

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 Have you ever had a similar sickness? 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 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?

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.

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 section 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 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

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

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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Member of 

 Financial
Ombudsman
Service



Corporate member of
Plain English Campaign
Committed to clearer communication

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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

Authorised and regulated by the Financial Services Authority (firm number 202081)

The ACE Group of Companies