

Personal Accident / Illness Claim Form



Thank you for notifying us of your claim.

Please complete this claim form and return it to:

Specialty Claims Services

PO Box 51541

LONDON

SE1 0XU

If you need any help in completing this form please contact us on 0870 905 8555.

Claimant Details

Full Name: _____ Date of Birth: ____/____/____

Occupation: _____

Claimant Address: _____

Postcode: _____

E-mail address: _____

Telephone: _____ Fax: _____

Employment Details (if applicable)

Company Name: _____

Company Contact Name / Department: _____

Company Address: _____

Postcode: _____

E-mail address: _____

Telephone: _____ Fax: _____

Insurance Details

Certificate Number: _____

Insurance Company: _____

Address of Broker: _____

Claim Details

PLEASE PROVIDE FULL DETAILS OF THE NATURE OF YOUR DISABILITY

Accident:
Date and time of occurrence:
____/____/____ __:____ AM PM

Illness:
Date and time upon which symptoms first appeared:
____/____/____ __:____ AM PM

Please describe the circumstances leading to your accident, or cause of your illness:

Are you still incapacitated as a result of your Accident/Illness? Yes No

If no then please provide the date of your return to: Part of your duties: ____/____/____

All of your duties: ____/____/____

Have you ever suffered from this or any connected disability, prior to the Insurance commencing?

Yes No

If yes, please provide details including dates:

Have you ever previously claimed benefits under this insurance? Yes No

If yes, please provide details:

Declaration

I certify that the foregoing statements are correct. I understand that some of the information provided will be made available to other insurers for underwriting or claims handling purposes. I consent to the seeking of information from other Insurers to check the answers I have provided, and I authorise the giving of such information.

Signature: _____

Date: ____/____/____

Medical Questionnaire (Page 1)

To be completed by the usual GP of the claimant. The claimant must obtain, at his or her own expense, the completion of the following Certificate from a duly qualified and Registered Medical Practitioner.

Are you the usual Medical Attendant to the Claimant? If yes, how long have you been so?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What date did you first attend upon the claimant for his/her present disability?	___/___/___
What date did you first sign the claimant off as unfit for work?	___/___/___

Please confirm the nature of illness or injury sustained, together with details of the precise diagnosis and treatment given:

Has the claimant suffered from this or any other associated complaint prior to this period of disability?

Yes No

If yes, please give dates and types treatment:

At the time of the accident or commencement of illness was the claimant suffering from any other illness or disease?

Yes No

If yes, please give details with medication prescribed and advise whether this will retard recovery of present disability:

Medical Questionnaire (Page 2)

Is the disability due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, abortion, or venereal disease or other sexually transmitted disease or HIV related illness including Acquired Immune Deficiency Syndrome (A.I.D.S) or A.I.D.S Related Complex? (A.R.C)? Yes No

If yes, please provide details:

Is the claimant presently confined to the house? Yes No

Has the claimant been confined to the house since commencement of disability? Yes No

When do you expect the claimant to return to work? ___/___/___

If the claimant has already returned to work, please state the date and whether he/she was able to return to all, or just part of his/her duties:

DECLARATION BY DOCTOR:

I confirm that the claimant is/was under my medical attention, and is/was totally prevented from working from working for remuneration or profit from his/her normal occupation.

From: ___/___/___ To: ___/___/___

Doctors Signature: _____

PRINT NAME: _____

Date: ___/___/___

OFFICIAL SURGERY STAMP:

Guidance Notes

The following documentation must be provided in order for your claim to be processed.

<i>Item</i>	<i>Enclosed</i>
A copy of your insurance schedule showing the dates of cover and premium paid	<input type="checkbox"/>
Wage slips for 12 weeks immediately prior to the incident date This will enable us to calculate the correct weekly benefit.	<input type="checkbox"/>
Medical Certificates confirming that you have been signed off from work These are given to you by the Doctor on a regular basis during the period of incapacity.	<input type="checkbox"/>
Fully Completed Medical Questionnaire (attached) This needs to be completed by your usual GP.	<input type="checkbox"/>