

Continuation Claim Form

Claim no.

Combined House, 15 Wheatfield Way, Kingston upon Thames, Surrey KT1 2PA
Authorised and regulated by the Financial Services Authority



Please ensure both sides of this form are completed and returned to Combined's European Headquarters. You should complete this side only, with your doctor completing the reverse.

This form should be returned on or the day you return to work, **whichever is earlier.**

In addition, please reply to those items where a tick has been indicated in the box(s)

Please **sign and date** the attached authorisation and **return to us.**

Please have **all of your employers** complete the attached Employer's Statement and **return to us.**

Please have your **college/school** complete the attached statement and **return to us.**

1

1.1 First name(s) 1.2 Surname

1.3 Address
 Postcode

1.4 Please confirm your **main** occupation

1.5 Please confirm **any other** additional occupations for which you receive payment

1.6 If unemployed or retired, from what date?

2

2.1 Please confirm the **primary** injury or condition from which you are suffering

2.2 Are you claiming **either**: a) Disability Allowance? Yes No or b) Unemployment Benefit? Yes No

2.3 If you answered **Yes** to **either** 2.2a) or b), when were the benefits claimed? From To

Your policy may cover you for **Total Disability**: to qualify, **you must be unable to perform each and every duty** of your usual business or occupation (or usual activities if not engaged in business or employment). It may also cover you for **Partial Disability**: to qualify, **you must be unable to perform one or more important duties** of your usual business or occupation (or usual activities if not engaged in business or employment).

2.4 How long have you been unable to attend to your usual business or occupation (or usual activities, if not engaged in business or employment) as defined above?

	From first day	To last day
2.5 Total Disablement of total disability	<input type="text"/>	<input type="text"/>
2.6 Partial Disablement of partial disability	<input type="text"/>	<input type="text"/>
2.7 Hospital Confinement of hospital confinement	<input type="text"/>	<input type="text"/>
2.8 If confined indoors under a doctor's direct instruction of confinement	<input type="text"/>	<input type="text"/>

2.9 To what extent have you been unable to attend to the duties of your usual business or occupation (or usual activities if not engaged in business or employment) **as defined above**?

Please list duties/activities	How are you restricted?
<input type="text"/>	<input type="text"/>

3

3.1 Other comments

'I declare that the above answers, which are full and complete, are true to the best of my knowledge and belief.'

Insured's signature* Date

* If the policyholder is under 16, the parent or guardian should sign the declaration and print their full name.

Medical Certificate



This medical certificate is to be completed by the claimant's doctor at the patient's expense.

1 Patient's details

1.1 Title (tick one) Mr Mrs Miss Ms Other (specify) 1.2 Date of birth

1.3 Patient's name 1.4 Occupation

2

2.1 Please confirm if the patient's claim is as a result of an **accident** or **sickness** (tick one) **Accident** **Sickness**

2.2 Please confirm the **primary** injury or condition from which the patient is suffering

2.3 Please confirm details of **any** other injury or condition from which the patient is suffering **in addition** to that noted above which may impact on the clinical features or recovery

2.4 Please confirm **all dates** you have seen the patient in respect of the **above injury or condition** since the initial diagnosis

3

3.1 Please describe **all** clinical features present in support of the injury or condition, as well as confirming the severity of those features and their frequency. The severity should be graded as (i) **Mild**, (ii) **Moderate** or (iii) **Severe**. The frequency should be graded as (i) **Constant**, (ii) **Regular**, (iii) **Intermittent** or (iv) **Nuisance**.

Clinical feature(s)	Severity	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>

3.2 Is the injury or condition and its clinical features suggestive of a progressive recovery? having reached a plateau? a worsening condition?

4

4.1 If symptoms are still present, what treatment is being undertaken and what is your treatment plan to ensure your patient can return to their usual activities?

4.2 Please confirm the dates i) Of any referral of the patient to a consultant

ii) First seen by the consultant

iii) Placed on a hospital list

5 Disability period

The patient's policy may cover **Total Disability**: to qualify, the patient **must be unable to perform each and every duty** of their usual business or occupation (or usual activities if not engaged in business or employment). It may also cover **Partial Disability**: to qualify, the patient **must be unable to perform one or more important duties** of their usual business or occupation (or usual activities if not engaged in business or employment).

5.1 Total Disablement **From first day** of total disability **To last day** of total disability

5.2 Partial Disablement **From first day** of partial disability **To last day** of partial disability

5.3 Hospital Confinement **From first day of** hospital confinement **To last day of** hospital confinement

5.4 How long do you believe **Total Disability** will continue Date returned to work

5.5 Are the periods mentioned above attributable **solely** to the patient's injury or condition? Yes No

6

6.1 Other comments

'I believe that the facts within this statement are true to the best of my knowledge and belief.'

Doctor's name

Doctor's signature Surgery/Hospital

Qualifications Date address or stamp