE DESCRIBE THE ANTICIPATED RESULT

.....  
.....  
.....  
.....

(If you need more space, please attach a separate sheet with the description of the anticipated result.)

6. HAVE YOU SUBMITTED A COMPLAINT BEFORE?

(Please mark with an **x** )

NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
IF YES, WHEN;			
WHAT WAS THE RESULT;			

.....  
.....  
.....

WERE YOU SATISFIED;

.....  
.....  
.....

7. ARE THERE ANY SUPPORTING DOCUMENTS EXCEPT FOR THE PRESENT FORM?

(Please mark with an **x** )

NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
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IF YES, PLEASE SPECIFY BELOW

1.	AUTHORISATION (SEE SECTION 1)	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
2.	COMPLAINT DESCRIPTION (SEE SECTION 4)	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
3.	ANTICIPATED RESULT DESCRIPTION (SEE SECTION 5)	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
4.		8.			
5.		9.			
6.		10.			
7.		11.			

8. DO YOU WISH TO PROVIDE US WITH ANY OTHER INFORMATION?

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.....  
.....  
.....



## 9. YOUR DECLARATION

I declare that:	The information provided in this document is complete and true.
	I have read the last edition of the Complaint Management Policy of the Mutual Insurance Cooperative.
I understand and Declare that:	The provision of false or misleading information constitutes a serious offence.
	Personal data is protected and can be disclosed to a third party only in exceptional circumstances, when required by the Greek legislation or in case that I have given my consent. I hereby freely give my consent to your insurance company to collect, keep in the archive and process all my personal data mentioned in the Form, as well as any details I may provide in the future, in order to examine and resolve my case, according to L.2472/97. Furthermore, I have been informed that, in accordance with articles 12 and 13 of Law 2472/97 and Regulation (EU) 2016/679, I have the right of access, objection and deletion regarding my personal data, as well as the "right to be forgotten", and I can refer in writing to GENIKI PANELLADIKI MUTUAL INSURANCE COOPERATIVE, 7 Voulis St., Sintagma, 10562 Athens, with the indication: Attn. The Data Controller.

Signature	
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Date	Day	Month	Year
	/	/	

Please submit/sent/attach this filled in form and the relevant documents (originals or/and photocopies) to the Complaints Management Department.

Headquarters:  
7 Voulis St., (Ch. Bolani Building)  
Sintagma, 10562 Athens, Greece  
T +30 210 3217801, F +30 210 3217109  
[complaints@genpan.gr](mailto:complaints@genpan.gr)

Thessaloniki Branch:  
42 M. Antipa St., Pilaia  
57001 Thessaloniki  
T +30 2310 474422, F +30 2310 473683  
[www.genikipanelladiki.gr](http://www.genikipanelladiki.gr)

We guarantee that we will take your request into account and inform you immediately.

Thank you.