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
PO Box 4510
Dunstable
LU6 9PZ

Financial Ombudsmar Service

Corporate member of Plain English Campaign 445
Committed to clearer communication

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UK Accident claim form (W)

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 contact us in complete confidence on 0800 169 7733 and request to speak with our Fraud Investigations Team 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 [X] No [X]
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 D D M M Y Y Y Y

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 accident

2.1 Please tell us the date of the accident D D M M Y Y Y Y

2.2 Please tell us the full details of the **injury** caused by the accident

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 X No X

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 X No X

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 D D M M Y Y Y Y To D D M M Y Y Y Y

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 X No X

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

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 X 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 D D M M Y Y Y Y To D D M M Y Y Y Y

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

4 Hospital treatment

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

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 D D M M Y Y Y Y Date discharged D D M M Y Y Y Y

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

4.3 What treatment did you receive?

4.4 Were you admitted to intensive care? Yes X No X

If **Yes**, date admitted to intensive care D D M M Y Y Y Y

date discharged from intensive care D D M M Y Y Y Y

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

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

When were you first seen by the consultant / specialist? D D M M Y Y Y Y

Please give us full details of the surgery you had:

4.6 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 surgery? Years Months

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

First attendance D D M M Y Y Y Y Second attendance D D M M Y Y Y Y

Third attendance D D M M Y Y Y Y Fourth attendance D D M M Y Y Y Y

Fifth attendance D D M M Y Y Y Y Sixth attendance D D M M Y Y Y Y

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 D D M Y Y Y Y

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 D D M M Y Y Y Y

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.

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 D D M M Y Y Y Y

1.4 Address

Postcode

2 Patient's claim details

2.1 Is the patient's claim due to an **accident** X ? or **sickness** X ? (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**

D D M M Y Y Y Y

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

D D M M Y Y Y Y

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 X No X

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 X No X

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 D D M M Y Y Y Y To D D M M Y Y Y Y

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 X No X

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 X No X

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 X No X

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

From D D M M Y Y Y Y To D D M M Y Y Y Y

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 X No X

If **Yes**, when was the patient referred? D D M Y Y Y Y

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

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 D D M M Y Y Y Y Second attendance D D M M Y Y Y Y

Third attendance D D M M Y Y Y Y Fourth attendance D D M M Y Y Y Y

Fifth attendance D D M M Y Y Y Y Sixth attendance D D M M Y Y Y Y

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 X No X

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 X No X

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

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

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

Postcode

Phone Date D D M M Y Y Y Y

Doctor's signature

Surgery or hospital stamp