

UK Accident 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 **6.3** (Access to Medical Reports and Statement of truth). Please check that your dates are accurate, as we assess your claim against this information. In section **6.4** (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.

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

Customer Services

Freephone: 0800 169 7733

or 0345 840 3535 from a mobile

Office hours: Monday to Friday, 9am to 6pm

Calls will be charged at standard local rates

E-mail

csd@uk.combined.com

Website

www.combinedinsurance.co.uk

Combined Insurance

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Corporate member of
Plain English Campaign
Committed to clearer communication

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

2.4 What were you doing when the accident happened?

2.5 What caused the accident to happen?

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

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.

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?

3.4 Have you returned to work? Yes No

If **Yes**, please state the date you returned to work

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).

3.5 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)

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

From To

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

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, regulators, or to any company, institution or medically qualified person (including, but not limited to, hospitals, doctors, nurses or consultants) who have been involved in the treatment or assessment of your condition. It may also be necessary to supply them with a copy of your original Policy Application. As required by the Data Protection Act 1998 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 and sensitive personal data will only be used for claims and policies administration and quality purposes. Your personal and sensitive 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 1988.
- 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 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.*

6.4 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, 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 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**, when was the patient referred?

When was the patient placed on the hospital's waiting list?

Please give details including the date of the procedure and the hospital where it was undertaken:

4.6 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

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

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

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.

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

Qualifications

Address

Phone

Postcode

Date

Doctor's signature

Surgery or hospital stamp