



**Please read carefully as this notice contains important information
to assist you with your claim.**

Dear Customer,

We are pleased to enclose a claim form.

Please note, that you must notify us within 30 days from the date of an accident or the commencement of disability due to sickness, or as soon as reasonably possible thereafter.

We will aim to respond to you within 10 business days of receipt of your completed claim form. We may arrange for a representative from the Claims Department to visit you in connection with your claim.

How to complete the claim form:

To avoid a delay in the processing of your claim, please quote your policy number(s) where indicated. Please fully complete the front side of the form and arrange for one of the doctors who attended you in respect of your accident or sickness to complete the doctor's statement on the reverse of the form. Please note that any charge made by your doctor for the completion of this form is not covered by your policy. If you are employed please request your employer to complete the employer's statement.

Access to Medical Records and Data Protection Act Consent Form:

We also enclose a medical report consent form which gives us your permission to obtain a medical report, or other information as required from a third party, in connection with the handling of your claim. This form also explains your rights under the Access to Medical Reports Act. Please read this form carefully, sign and date it and tick one of the boxes indicating whether you wish to see any requested medical report before it is sent to the Company. We will keep you informed should we find it necessary to obtain additional medical information or any other information during the processing of your claim.

Freephone: 0800 169 7733 (Monday to Friday 8 am – 7 pm) • Customer Services Facsimile: 020 8541 6294
Claims Facsimile: 020 8974 5025 • Your call may be monitored or recorded for training and quality control.

Combined Insurance Company of America
European Headquarters: Combined House, 15 Wheatfield Way, Kingston upon Thames, Surrey, KT1 2PA
Telephone: 020 8546 7733 • Facsimile: 020 8541 6294 • Email: csd@uk.combined.com
Website: www.combinedinsurance.co.uk

A company with limited liability incorporated in Illinois, U.S.A. Combined is registered in the UK: FC005307 as a branch: BR000634. Northern Ireland: NF001593.
Authorised and regulated by the Financial Services Authority (Firm no: 202081).

Stationery no: 234642 06/06

Payment of Benefits:

Disability benefits under our accident and sickness policies are payable monthly in accordance with the medical information submitted. Provided your claim is accepted each benefit cheque you receive will be sent with a continuation claim form to allow for further payments to be considered.

Enquiries concerning your claim:

If you have an enquiry concerning your claim, you may either write to the Claims Department, Combined House, 15 Wheatfield Way, Kingston upon Thames, Surrey, KT1 2PA, or telephone our Customer Services on Freephone: 0800 169 7733 or email csd@uk.combined.com

Complaints Procedure:

We are committed to resolving complaints fairly and promptly and have a procedure that meets the requirements of the Financial Services Authority.

If you need to make a complaint regarding your claim, please either write to the Claims Department, Combined Insurance Company of America, Combined House, 15 Wheatfield Way, Kingston upon Thames, Surrey, KT1 2PA, or telephone our Customer Services on **Freephone 0800 169 7733**.

If we are unable to resolve your complaint immediately, we will, within 5 business days of receiving your complaint, inform you of the person who will deal with it and when you can expect to receive a further response. If we are unable to provide you with a response within 20 business days, we will inform you in writing why this is so and when you should expect a response.

Should you remain dissatisfied with our response to your complaint, please write to the Claims Manager at the above address, who will review your complaint to ensure our decision was sound and that we explained our reasons clearly.

If you still remain dissatisfied, you can refer your complaint to the Financial Ombudsman Service at South Quay Plaza, 183 Marsh Wall, London E14 9SR. Telephone 0845 080 1800.

Warning: Making a false or exaggerated insurance claim is a crime.

Combined Insurance Company of America

Combined House, 15 Wheatfield Way, Kingston, KT1 2PA Tel: 0800 169 7733

Authorised and regulated by the Financial Services Authority

Claim Number:

CLAIM FORM Please complete and return BOTH forms enclosed immediately.

DO NOT WAIT until you are discharged by your doctor. Additional forms will be sent if you are still disabled.

Please ensure reverse of form is completed by a doctor.

IMPORTANT:

To prevent delay, please ensure that the form is fully completed and your policy numbers are listed.

Policy Number(s)	Form Number(s)	Last Payment Date

Claimant's Full Name: h Mr h Mrs
h Miss h M/s

Address: Tel:

Date of Birth: Height: Ft Ins Weight: St Lbs Occupation:
(If self employed include description)

Employer's Name and Address:

If Claim is for Accident Please Complete	Date of accident: AM PM	Nature of Injuries:		
	Please state exactly where you were when accident occurred:			
	What were you doing when accident occurred?			
	Please describe in detail how accident occurred:			
If Claim is for Sickness Please Complete	Date of first symptoms:	Have you ever had same or similar condition? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, give date:		
	Condition for which you are claiming:			
Please Complete for both Accident and Sickness Claims	Name and address of hospital you attended:			
	Between which dates were you confined to Hospital?		Date of admission:	Date of discharge:
	Was any part of this in Intensive Care? If YES:		From:	To:
	Did you undergo an invasive surgical procedure? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	If 'Yes', please give details of the procedure:			
	Names and addresses of doctors who attended you (if known)		Dates of Treatment	
	
	
(A) TOTAL DISABILITY: Between which dates were you unable to perform any duties?		From:	To:	
(B) IF CONFINED INDOORS: During above period, please give dates:		From:	To:	
(C) PARTIAL DISABILITY Between which dates were you able to perform only some duties?		From:	To:	

DATA PROTECTION ACT – In order to process your claim we may be required to pass your Health/Medical details to our 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 below will signify your consent. Failure to do so may prevent us from settling the claim to your satisfaction. Your personal data will only be used to administer your claim and will not be used for any other purpose by the Reinsurers.

I hereby warrant that everything I state above is correct and true to the best of my belief and I have not withheld any information likely to affect the handling of this claim:

Dated: Signed: Claimant's Signature
(if Minor, Parent's Signature)

EMPLOYER'S STATEMENT (necessary for all Loss of Time claims)

Employee's Name: If Accident: were injuries sustained at work? YES NO
TOTAL DISABILITY: Between which dates did employee give up all duties? From: To:
PARTIAL DISABILITY: Between which dates did employee perform only part of duties? From: To:
Date: Title: Signature:

DOCTOR'S STATEMENT

THIS MEDICAL CERTIFICATE TO BE COMPLETED BY DOCTOR AT CLAIMANT'S EXPENSE

Name of Claimant: Date of Birth:
Address:
1. When did you first attend upon the claimant in consequence of the illness/accident sustained?
2. Are you still in attendance? YES NO

PLEASE COMPLETE EITHER 3.1 OR 3.2

3.1 IN THE EVENT OF ILLNESS PLEASE CONFIRM:

- a) Nature of illness: b) Date of onset of presenting symptoms:
- c) If claim for Heart Attack, how was the clinical diagnosis confirmed?
- d) Are the symptoms due to: 1) the illness alone,
or, 2) are they traceable to any other cause? If YES, please give details:
- e) What treatment was undertaken?

3.2 IN THE EVENT OF ACCIDENT PLEASE CONFIRM:

- a) Injuries sustained:
- b) Date of accident:
- 1) Regions injured (if hand or arm, a foot or leg, state whether left or right?.....
1a) If upper limb, please indicate whether Claimant is right or left handed:
- 2) Nature and extent of injuries:.....
- 3) Are the symptoms from which he/she suffers due to: (i) the accident alone, or
(ii) are they traceable to any other cause? If YES, please give details:
- 4) What was the cause of the accident, so far as you know?.....
- 5) What treatment was undertaken?

PLEASE COMPLETE 4, 5, 6, 7, 8, 9, 10 & 11 IN ALL CASES

- 4. Are you aware of anything in your patient's history which may have contributed directly or indirectly to the illness/accident or which may delay recovery?.....
If so, to what degree in percentage terms%
- 5. If the Claimant has suffered from his/her current illness/injuries previously, please state when and treatment given:
- 6. Was the Claimant confined to the house by your directions? If so, please give the dates:
- 7. Was the Claimant under the influence of alcohol or drugs at the time of the accident? Please give alcohol levels if known:
- 8. a) From what date has claimant been **unable to do any work** From: To:.....
due to the sickness or injuries received? First Day of Total Disability Last Day of Total Disability
b) From what date has claimant been **able to do some work** From: To:.....
due to the sickness or injuries received? First Day of Partial Disability Last Day of Partial Disability
If claim is for student, please indicate: a) the date he/she would have been unable to attend school at all,
and b) when at school but not taking part in all activities.
- 9. If patient has suffered loss of sight, speech or hearing, is this total and permanent? YES NO Percentage of loss%
- 10. a) If Claimant has been an In-Patient at a hospital for this condition, please give name of hospital and dates he/she was an In-Patient.
Hospital: Date of Admission: Date of Discharge:
b) Was any part of Confinement spent in Intensive/Cardiac Care Unit? If YES, dates: From: To:
c) Did patient undergo an invasive surgical procedure? If YES, please give details:
- 11. If Claimant has returned to work, please give date total disablement ceased:

Signature: Qualifications: Date:
Address:



ACCESS TO MEDICAL RECORDS/REPORTS

I have read overleaf the explanation of my rights under the Access to Medical Reports Act 1988 and consent to Combined being provided with medical information, including copies of my medical records, from any doctor who has attended me concerning anything which affects my physical or mental health condition.

- I DO
- I DO NOT

wish to see the Reports before they are sent out to the Chief Medical Officer

please tick (✓) one box only. If no box is ticked it will be assumed that you do not wish to see the report.

DATA PROTECTION ACT 1998

- (a) I consent to Combined Insurance Company of America ("Combined") being provided with confidential information, concerning the admission and continuation of the claim, including but not limited to information concerning any physical and/or mental health or condition from any third party.
- (b) I authorise the release of confidential information, including but not limited to, information concerning my physical and/or mental health obtained by Combined to any doctors or specialists appointed by Combined in relation to the claim or to any third party, who requires such information for lawful purposes.
- (c) My signature below confirms my consent to all of the above.

Signature Date

Full Name

(BLOCK CAPITALS PLEASE)

Claim No.

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Website: www.combinedeurope.com

ACCESS TO MEDICAL REPORTS ACT 1988

(or in relation to Isle of Man, Access to Health Records and Reports Act 1993)

Important Notice Please read carefully

Before signing in the space overleaf, you should know that you have certain rights under the Act. These are set out below, but the main points are as follows:

- (a) You can withhold your consent
- (b) You can see the report before it is sent to us, or during the 6 months after that.
- (c) You can ask the Doctor if he will amend any part of the report which you consider to be incorrect, misleading or incomplete. If the Doctor is not prepared to amend it, you may attach your comments in writing.
- (d) The doctor can withhold from you the report, or any part of it, if he thinks you would be harmed by seeing it.

WE WOULD POINT OUT THAT SHOULD YOU EXERCISE YOUR STATUTORY RIGHT TO WITHHOLD YOUR CONSENT, WE WOULD BE UNABLE TO GIVE FURTHER CONSIDERATION TO YOUR CLAIM.

DETAILED WORDING

As, under the terms of your policy, we require completion of a medical report by the doctor who is caring for you, to enable us to deal with your claim, we need your consent by signing in the space indicated overleaf. Before doing so, however, you should read this note carefully, as it sets out your rights under the Act and the procedures for dealing with reports. You do not have to give your consent to our Chief Medical Officer being provided with the report but, if you do, you have the right to tell the doctor you wish to see the report before it is sent to us, in which case the doctor cannot send it to us unless either he has shown it to you, or 21 days have passed without you having contacted your doctor about arrangements for you to see it. Of course, the quicker you act, the quicker your claim can be considered, and we may not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied, if you ask.

If you ask the doctor for a copy of the report, they can charge you a reasonable fee to cover their costs.

Once you have seen a report before it is sent to us, the doctor cannot submit it until they have your consent. You can write to the doctor asking them to amend any part of the report which you consider to be incorrect, misleading or incomplete, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of a report if, in their opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intentions towards you, or if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole of the report which is affected, they must not send it unless you give your consent.

Combined Insurance Company of America

Combined House, 15 Wheatfield Way, Kingston upon Thames, Surrey KT1 2PA

FULL TIME EMPLOYER'S STATEMENT

CLAIM No.....

Employee's name:

If Accident: were injuries
sustained at Work?

YES NO

From what date has employee been
unable to do ANY work due to
the sickness or injuries received?

From first day of
Total Disability

To last day of
Total Disability

From what date has employee been
able to do SOME work due to
the sickness or injuries received?

From first day of
Partial Disability

To last day of
Partial Disability

Please give description of duties performed by employee

Title.....

Employer's
Signature Date.....

Company Stamp