

2.3 Where were you when the accident happened? Please tell us the specific place or address.

Two empty rectangular text boxes for providing the location of the accident.

2.4 What were you doing when the accident happened?

Two empty rectangular text boxes for describing the activity during the accident.

2.5 What caused the accident to happen?

One empty rectangular text box for describing the cause of the accident.

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

Two empty rectangular text boxes for listing medical treatments or medications.

2.7 Have you ever had a similar injury? Yes No

If **Yes**, please tell us the full details. Please include the date of the injury, details of the treatment you received and information about your recovery from the injury.

Three empty rectangular text boxes for providing details of a similar injury.

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 injury 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 injury stopping you from performing these duties?

Three empty rectangular text boxes for describing activities and how the injury affects them.

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 injury 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 injury stopping you from performing these duties?

Three empty rectangular text boxes for describing activities and how the injury affects them.

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

6.1 Data Protection Act

In order to process your claim we may be required to pass your Health/Medical details to our administrators, reinsurers and/or Regulatory Bodies. It may also be necessary to supply them with a copy of your original Policy Application. As required by the Data Protection Act we request your consent to forward this data. **Your signature in 6.3 will signify this consent.** Failure to do so may prevent us from settling the claim to your satisfaction. Your personal data will only be used for claims and policies administration and quality purposes. Your personal data will not be used for any other purpose by the reinsurers.

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 and quality assurance.

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 declaration should be completed by the parent or legal guardian

6.3 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 declaration should be completed by the parent or legal guardian

6.4 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, if the account is in the name of the parent/guardian; or
- The payment is less than £20,000.

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.

Section B – to be completed by your doctor

- This certificate must be completed by the patient's doctor at the patient's expense.
- Please answer all questions in full to help us process the claim.
- Complete all sections with a **ballpoint pen** in **black ink** and **CAPITAL LETTERS**.

1 Patient's details

1.1 Last name

1.2 First names

1.3 Date of birth

1.4 Address

 Postcode

2 Patient's claim details

- 2.1 Is the patient's claim due to an **accident?** or **sickness?** (cross one)
- 2.2 Please give **full details of the injury or injuries caused by the accident or the sickness diagnosis and symptoms*** ** If left or right limb, please specify.*

- 2.3 Please confirm the date of the **accident** or the date of onset of the **sickness condition**

: am pm (cross one)

- 2.4 What date did the patient first consult you due to the **accident** or **sickness**?

- 2.5 What was the cause of the **accident** or **sickness**?

- 2.6 If a fracture occurred, please state bone(s) fractured

- 2.7 Has the fracture been confirmed by an x-ray? Yes No

If **Yes**, please attach a copy of the x-ray report. If **No**, please advise basis of clinical diagnosis.

3 Loss of time

- The patient's policy may cover **total disability**: to qualify, their condition must prevent them from being able to perform each and every duty of their usual business or occupation (or usual activities if not engaged in business or employment).

3.1 Given the **above definition**, was the patient **totally disabled**? Yes No

If **Yes**, go to question 3.2

If **No**, go to question 3.5

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

From To

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

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

Full-time

Part-time

- 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

To

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

To

From

To

4.3 If the patient was admitted to intensive care, please confirm dates.

From

To

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

4.5 Was an invasive surgical procedure performed? Yes No

If **Yes**, please give details including the date of the procedure and the hospital where it was undertaken

[Empty text boxes for details of procedure]

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

First attendance [DDMMYYYY] Second attendance [DDMMYYYY]
Third attendance [DDMMYYYY] Fourth attendance [DDMMYYYY]
Fifth attendance [DDMMYYYY] Sixth attendance [DDMMYYYY]

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

[Empty text boxes for treatment details]

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

[Empty text boxes for treatment plan]

4.9 Has the patient suffered the same or similar injury or condition previously, or an injury or condition which may, directly or indirectly, delay recovery? Yes No
If **Yes**, please provide full dates and details.

[Empty text boxes for previous injury details]

4.10 Was the patient under the influence of alcohol or drugs at the time of the injury? Yes No

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

4.11 If the patient has suffered loss of sight, speech or hearing, is this permanent? Yes No

If **Yes**, state percentage (%) of loss.

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 [Grid of boxes]

Qualifications [Grid of boxes]

Address [Grid of boxes]

Postcode [Grid of boxes]

Phone [Grid of boxes] Date [DDMMYYYY]

Doctor's signature [Text box]

Surgery or hospital stamp [Text box]

What to do next...

1. Have you completed **all the relevant sections** and signed the claim form?
2. Have you carefully read, then signed and dated, **6.2** and **6.3** (Access to Medical Reports and statement of truth) and **6.4** (claims payment)?
3. Has your doctor **completed and signed section B**?
4. If you have been admitted as an inpatient to a ward, have you enclosed your hospital admission/discharge summary sheet(s)?
5. If you have completed all of the above, please return the claim form and any additional sheets to the address below.
6. Please read and retain your claim Guidance Notes.

Customer Services

Freephone: 0800 169 7733

Main switchboard: 020 8546 7733

Office hours: Monday to Friday, 9am to 7pm

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Insurance cover provided by

Combined Insurance Company of America (Combined Insurance)

A company with limited liability incorporated in Illinois, USA

Combined Insurance is registered in the UK: FC005307 and as a branch: BR000634

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