

# 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 **6.3** (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.

**Important: 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 7pm

Calls will be charged at standard local rates

### E-mail

[csd@uk.combined.com](mailto:csd@uk.combined.com)

### Website

[www.combinedinsurance.co.uk](http://www.combinedinsurance.co.uk)

### Combined Insurance

PO Box 4510

Dunstable

LU6 9PZ



Corporate member of  
Plain English Campaign  
Committed to clearer communication

445

Combined Insurance is a trading name used by the ACE Group of Companies including ACE European Group Limited (AEGL) & ACE Europe Life Limited (AELL). Combined Insurance's general insurance products are provided by AEGL and its life assurance and permanent health products by AELL. AEGL (company number 1112892) & AELL (05936400) are registered in England & Wales with registered offices at 100 Leadenhall Street London EC3A 3BP. AEGL and AELL are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

# UK Sickness 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  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.

Two empty text boxes for diagnosis details.

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

Two empty text boxes for initial treatment details.

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

One empty text box for current treatment details.

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

Two empty text boxes for ongoing treatment details.

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.

Three empty text boxes for details of a similar sickness.

### 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?

Three empty text boxes for describing activities and how the sickness stops 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 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?

Two empty text boxes for describing activities and how the sickness stops 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, 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.



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

Two empty rectangular boxes for text input.

3.4 Has the patient returned to work? Yes  No

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

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

Full-time DDMMYYYY

Part-time DDMMYYYY

- 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 DDMMYYYY

To DDMMYYYY

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

Three empty rectangular boxes for text input.

## 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 DDMMYYYY

To DDMMYYYY

From DDMMYYYY

To DDMMYYYY

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

Three empty rectangular boxes for text input.

4.4 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

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

Three empty rectangular boxes for providing details of treatment or medication.

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

Three empty rectangular boxes for providing a treatment plan.

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.

Three empty rectangular boxes for providing dates and details if applicable.

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) [Empty rectangular box]

## 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 20 empty boxes]

[Grid of 20 empty boxes]

Qualifications [Grid of 20 empty boxes]

Address [Grid of 20 empty boxes]

[Grid of 20 empty boxes]

[Grid of 20 empty boxes]

Postcode [Grid of 6 empty boxes]

Phone [Grid of 12 empty boxes]

Date [Grid with letters D, D, M, M, Y, Y, Y, Y]

Doctor's signature [Empty rectangular box]

Surgery or hospital stamp [Empty rectangular box]