

UK Sickness claim form

Please make sure...

1. That you complete **all the relevant sections** and **sign** the claim form.
2. That you carefully read, then **sign and date**, sections **6.2** and **6.4** (Access to Medical Reports and Statement of truth). Please check that your dates are accurate, as we assess your claim against this information. Please also read and complete section **6.3** (Explicit Consent). In section **6.5** (claims payment), don't forget to write the last 4 digits of the account you would prefer to be credited
3. That your doctor fully **completes and signs section B**.
4. If you have been admitted as an inpatient to a ward, enclose your hospital admission/discharge summary sheet(s).
5. When you have completed all of the above, return the claim form and any additional sheets in the pre-addressed envelope. If you use your own envelope, please send it to the address below.
6. That you read and retain your claim Guidance Notes.

Important: You will not be issued with a claim number until we receive your completed claim form.

Customer Services

Freephone: 0800 169 7733

free from a UK landline or mobile phone

Office hours: Monday to Friday, 9am to 5:30pm

Calls will be charged at standard local rates

E-mail

csd@uk.combined.com

Website

www.combinedinsurance.co.uk

Combined Insurance

PO Box 683

WINCHESTER

SO23 5AH



Corporate member of
Plain English Campaign
Committed to clearer communication

445

Combined Insurance is a trading name of Chubb European Group Limited registered number 1112892 and ACE Europe Life Limited registered number 5936400, each registered in England & Wales with registered offices at 100 Leadenhall Street London EC3A 3BP. Combined Insurance's general insurance products are provided by Chubb European Group Limited and its life assurance and permanent health products by ACE Europe Life Limited. Each company is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Full details can be found online at <https://register.fca.org.uk>

04/17

UK Sickness claim form (W)

Customer Account number _____

Combined Insurance seeks to pay all genuine claims. We check all claims carefully to identify fraudulent or exaggerated claims. This keeps the cost of insurance down for everyone.

We exchange information with other insurers and take other measures to prevent fraud. Please be aware that making a fraudulent or exaggerated claim can lead to prosecution. You can call our Fraud Hotline in complete confidence on 020 8541 6085 if you think a false claim is being made. Thank you.

Section A – to be completed by you

- Please answer all questions in full to help us process your claim.
- Complete all sections with a ballpoint pen in black ink and CAPITAL LETTERS.

1 Personal details (insured)

Important note: is the claim for an insured person under 18? Yes No

If **Yes**, the insured's parent or legal guardian must fill in this form, starting at **1.1**. If **No**, go to **1.3**.

1.1 Full name of parent or legal guardian

1.2 Relationship to insured (e.g. father)

Full name of insured:

1.3 Date of birth

1.4 Address

Postcode

1.5 Home phone number

Mobile number

Work number

E-mail Address

1.6 Are you? Self-employed Employed Other (please tell us, e.g. student, retired)

1.7 What is your job or occupation (e.g. plumber, courier)

Please tell us any other jobs that you are paid for

2 Details of sickness

2.1 Please tell us the full details of the sickness you are claiming for

2.2 What date did you first notice symptoms of your sickness?

2.3 If your sickness has been diagnosed, please tell us what it is.

2.4 What treatment or medication did you have **at first**, but are no longer having, for your sickness?

2.5 What treatment or medication are you having for your sickness **now**?

2.6 What treatment or medication did you have, or are you still having, for your sickness?

2.7 Have you ever suffered a similar sickness?

Yes

No

If **Yes**, please tell us the full details. Please include the date when you first noticed symptoms of your sickness, details of the treatment you received and information about recovery.

3 Loss of time

Total loss of time – your condition must prevent you from carrying out each and every duty of your usual business or occupation (or usual activities if not engaged in business or employment).

3.1 Has the sickness prevented you from performing all of your usual working activities (or usual activities if not in paid employment)?

Yes

No

If **Yes**, go to question 3.2

If **No**, go to question 3.4

3.2 Between what dates have you been unable to perform all of these activities?

From To

3.3 Please describe in **full** the activities you cannot perform. **How** is the sickness stopping you from performing these duties?

Partial loss of time – your condition must prevent you from carrying out one or more important duties of your usual business or occupation (or usual activities if not engaged in business or employment).

3.4 Has there been a time since your sickness when you have returned to work, but have been unable to carry out all of your working activities (or your usual activities if you are not in paid employment)?

Yes

No

If **Yes**, go to question 3.5

If **No**, go to section 4 (Hospital treatment)

3.5 Between what dates have you been unable to perform all of these activities?

From To

What date did you go back to work?

3.6 Please describe in **full** the activities you cannot perform. **How** is the sickness stopping you from performing these duties?

4 Hospital treatment

4.1 Did you attend a hospital as a result of your sickness? Yes No

If **Yes**, go to question 4.2

If **No**, go to section 5 (Your doctor)

4.2 If you were an **inpatient*** at hospital please confirm the dates you were **admitted** and **discharged** and attach a copy of your hospital admission/discharge summary.

Date admitted Date discharged

*Someone who is admitted to a hospital ward and stays at least one night.

4.3 What treatment did you receive?

4.4 Did you have an operation when you were in hospital? Yes No

If **Yes**, when did your doctor refer you for surgery?

When were you first seen by the consultant / specialist?

Please give us full details of the surgery you had:

4.5 Please provide the name and address of the hospital and the specialist you saw for your treatment**

Full name of specialist

Hospital name and address

 Postcode

** If you attended more than one hospital or saw more than one specialist, please provide further details on a separate sheet and enclose with your claim form.

5 Your doctor

5.1 Please provide the full name and address of your doctor (GP)

Full name of doctor (GP)

Practice name and address

 Postcode

5.2 How long have you been with this practice? Years Months

5.3 Please confirm the dates you visited your doctor for the sickness you are claiming for:

First attendance Second attendance
 Third attendance Fourth attendance
 Fifth attendance Sixth attendance

6 Data Protection Act, Access to Medical Reports, statement of truth and claims payment

6.1 Data Protection Act

We use personal information which you supply to us for underwriting, policy administration, claims management and other insurance purposes, as further described in our Privacy Policy, available here: <http://www.combinedinsurance.co.uk/privacy.html> or by searching ' Privacy Policy' on <http://www.combinedinsurance.co.uk> You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

6.2 Access to Medical Reports (please see Guidance Notes booklet)

- I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.
- I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my claim.
- You may gather relevant information from other insurers about any other claims that I have made.
- I authorise those asked to provide medical information when they see a copy of this consent form.
- This form allows you to gather medical reports within six months of the date of my claim, or after my death to support my claim.
- This information can also be used to maintain management information for business analysis.

I DO wish to see the report before it is sent to Combined Insurance.

I DO NOT wish to see the report before it is sent to Combined Insurance.

Cross one box only. If you do not cross a box, we will assume you do not wish to see the report.

Full name* Date

Signed

** If the insured is under the age of 18, the parent or legal guardian should complete the declaration.*

6.3 Explicit Consent

We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us. **You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here.**

We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim. **Please tick the following box to indicate your consent to our use of your health information in this way.**

6.4 Statement of truth

- I understand that by returning this completed claim form, Combined Insurance shall not be held to admit the validity of any claim presented, or to have waived any of its rights in defence of any claim arising under the terms of the policy.
- I declare that the information provided within this claim form is true to the best of my knowledge and belief.
- I have sought to provide all information relating to my claim and I understand that telephone calls made to and from Combined Insurance's Claims and Customer Services Department may be recorded for training and claims validation purposes.

Full name* Date

Signed

** If the insured is under the age of 18, the parent or legal guardian should complete the declaration.*

6.5 Claims payment

If the claim has been approved we will pay the claim payments directly into the bank account used to pay premiums, provided:

- The account is in your name;
- If the insured is under 18, the account is in the name of the parent/guardian

If you pay premiums from more than one bank account please confirm the last 4 digits of the account you would prefer to be credited:

This payment method is speedier and safer than by cheque. If you do not pay your premiums by direct debit or if one of the above does not apply, we will pay by cheque.

3.3 Please state how the patient's injury(ies) or sickness prevents them from performing **any** of their usual working duties or daily activities

3.4 Has the patient returned to work? Yes No

If **Yes**, please state the date they first returned to work

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

If **No**, when do you think the patient will be able to return to work or usual daily activities?

Full-time

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Part-time

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

- The patient's policy may also cover **partial disability**: to qualify, their condition must prevent them from being able to perform one or more important duties of their usual business or occupation (or usual activities if not engaged in business or employment).

3.5 Given the **above definition**, was the patient **partially disabled**? Yes No

If **Yes**, go to question 3.6

If **No**, go to section 4 (Hospital treatment)

3.6 Between what dates has the patient been unable to perform **some** of their usual working duties (or daily activities if they are not in paid employment)?

From

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

To

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

3.7 Please state how the patient's injury(ies) or sickness prevents them from performing **some** of their usual working duties or daily activities

4 Hospital treatment

- The patient's policy may cover inpatient **hospitalisation** if they were admitted for an overnight stay in hospital.

4.1 Was the patient admitted to hospital for an overnight stay? Yes No

If **Yes**, go to question 4.2

If **No**, go to question 4.5

4.2 Between what dates was the patient confined in hospital as an in-patient?

From

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

To

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

From

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

To

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

4.3 Please provide the name of the consultant who attended the patient and the full name and address of their hospital

4.4 Please state all the dates the patient attended your surgery or hospital for this **accident** or **sickness**:

First attendance

Second attendance

Third attendance

Fourth attendance

Fifth attendance

Sixth attendance

4.5 Please provide details of all treatment or medication received in respect of the **accident** or **sickness**:

4.6 If symptoms are still present, what is your treatment plan for ensuring your patient can return to their usual activities?

4.7 Has the patient suffered the same or similar sickness or condition previously, or a sickness or condition which may, directly or indirectly, delay recovery? Yes No

If **Yes**, please provide full dates and details.

4.8 Was the patient under the influence of alcohol or drugs at the time of the sickness? Yes No

If **Yes**, detail alcohol levels (if known)

5 Doctor's declaration and statement of truth

- I believe that the facts I have given in this statement are true and that the opinions I have expressed are correct.

Full name of doctor

Qualifications

Address

Postcode

Phone

Date

Doctor's
Signature

Surgery or
hospital stamp